

**H.R. 712; H.R. 1647; H.R. 3083; H.R. 485; DISCUS-
SION DRAFT, SPECIALLY ADAPTIVE HOUSING,
AND DISCUSSION DRAFT, WORK STUDY**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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H.R. 712; H.R. 1647; H.R. 3083; H.R. 485; DISCUSSION DRAFT, SPECIALLY ADAPTIVE HOUSING, AND DISCUSSION DRAFT, WORK STUDY

Thursday, June 20, 2019

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

The Committee met, pursuant to notice, at 2:06 p.m., in Room 210, House Visitors Center, Hon. Mark Takano [Chairman of the Committee] presiding.

Present: Representatives Takano, Brownley, Rice, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Radewagen, Bost, Dunn, Bergman, Barr, Meuser, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good afternoon. I call this hearing to order.

I would like to start by thanking the Veterans Service Organizations for being here. Without your advocacy, the Blue Water Navy Vietnam Veterans Act would not be on the President's desk awaiting his signature.

[Applause.]

The CHAIRMAN. Thank you, everybody, actually. Thank everyone on this Committee. Dr. Roe, thank you especially, and our Republican colleagues. This is a tremendous accomplishment.

We rely on you, the Veterans Service Organizations, to provide feedback and expert testimony on legislation affecting veterans, and today we ask you for the same. The legislation on the agenda for this hearing covers a range of veterans' issues, from health care to educational and housing benefits, to transition assistance. Today, we hope to generate discussion on each of the agenda items, so we can make informed decisions on whether the legislation is ready to be considered in markup.

Four agenda items are related to medicinal cannabis. Now, I believe cannabis must be objective researched, period. Medical cannabis may have the potential to manage chronic pain better than opioids and treat PTSD. However, other research shows that cannabis may significantly affect brain development into early adult. Young servicemembers enlisting at age 17 or 18 and separating from the military at age 22 may be particularly vulnerable to its negative side effects.

I want to make sure that any research legislation this Committee votes on is not written to achieve one outcome or used to fast-track

treatments for veterans. Clinicians need to understand the efficacy of this drug and any negative side effects. In those states that allow medical cannabis, VA doctors should be able to provide recommendations to veterans for medical cannabis programs.

I also place H.R. 3083, the AIR Acceleration Act, on the agenda today, because I have serious concerns about VA's implementation of the AIR Act. We have received no information from VA on the market assessments to give this Committee confidence that the mission when it is scheduled to meet will actually have the data it needs to make informed decisions. It is important that we have a public discussion of these concerns and hear from stakeholders, because I do not believe it makes sense to speed up this process now. VA's lack of transparency should be concerning to us all.

I would also like to highlight two bills introduced by Representative Cisneros that I support, H.R. 2942, that authorizes an existing Air Force Women's Health TAP pilot program, and H.R. 2943 would codify an existing regulation that all VA fact sheets be available to veterans in Spanish.

During a recent visit to the VA Medical Center in San Juan, Puerto Rico, Committee staff saw firsthand why VA should be mandated by law to provide materials in Spanish. I was shocked to learn that key letters, fact sheets, and employee training modules developed to educate veterans and staff on the MISSION Act were only produced and mailed to veterans in English. In Puerto Rico, where Spanish is the predominant language, this means veterans and hospital employees were not notified about the upcoming changes with the MISSION Act and employees were not prepared to implement the law on June 6th. Hospital staff in San Juan, to their credit, translated and reproduced materials in Spanish on their own, because the translation provided by a contracted vendor was poor and inadequate.

The Veterans Crisis Line, a lifeline for veterans thinking about suicide, operates only in English. The Puerto Rico VA Medical Center established its own local crisis line in Spanish, but when my staff called the number on several occasions, no one answered. Well, think about that for a moment: help is only available at the VA in Puerto Rico if you understand English.

According to the 2015 census, on average, 73 percent of Hispanics speak a language other than English at home, and 31 percent of Hispanics state that they are not fluent in English. VA statistics predict an increase in the Hispanic veteran population from 7.4 percent in 2017 to 11.2 percent by 2037. Failing to provide veterans with clear explanations of their benefits in Spanish means Latin veterans will lose out on GI Bill benefits, VA home loans, or health care programs like the MISSION Act. Veterans won't receive their burial benefits if their surviving family members do not understand English. A Spanish-speaking veteran's call to the Veterans Crisis Line would in effect remain unanswered.

So VA should be providing Spanish language materials, but it is falling short in too many cases. And, when I became Chairman of this Committee, I committed to you that we would work to break down barriers for veterans from minority and under-served communities; Mr. Cisneros' bill is one small step towards this effort. It is not enough that this is a VA regulation, we must make this the

law and exercise this Committee's oversight authority to make sure VA is following it.

So I want to just say this slightly different—

[Speaking Spanish.]

The CHAIRMAN. So, that concludes my opening remarks.

Dr. Roe, you are now recognized for 5 minutes to give your opening statement.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman. I appreciate you holding this hearing this afternoon to discuss ten bills, many of which I support, for and including my bill, H.R. 3083, on today's agenda.

H.R. 3083, the Asset Infrastructure Review, or AIR, Acceleration Act would eliminate the requirement in current law that the AIR Commission meet only in calendar years 2022 and 2023.

The AIR Act was signed into law last year as part of the MISSION Act. It established a methodical, objective, transparent process to recommend how the VA health care system could be realigned and modernized to better meet the needs of our veterans. That process was developed in response to a recommendation made in the 2016 Bipartisan Commission on Care, after finding that VA medical sites on average are five times older than medical facilities in the private sector, and have been designed and built to meet markedly different health care needs in a markedly different health care market than veterans experience today. That finding was further supported by a 2017 Government Accountability Office report, which found that the VA health care system is misaligned with the veteran population and no longer well-suited to providing care in many instances.

VA concurred with the GAO in testimony before this Committee later that year and further noted that the majority of VA facilities have outlived their useful life cycle. It is clear beyond a shadow of a doubt that the AIR Act is necessary for those and for many other reasons. That is why every major Veterans Service Organization joined together in support of the inclusion of the AIR Act in the MISSION Act last year.

At the time, it was expected that the market assessments that will underlie much of the commission's work could take many years to complete and, therefore, the commission should not be allowed to meet until 2022 at the earliest. However, in the last several months Secretary Wilkie has testified multiple times before this Committee and before the Senate Committee on Veterans' Affairs that those market assessments will be complete next summer. Because of that, the Secretary has urged Congress to give the AIR Commission the flexibility to begin their deliberations prior to 2022; the AIR Acceleration Act would provide that flexibility. This would give the commission more time to do its work by allowing deliberations to begin before 2022 and extend after 2023, as needed.

Note that none of the other deadlines including in the AIR Act deadlines that were carefully coordinated with the Veterans Service Organizations, who I worked very closely with on every aspect of this legislation, would be impacted by the AIR Acceleration Act.

I am grateful for the support of the Wounded Warrior Project, and Iraq and Afghanistan, the IAVA, on this legislation.

Also, Mr. Chairman, I would appreciate a letter that we received just yesterday from Concerned Veterans For America that it be admitted into the record. At the newest—

The CHAIRMAN. Without objection, so ordered.

Mr. ROE. Thank you, Mr. Chairman.

As the newest VSO representing the most recent generation of veterans, IAVA and WWP are perhaps uniquely positioned to recognize just how critical the AIR Act is to VA's future success and sustainability, and just how much veterans stand to lose by waiting to begin the commission's important work while VA's infrastructure continues to worsen. I thank these VSOs for their support.

That said, I recognize that VSOs have concerns about the AIR Acceleration Act, primarily because they fear rushing the AIR Act process. And while I note that only in government is the thought that starting something 2 years after it was signed in law rushing, I still look forward to beginning the dialogue with them today about that fear and how we can move forward to address their concerns.

And just off script for a minute. It is not just the VA health care system; it is the American health care system is going to have to be re-looked at. Heads in beds actually maximized in 1981 and 1982; in other words, the number of people who were in a hospital bed maximized then. The population has grown 40 percent since that time and we actually have 10 percent—on any one day, 10 percent less people in a hospital bed than we did 40 years ago almost. And why? Because of the changes in medicine, the way we deliver health care, and I am a perfect example of it. I have had two major operations in the last 2 years and spent less than 48 hours in the hospital for both of them.

So it is not just VA and we no longer can support 1100 empty buildings. We need to take those resources and put those resources where the veterans are, into their health care, into other benefits for veterans.

The two other bills that I support on the agenda are draft bills. The first draft bill was sponsored by Representative Rodney Davis and would improve the payment of work study benefits to GI Bill beneficiaries. The idea of this bill came from the student veterans themselves at a GI Bill forum that Representative Davis hosted in his district last year, which I was glad to attend that forum with Congressman Davis, and I commend him for representing the student veterans in his district so well.

The other draft bill is sponsored by my good friend Gus Bilirakis, the Ranking member on Economic Opportunity Subcommittee. It would make needed improvements to the Specially Adaptive Housing Program to help severely disabled servicemembers and veterans adapt their homes to meet their needs.

This afternoon's agenda also includes several bills, including medical marijuana. One of those bills, 712, the VA Medicinal Cannabis Research Act, I fully support requiring VA to conduct research regarding medical marijuana and have said so for many years. And that is why under my chairmanship last year this Committee unanimously reported bipartisan legislation sponsored by

then Ranking Member Walz and me that would authorize VA to research medical cannabis. It is also why I introduced the same bill, H.R. 747, this year after strengthening it to not authorize, but require the VA to conduct research in medicinal cannabis.

However, H.R. 712 includes numerous restrictions regarding what the research VA must conduct on medicinal cannabis should look like. According to VA, those restrictions are inconsistent with the standards and practices of scientific research. It is wholly inappropriate for members of Congress to dictate the research that scientists are being asked to perform and, therefore, I oppose H.R. 712 and express disappointment that, despite my request, H.R. 747 was not included on today's agenda, so that we could have an open discussion about which approach this important issue is most likely to benefit our Nation's veterans.

With that, I thank the witnesses for being here, and I yield back.

The CHAIRMAN. Thank you, Chairman Roe. And we will discuss this more, but I recognize your—I think you have raised some very valid points about the research.

I would now like to welcome non-committee members to our first panel. I see that we have the Honorable Lou Correa, Luis Correa, a Member of Congress from my own home state, California, California's 46th District. We have two other Members, but they are not here, and I will introduce them as they arrive.

So, Mr. Correa, you are recognized for 5 minutes. Go ahead.

OPENING STATEMENT OF LUIS CORREA

Mr. CORREA. Thank you, Mr. Chairman, Chairman Takano and Ranking Member Roe, for inviting me to speak on my bipartisan bill, H.R. 712, the VA Medicinal Cannabis Research Act. I appreciate the chance to return to the VA Affairs Committee where I served in the last Congress to speak on this very important issue on the need of research on medical cannabis as a possible treatment option for our Nation's veterans.

The U.S. Department of Veterans Affairs is in a unique position to pursue necessary research in what cannabis can and cannot do for our veterans.

Our brave men and women return from military service from Iraq and Afghanistan, and many times with both visible and invisible wounds sustained in battle.

Unfortunately, for many of these veterans with PTSD and chronic pain, the use of prescription opioids has been ineffective in providing relief. And, even worse, the use of prescription opioids has led to addiction and even death.

Tragically, VA patients are almost twice as likely to die from accidental opioid overdose than non-veterans.

In California, I have met with many veterans who use medical cannabis as an alternative to prescription opioids and other medical treatment options, and all of them vouch for the therapeutic benefits of medical cannabis and support further research into this issue.

In fact, according to the Iraq and Afghanistan Veterans of America, over 90 percent of their members support medical cannabis research. And more veterans use cannabis for medical purposes, and

it is important that doctors be able to fully advise on the potential benefits and effectiveness of medical cannabis.

Presently, VA doctors can discuss cannabis usage with their patients, but they have very limited federally approved research on which to base recommendations or clinical options.

For that reason, with my colleague and friend Congressman Clay Higgins of Louisiana, we have introduced the VA Medicinal Cannabis Research Act.

The bill requires the U.S. Department of VA to conduct double-blind clinical studies on the safety and effectiveness of medical cannabis. Let me repeat: this bill requires the VA conduct double-blind clinical study on the safety and effectiveness of medical cannabis. The legislation provides a framework for that research to ensure that scientifically-sound studies are conducted on this issue.

And, finally, let me thank the Iraq and Afghanistan Veterans of America, Veterans of Foreign Wars, Disabled American Veterans, and many others for their support of this bill. And I look forward to working with you on this most important piece of legislation.

And, if I may, Dr. Roe, I just wanted to address some of your concerns with this legislation.

I know last year we worked together on some of this legislation and I understand your concern that we are mandating to the VA how to conduct scientific research. Yet, I have to tell you, over the last 2 years and dealing with the VA, they have told us different opinions as to what they can and can't do at the VA. First, they said, we don't have the authority to do the research; then they said, we have the authority to do research.

I am not quite sure who is telling us the truth, where there is a truth, but what we are simply doing with this bill is assuring that there is no bias in the research of medical cannabis, there is no bias on the part of the researchers or on the individuals that are actually being researched. That is what this bill is about, making sure we get good data for our veterans.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Correa, for your testimony.

I now would like to recognize Dr. Roe for 5 minutes to speak about his bill.

Mr. ROE. Thank you. And, Mr. Correa, thank you for your 2 years of service on this Committee and your service in California for veterans there. And I know of no one who has the interests of veterans any more than you do. You and I are good friends, and I respect you and respect what you want to do. And we authorized, Congressman Walz and I, last year the VA to do the studies; they didn't do it.

My concern is just this, is that we don't need to be prescribing from on the high here in Washington how to carry on clinical research. We need to make sure that they do—that the VA not authorizes, but has to study either chronic pain or opioid, a substitute for opioids, or PTSD treatment. And I have read this morning probably a dozen articles on various research that is done around the country. I just don't think that—I know, as a scientist, we shouldn't as politicians be telling the scientists how to design their studies.

I agree with everything you said and your bill and would support it, if it just allowed VA the ability to be able to design their trials based on what they think are the best ways to do it and not how we think are the best ways. And that is all my bill said was that, look, you have to do the studies, but let the scientists at Yale or wherever they are, at whichever medical center or multiple medical centers that are done, that are able to do it.

And, with that, I yield back.

The CHAIRMAN. Okay. I now would like to recognize Mr. Cisneros, Congressman Cisneros, you are recognized for 5 minutes.

OPENING STATEMENT OF GILBERT CISNEROS

Mr. CISNEROS. Thank you, Chairman Takano and Ranking Member Roe. I really appreciate the opportunity to testify about my bill, the Providing Benefits Information in Spanish for Veterans and Families Act.

This legislation would direct the Secretary of Veterans Affairs to make all Department of Veterans Affairs fact sheets available in English and Spanish.

According to the U.S. Census, as of July 1st, 2017, the U.S. Hispanic population is approximately 58.9 million, constituting 18.1 percent of the Nation's total population, making people of Hispanic origin the Nation's largest ethnic and racial minority.

With the changing demographic of the U.S. population overall trending towards a more racially and ethnically diverse majority, the veteran population is diversifying at similar rates. The share of veterans who are Hispanic is expected to double from 7 to 13 percent, according to the Pew Research Center.

With Spanish as the first language of an increasing number of veterans and their families, it is important that the facts sheet offered by the VA are made available. This bill would serve as an important first marker in ensuring veterans and their families with limited English proficiency have full access and information on VA services without burden or barriers, benefits they have rightfully earned.

Additionally, I have been informed by Representatives from this Committee that this issue is of particular importance to veterans in Puerto Rico, in which approximately 300,000 veterans live.

I urge you to join me in support of this legislation, H.R. 2943.

I yield back the balance of my time.

The CHAIRMAN. Mr. Cisneros, thank you for your testimony on your bill.

I understand you have a second piece of legislation that you would like to discuss, so I recognize you for 5 minutes to discuss your second bill.

Mr. CISNEROS. Yes. Thank you again, Mr. Chairman, and thank you again, Ranking Member Roe.

This bill is H.R. 2942, Health for Women Veterans Act. I really appreciate the opportunity to testify about my bill helping to expand and launch Transitional Health—or Health for Women Veterans Act, introduced with my distinguished colleague and fellow vet Congresswoman Chrissy Houlahan.

As a veteran myself, one of my top priorities is ensuring active servicemembers who are transitioning into the civilian world who

are connected to the VA system—well, to make sure that they are connected to the VA and provided with the best education and tools needed to succeed as civilians.

Despite being the fastest-growing cohort in our military community, many servicewomen face unique challenges related to their transition into civilian life. Too often, women veterans report not feeling comfortable seeking woman-specific care in the male-dominant VA health system.

Studies have shown that women veterans do not connect with the VA until approximately 2.7 years post-military service on average or until health issues have manifested, contributing to higher rates of mental health issues. In fact, over 60 percent of servicewomen report that military service has negatively affected their mental health, often due to military sexual trauma and issues surrounding gender isolation.

My bill would require the Department of Veterans Affairs to extend an ongoing pilot program jointly run with the U.S. Air Force under the Transition Assistant Program that educates transitioning servicewomen about women's health care at the VA. Participants of this pilot program have shown higher rates of confidence with the VA, and reported an increased likelihood to use the VA health care and resources.

Specifically, the bill would mandate an extension of the program across all service branches and require a report on the feasibility of making it permanent. It is time our women servicemembers and veterans receive the care they need.

I would like again to share my sincere appreciation for my colleague Representative Houlahan for her work with me on this effort to expand transitional assistance for women servicemembers and veterans. Under her leadership, we secured a complementary provision in the fiscal year 2020 National Defense Authorization Act as approved by the Committee on Armed Services last week, requiring DoD to expand and encourage participation in this program. I look forward to closing the loop on the VA's responsibility in this pilot program through this Committee as well.

And the last thing I will say is that it was testified in front of this Committee, I believe maybe the Health Subcommittee, but this program is working in the Air Force, this pilot program, and it is time for us to expand it into the other services to make sure that our women veterans are getting the support that they need when they transition into civilian life.

I thank you all for the consideration of my bill and I yield back the balance of my time.

The CHAIRMAN. Thank you, Mr. Cisneros.

Congressman Bilirakis, I understand you have a bill you would like to present.

Mr. BILIRAKIS. Yes.

The CHAIRMAN. You are recognized for 5 minutes.

OPENING STATEMENT OF GUS BILIRAKIS

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I appreciate it. Again, thank you for recognizing me and thank you for putting my draft bill, the Ryan Kules Specially Adaptive Housing Improvement Act of 2019, on today's agenda.

This bill, which I will be introducing soon with Chairman Levin—by the way, I commend you for selecting Chairman Levin as the Chairman of the Economic Opportunity Committee; he is doing an outstanding job, Mr. Chairman. So this bill would make needed improvements to the VA's Specially Adaptive Housing Program.

This benefit provides funding to severely service-connected disabled and services to adapt their homes and meet the needs of their disability. This grant can be used on all kinds of adaptations, to include grab bars, wheelchair ramps, lifts, lower counter tops, wider doorways, and other necessary home adaptations.

While this great benefit has helped thousands of veterans over the years, there is a need to make improvements. Many of the ideas proposed in this bill came from testimony provided last Congress to the Subcommittee on Economic Opportunity by several VSO witnesses.

One of these many witnesses was Mr. Ryan Kules of the Wounded Warrior Project. Mr. Kules is an Iraq War veteran of the U.S. Army and is a recipient of this grant. And Mr. Kules is here.

Mr. Kules, thank you so very much for your input. I am so excited about this bill and we are going to get it across the finish line. Can you please wave?

Thank you so very much, sir. Thank you for your service to our country and your continued service.

And I want to thank the Wounded Warrior Project as well. I thank you and the other VSOs who testified, especially the Paralyzed Veterans of America, for their suggestions on how to improve this program, very important program.

This bill would require prioritization when processing SAH for those with serious life-threatening illnesses such as ALS, better known as Lou Gehrig disease. It would also double the number of times a veteran may use this grant from three to six times, and increase the base amount of funding available to participants by 15 percent.

Finally, this bill would authorize VA to provide a second part of funding for veterans 10 years after they use the SAH grant to make further improvements if they need more assistance.

While I know that this bill is not the perfect remedy to address every issue some veterans have within the SAH program, I am hopeful that this bill will be viewed as a down payment on much-needed reforms that will help the most severely disabled veterans live more independently in their own home. That is the goal, Mr. Chairman.

So I want to thank you for agenda-ing me this draft and I look forward to the discussion today. I yield back the balance of my time.

The CHAIRMAN. Thank you.

We have—I think that concludes the presentation of bills from our first panel. If there are any questions from members of the members who presented on the first panel? I don't see any and we will move on to the second panel. All right, so we will move on to the second panel.

The second panel consists of members of our Veterans Service Organizations and a clinical expert. I would like to call up to the

table Mr. Adrian Atizado, Deputy National Legislative Director of Disabled American Veterans; Mr. Travis Horr, Director of Government Affairs of the Iraq and Afghanistan Veterans of America; Mr. Carlos Fuentes, Director, National Legislative Service of the Veterans of Foreign Wars; Mr. Derek Fronabarger, Director of Government[DF1] Affairs at the Wounded Warrior Project; and Dr. Igor Grant, Director for the Center for Medicinal Cannabis Research at the University of California.

Are we all situated there? We will give people a chance to get settled. I see Mr. Atizado is settled in.

Mr. Atizado, you are recognized for 5 minutes.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Thank you, Mr. Chairman, members of the Committee. I would like to thank everybody here for inviting DAV to testify at this legislative hearing.

DAV is a non-profit Veterans Service Organization. We have about more than one million wartime service-disabled veterans and they are all dedicated to making sure veterans lead high-quality lives with respect and dignity.

We are pleased to support both the Medicinal Cannabis Research Act and the VA Survey of Cannabis Use Act based on DAV's Resolution No. 023. This resolution calls for more comprehensive and scientifically rigorous research into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans.

Medical literature has thus far been rather inconclusive about the effectiveness of marijuana for improving symptoms of chronic pain and PTSD in veterans, noting that there are both risks and in some cases benefits, and many veterans report the use of medical cannabis for these purposes is in fact beneficial to them. So we want to ensure the survey and the research contemplated by these bills will yield scientifically-valid and reliable data, and we do urge this Committee to work with the research community on any issues with regards to research design. Correspondingly, we urge VA to recognize its current effort in this area is not meeting the needs of veterans.

These bills should be treated as an opportunity to find the right balance between the glacial movement of research in this particular area and the need for expedience, with the health and well-being of our Nation's veterans being on the line.

DAV also supports H.R. 485, which addresses VA's routine denial of medical ambulance reimbursement claims, because the Department does not consistently apply its existing authority to pay for such transportation to a VA facility for additional care. In light of VA's inconsistent performance in administering this authority, we do urge the Committee to include an evaluation and reporting requirement of VA's actual performance in executing the intent of this legislation, and it should be conducted by an entity independent of the Veterans Health Administration.

DAV is proud to be a strong supporter of H.R. 2942 and thanks Congressman Cisneros for introducing this bill that would build from a successful ongoing transition assistance pilot program between VA and the Air Force.

DAV made this policy recommendation in our report, “Women Veterans: The Long Journey Home.”

Our report also recommends the TAP program address employment, educational opportunities, and gender-specific information needs in additional workshops 6 to 12 months after separation. We believe this kind of training may arm women veterans with information they need to prevent or otherwise minimize transition challenges, and prevent health and mental health conditions from getting worse or leading to tragedies such as homelessness or even suicide, which too many of our veterans, both male and female, are lost to.

DAV strongly opposes H.R. 3083, the VA Asset and Infrastructure Review Acceleration Act, which would eliminate the prohibition for the Asset and Infrastructure Review Commission to convene before 2022.

By removing the time constraints on the commission, VA will accelerate the asset and review process and, in doing so, undercut one of the key elements of the compromise that allowed the AIR Act to be part of the MISSION Act to begin with, and that is to have a truly transparent, inclusive, deliberative, and data-driven process.

VA has already shown its proclivity to move unilaterally or otherwise not meaningfully consult with veterans and Veterans Service Organizations in other matters regarding the VA health care system on which our members depend.

The timing within the AIR Act is another key element to guard against premature decisions on VA’s health care infrastructure. The new integrated networks under the VA MISSION Act must first be optimized. Note it was just rolled out a few weeks ago. The new patient demand and referral patterns that will result because of this new integrated network must yield sufficient historical data before accurate forecasting and market assessments can begin the process to decide the future alignment of VA’s health care infrastructure.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions the Committee may have.

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

The CHAIRMAN. Thank you, Mr. Atizado.

Mr. Travis Horr, you are recognized for 5 minutes.

STATEMENT OF TRAVIS HARR

Mr. HARR. Thank you, Chairman Takano, Ranking Member Roe, and members of the Committee. On behalf of Iraq and Afghanistan Veterans of America and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data and experiences on the pending legislation before the Committee today.

While I serve as Director of Government Affairs at IAVA, I am also a Marine Corps veteran. I enlisted in the infantry in 2007 and deployed to Helmand, Afghanistan in 2010. The issues of the Post-9/11 generation are my issues. I was exposed to burn pits on a remote patrol base, I utilized the Post-9/11 GI Bill, and I have seen first-hand the positive impact that medicinal cannabis can have.

Sadly, I have lost too many of my friends to the veterans' suicide epidemic. These issues are personal to me and I am proud to represent IAVA's views in front of the Committee today.

In IAVA's latest member survey, a resounding 90 percent believe cannabis should be researched for medicinal uses. IAVA members are vastly in support of cannabis research and it is time for the VA to catch up.

For these reasons, the VA Medicinal Cannabis Research Act is the centerpiece of IAVA's Cannabis for Vets campaign. Without this research, we are unable to make policy decisions that could improve the lives of veterans.

One such veteran whose life was improved through medicinal cannabis is Army veteran and former IAVA intern Julie Howell. Her story, in her own words, follows.

"For years after I returned from Iraq, I struggled to sleep through the night. As it turns out, I suffer from something known as maintenance insomnia. I would fall asleep, but would wake for hours in the middle of the night, and then fall back asleep right before needing to wake up. Thanks to California passing legislation regarding medicinal cannabis, I now have access to a product that I ingest that helps me sleep through the night. I do not use cannabis recreationally, but this product has allowed me to thrive. I am currently working through a master's degree in public policy with the hope of assisting veterans like me."

In addition to Julie, over 100 IAVA members have shared their stories of their cannabis use, with dozens sharing how VA retaliated against them or mishandled them. In fact, it is because of these reasons that Julie herself, even after advocating here on Capitol Hill and back home in California, still hasn't talked to her VA doctor about her use, and Julie isn't alone. Twenty percent of IAVA members report using cannabis for medicinal purposes and of those only 31 percent have talked to their doctor about it.

If veterans are unable to receive the care that they deserve, then they will go around it. We must ensure that VA clinicians can have open and honest discussions with their patients.

For these reasons, IAVA is proud to support the Veterans Equal Access Act.

IAVA is also supportive of the VA Survey of Cannabis Use Act, and H.R. 2677 to increase clinician training for medicinal cannabis.

Millions of veterans also rely on VA for their health care. We need a system that leverages the use of these new technologies and streamlined processes and enable VA to respond to the needs of today's veterans. Even so, the best technology will not save a system if it is built upon outdated structures. Because of these reasons, IAVA supports the AIR Acceleration Act, which will allow the commission to be nominated, appointed, and start their important work as soon as possible. However, we strongly recommend that the Secretary not move forward with this process until the VA completes local capacity and commercial market assessments with full stakeholder consultation, and stabilizes community care efforts.

Additionally, IAVA is supportive of H.R. 2943, to ensure that all VA fact sheets are produced in both English and Spanish; H.R. 485, to expand VA's ability to reimburse emergency ambulance

services; and the draft legislation concerning specially adaptive housing.

Data shows that women veterans on average do not seek support from VHA until 2.7 years after leaving service. Women veterans also tend to face more health-related challenges than their male counterparts. And most importantly, since 2001, the suicide rate for women veterans has increased by 85 percent while the suicide rate for males has increased by 30 percent.

It is because of these reasons that the VA Air Force Women's Health Transition Training pilot was created. It is aiming to provide servicewomen with a deeper understanding of women's health services within the VA system and allow a warm handoff between DoD and VA.

The Helping Expand and Launch Transitional Health for Women Veterans Act is consistent with IAVA's groundbreaking She Who Borne the Battle campaign, to recognize the service of and fill gaps in care for women veterans. Women veterans are the fastest-growing cohort of veterans and it is critically important that they receive the same care as their male peers. IAVA supports H.R. 2942.

Veterans are proven to be more productive and have higher retention rates once hired into careers, and ensuring that they have appropriate training and degrees is paramount to their success. The successful transition to the civilian workforce often begins on college campuses.

To this end, IAVA is supportive of the draft legislation that addresses and improves the VA Work Study program. We believe that by using the Department of Education as a model VA will be able to make work study payments more reliably. Ensuring that veterans are supported on campus is of utmost importance.

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

[THE PREPARED STATEMENT OF TRAVIS HARR APPEARS IN THE APPENDIX]

The CHAIRMAN. Well, I am impressed, 5 minutes exactly.

[Laughter.]

The CHAIRMAN. I was like, will he do it or not?

Thank you, Mr. Horr, for your very exact timing.

Mr. Fuentes, you are recognized for 5 minutes.

STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Thank you, Mr. Chairman. I first want to say kudos with the Spanish. I think you may be speaking better Spanish than I do, but well done.

Chairman Takano, Ranking Member Roe, and members of the Committee, on behalf of the 1.6 million members of the VFW and our Auxiliary, I would like to thank you for the opportunity to present our views before the Committee.

The VFW is proud to support the VA Medicinal Cannabis Research Act of 2019. VA's over reliance on opioids to treat chronic pain and other conditions has, unfortunately, led to addiction and even death. To its credit, VA has made a concerted effort to reduce the reliance on pharmaceutical treatments, now VA must expand

research on the efficacy of nontraditional alternatives to opioids, like medical cannabis and other holistic approaches.

VFW members tell us that medicinal cannabis works, and it is a better alternative than the cocktail of drugs the VA provides. The VFW and Student Veterans of America Fellow Christopher Lamy, an Army veteran and LSU Law School student, focused his semester-long research on medicinal cannabis. Chris found that veterans experience chronic pain at 40 percent higher rates than non-veterans and, if not properly treated, such chronic pain leads to depression, anxiety, and decreased quality of life.

Chris also discovered that veterans fear they may be wrongfully denied care or have their care altered without their consent if they discuss their use of medicinal cannabis with their VA doctors.

To ensure participants of this study do not have their VA health care impacted, the VFW recommends prohibiting VA doctors from denying or altering treatment to patients without consultation and concurrence of such veterans.

The VFW also supports the Veterans Reimbursement for Emergency Ambulance Service Act and has a recommendation to improve it. The VA emergency transportation reimbursement process is cumbersome and unreasonably long. Veterans who believe they are experiencing an emergency should not be delayed or deterred from contacting 911 for emergency assistance because VA may refuse to cover the cost of emergency transportation and leave them in crippling health care debt.

This bill would rightfully streamline VA's authority to reimburse emergency transportation costs; however, it would require that veterans be taken to the closest and most appropriate medical facility as a prerequisite for reimbursement. Veterans experiencing emergencies typically don't have the ability to influence where they are taken. For that reason, we would recommend removing that restriction, so that veterans aren't forced to pay ambulance fees simply because the VA and ambulance service can't agree on what constitutes closest and most appropriate.

The VFW fully supported the Asset and Infrastructure Review, or AIR, provisions of the VA MISSION Act of 2018. They are important to fully examine VA's aging infrastructure and determine what changes are needed to improve the high-quality care VA provides veterans. However, we would be very concerned with expediting this process. It is vitally important that the AIR process be implemented correctly. The VFW warns Congress not to rush the AIR process, because it may cause irrevocable harm to the care and benefits America provides veterans.

The VFW supports draft legislation to expand the VA's Specially Adaptive Housing grants, which help veterans with service-connected conditions live independently in barrier-free environments by providing critical housing adaptation. The VFW is pleased this would increase the number applicants VA is able to approve annually from 30 to 120; however, we do not think a cap is needed for this important. Every veteran who needs to adapt their house because of a service-connected condition should have the ability to do so.

The VFW also thanks the Committee for its intention on a VA Work Study program, which student veterans use to supplement

their income. This important program must be improved to ensure veterans receive their payments on a timely basis. VA's outdated, paper-based payment process forces veterans to wait several weeks or months to receive their work study payments, which they need to make ends meet.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you or members of the Committee may have.

[THE PREPARED STATEMENT OF CARLOS FUENTES APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. Thank you, Mr. Fuentes.

I would now like to recognize Mr. Fronabarger for 5 minutes.

STATEMENT OF DEREK FRONABARGER

Mr. FRONABARGER. Chairman Takano, Ranking Member Roe, distinguished members of the Committee, thank you for inviting Wounded Warrior Project to testify about legislation before this Committee this afternoon. While there are many significant bills and issues being considered today, and our written testimony outlines our stance on each of them, Wounded Warrior Project would like to use this time to highlight one bill that is extremely important to us, the Ryan Kules Specially Adapted Housing Improvement Act of 2019.

As you already know, he is currently sitting directly behind me and I invite you all to speak with him after the hearing to better understand his personal story. Retired Army Captain Kules is 24 years old and newly married when he was injured in Iraq in 2005. While on patrol, an IED struck his vehicle. In that attack, Captain Kules lost his right arm and left leg and fellow servicemembers from his unit. While this was a tragic loss, this event did not define him or hold him back from leading a productive life.

After multiple surgeries and rehabilitation, Captain Kules is ready to transition into civilian life. And in 2019, he was in the position to purchase a home in the DC area for his growing family. He used the specially adapted housing grant to alter this home to meet current needs. The key phrase being his current needs. Unfortunately, the existing SAH grant does not account for future needs of the catastrophically injured veteran population.

Although Captain Kules was provided with \$64,000 through the VA SAH grant, there was a gap of nearly \$40,000 that was needed to cover in order to make necessary home modifications that would ultimately total more than \$100,000.

Captain Kules would then move six years later to a new home after he and his wife welcomed their second child into their family. As is the case for some homeowners, the Kules family did not recoup the cost of their home adaptation improvements when they sold their first house. As a result, Captain Kules and his family were required to financially pay for the new adaptations. These new adaptations would total more than \$90,000 for a second home.

Catastrophically injured veterans should not be obligated to pay for disability accommodations due to injuries sustained while service to this country. The SAH grant program honors that commitment but it does not reflect the fact that many veterans, like other adults in this country, will have needs that change. In this case,

younger critically injured veterans will age, many will marry, and some will be fortunate enough to grow families with children.

Injured veterans can also be expected to have disabilities that worsen over time. Adaptations for one stage of a disability may not be suitable for later stages and new adaptations will cost money. Additionally, we want warriors to thrive in their workplace and personal lives. For those who seek new and better opportunities in life and career, relocation has to be an option. It is, in our estimation, unreasonable to expect a veteran to buy a home and never leave. Therefore, we are pleased to see that this draft legislation before the Committee today addresses the points raised in this testimony.

The bill would allow previous beneficiaries the opportunity to refresh their specially adapted housing grant every ten years. This means that veterans can update or move homes and not be expected to pay for adaptations. Moreover, this bill raises the current grant amount of \$85,000 to \$98,000, which falls in line with what home adaptations can cost. It will also eliminate the three time use cap that restricts the full and intended potential of this program.

If passed, this bill would ensure that when critically injured veterans need a new home, whether it is because they have had more children, found a different job, or retire, that they will not be expected to pay for these home adaptations themselves. This benefit is reserved for those catastrophically injured and who deserve our assistance throughout their entire life, not just one portion of it.

On behalf of Wounded Warrior Project, I thank the Committee and its distinguished members for the invitation to testify. Additionally, a special thank you to Congressman Bilirakis and Congressman Levin for your continued work on this legislation. We look forward to any questions this Committee may have.

[THE PREPARED STATEMENT OF DEREK FRONABARGER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Fronabarger. Dr. Grant, you are recognized for 5 minutes.

STATEMENT OF IGOR GRANT

Dr. GRANT. Thank you, Chairman Takano, Ranking Member Roe, and distinguished members. Good afternoon. My name is Igor Grant. I am a physician, neuro-psychiatrist, and professor at the University of California, San Diego, where I direct the center for medicinal cannabis research. During my career, I also served three decades as a staff physician at the VA San Diego Medical Center.

Some of the prevalent health problems of our veterans include chronic pain, post-traumatic stress disorder, traumatic brain injury, as well as sleep disorders. Our veterans have not always found the treatments that we offer them to be fully beneficial and they therefore sought recourse outside the VA medical framework, including with medicinal cannabis in states where it has been legalized.

I am here today to provide you with my medical opinion as to the current state of knowledge on medicinal cannabis. Clearly, this is a controversial area, but there are important facts that are emerging. The Center for Medicinal Cannabis Research at UC San

Diego was established following the passage in 1996 of the Compassionate Use Act, which was California's initiative to enable medicinal cannabis.

We have since completed eight different shorter term clinical trials with cannabis provided to us by NIDA through their drug supply program. As you may know, NIDA is the only legal source of cannabis for medical research. Our studies found that THC contained in cannabis, ranging in strength from two percent to seven percent showed benefit—type of chronic pain called neuropathic pain, which is sometimes difficult to control with traditional medicines.

Our results dovetailed with emerging data from other investigations, as well as the 2017 report from the National Academies of Sciences, Engineering and Medicine. Now, that report also noted that there was some evidence for benefits for certain sleep disorders, particularly where pain was a factor and possibly for anxiety control, including PTSD.

As you know, most recently cannabidiol, which is a non-psychoactive constituent of cannabis has been shown to be effective in control of certain uncommon intractable epilepsies of children. We have started, or will be beginning studies soon, to determine whether THC, THC CBD combinations, or CBD alone may be helpful in the treatment of some symptoms of PTSD, psychosis, anxiety, autism, essential tremor, and sleep disorders.

Another area of increasing interest, as has been mentioned already is the possibilities the cannabinoids may have a so-called opioid sparing effect. What this means is it may be possible that the administration of cannabis or cannabinoids may reduce requirement for opioids or potentially completely substitute for them.

Now, in summary, I would recommend to you that the area of medicinal applications of cannabis and cannabinoids have matured to the level that it is now clear these drugs can be helpful for some conditions, including conditions that are found in moderately high prevalence among our veteran population.

As such, it is my opinion that the VA would be benefitting veterans by making sure providers are informed of the state of medical science concerning the cannabinoids and that ultimately providers are authorized to recommend these products, where that is legal and medically and scientifically justified.

This leads me to my final comment. It is essential, as everyone has said previously that high quality medical studies continue to be done in this area. I recommend that the VA work closely with academic universities that have expertise in the area to pave the way to a better understanding of efficacy and limitations of these products. It is important, also, to focus on specific cannabinoids, their combinations, their pharmacology, which we don't know a lot about, particularly as it is influenced by root of administration and interaction with other medicines, as well as understand the optimum duration of treatment.

May years ago, when I was in training as a psychiatrist, I learned about the VA's landmark role in determining the value and limitations of anti-psychotic medicines in the treatment of schizophrenia. I believe the VA, with its academic partners, can be at the forefront again of creating a better understanding of the place of

cannabis and cannabinoids in addressing the health needs of our patients.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF IGOR GRANT APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Doctor. And you hit the zero, just five minutes exactly. All right. Thank you. I am going to begin the questioning. I recognize myself for 5 minutes.

I will start my question with Mr. Fuentes, so the VFW. Your testimony states that the VFW members have no indicated that lack of Spanish language materials present a barrier to accessing benefits. Has the VFW recently spoken to its members in Puerto Rico about the Mission Act and whether veterans understand the new law?

Mr. FUENTES. Thank you, Mr. Chairman. We reached out. We haven't heard back yet exactly on the barriers to access. Just to be clear, the VFW supports eliminating all access—all barriers to access to care and benefits for veterans. This is just not one that we have been hearing about often.

The CHAIRMAN. Okay. So let us know what you hear from your members from Puerto Rico. Has the VFW called the Spanish language veteran's crisis line in Puerto Rico?

Mr. FUENTES. I have not, but I will do so when we get out of here.

The CHAIRMAN. Okay. All right. They are probably going to turn it on now. That will be—we put them on blast right now. I haven't used that word since I was a teacher, "Put them on blast." I don't even know if they still use that, the students. Do you have any other recommendations to improve the bill?

Mr. FUENTES. We do. So the VFW has posts in Puerto Rico, also in Panama, but throughout southeast Asia, in Europe, and even in Australia, where their English is a little bit different too. But we recommend just do an analysis to determine if it is more than just Spanish. I mean, VA does have a post—I am sorry, a CBOC in the Philippines and some of its literature in Tagalog as well. So maybe there is a need elsewhere. It would be good to do an analysis to determine if there are other languages that could be barriers as well.

The CHAIRMAN. Okay. Well, thank you. Thank you for that.

I would like to go to the—is this on the third panel? This one? This question here? Okay, great.

We all want to update and right size VA's medical infrastructure, but in an abundance of caution, without understanding the impact of the access standards, without knowing if they are assessments will accurately depict veterans' medical needs today and into the future, and both VA's and the community's capability to supply some or all of the care, I feel that this is the wrong road to go down.

What are your chief concerns with accelerating the timeline of the Air Act Commission? And I want to just have all of the VSOs, starting with Mr. Atizado to give kind of a brief answer to that.

Mr. ATIZADO. A brief answer?

The CHAIRMAN. Well, what you can. I have two and a half minutes.

Mr. ATIZADO. Mr. Takano, listen, I thank you for that question and I appreciate the comments that Ranking Member Roe has made about the bill. You raised the issue about whether their role is going to help or hurt the infrastructure realignment of the VA and I think—our impression is if you allow commission to meet without the preliminary work ready for them then there is additional pressure to create the preliminary work. And the kind of work that needs to be done is quite complex. It is a heavy lift for VA. And the information from which they are trying to gather that data for the commission still has not been—it is still not there. There is no reality for that.

This Committee is very well aware of VA's ability to forecast community care. It has come to VA a couple of times over the last several years for emergency supplemental funding for care in the community through the Choice Act. There is just not enough data in VA's health care system to forecast what the demand is going to be like in the Choice program. And now we have a new program with, as you had mentioned, different eligibility criteria.

This new network has not been integrated. It hasn't been optimized. The behavior patterns and the demand on VA for health care because we are allowing a fivefold increase in a number of veterans who would otherwise be eligible for community care, that kind of data is not going to be had by VA for at least two or three years. That is what they need to do proper forecasting, accurate forecasting.

And if we are to look at and realign VA's health care infrastructure into the future by using historical data, I would think that we would want to make sure we use valid and reliable data. And that is what we are most concerned about. There will be pressure to accelerate and we have seen what VA has done in times of pressure to perform and it has not yielded very good results for our members.

The CHAIRMAN. Well, thank you. I want to be consistent with myself. I am out of time, so I want to just go ahead and recognize Dr. Roe, even though I really want to hear from the other VSOs, their response to this question. Go ahead, Dr. Roe, 5 minutes.

Mr. ROE. Thank you. I am going to go quickly and put my doctor hat on first. And Dr. Grant, thank you for the work you have done with our veterans over the years, the decades of years you have been spent doing that. I have—look, every single person up there I think wants medical marijuana, cannabinoids studied. The question is how you do it. And I am just going to ask—and let me just introduce this with the NIH.

U.S. Food and Drug Administration hasn't approved marijuana, the plant, for treating any health problems. However, some states and the District of Columbia allowed its use for certain health purposes. While the marijuana has therapeutic benefits and outweighs the health risks is uncertain.

And as a physician, let me just go over how complicated this is. Here is a Yale study that I have right here. And individual, personal testimonials are good. They can head you in a direction, but they are not science. And here is—basically this Yale study says

that stopping marijuana during the treatment and contrast was associated with the greatest improvement in PTSD. Our findings do now suggest, however, that marijuana is associated with improvement in PTSD. Previous evidence suggests that marijuana improves PTSD symptoms come from—reports. Another possible interpretation of this data is that marijuana use in patients with PTSD provides transient relief, but the subsequent periods of withdrawal contribute to a worsening of baseline symptoms.

Now, this is what—I have read 15 articles this morning in a couple of hours. It is very confusing. What I would like to do is to take the shackles off Dr. Grant and the other scientists that are out there, and don't prescribe to them how we do these studies, but do have a study on whether you can reduce opioids. And I do have—multiple studies, actually, would be better as you well know in different populations to refute or to—look, it may work very well. I don't know from reading all of this. And literally, I spent two hours this morning doing that, reading, and I have got the articles right here in my binder.

Dr. Grant, would you like to be constrained or would you like to be allowed just to open up and study this, an expert like you for 30 years, would you like me telling you how to do it or would you like to allow the scientists to figure out how to do it?

Dr. GRANT. Am I allowed—I don't like to be told what to do, but that is just my personality.

You know, I think it is right that first of all, one should get down to the concepts that need to be clarified. And these include things that have been mentioned already, for example, are there particular conditions that particularly are benefitted. If so, for how long? Are there restrictions on age, for example, or co-morbidities, like if you have diabetes and so on and so forth.

Another set of questions relates to the compounds themselves. It is important to have a certain strength of THC, CBD, some mix of those things? We really don't know that. Another has to do with route of administration. Not everybody is smoking marijuana anymore. In fact, okay, there is vaping, but a lot of it is being taken by mouth.

We know much less about the whole pharmacology of these drugs taken by mouth. And we also don't know much about what happens to the endo-cannabinoid system, our own internal signaling system and physiology in response to these things.

My own thought would be that what one needs to do is really set up some kind of centers of excellence or something of that nature, as the VA has done with some other topic areas where you could look at this from many perspectives and at different parts of the country and look at different populations.

That might be an approach that would bring together a lot more things than trying to do everything in one study. Having said that, if it is kind of do this study or zero, I guess I would prefer to see this go forward than nothing happen. So I don't know if that answers your question.

Mr. ROE. I would rather do it right and I think what you mentioned is right.

I am just going to make a couple because I have very little time left, but just on the Air Act, changing the dates or expanding the

time available for the commission would not in any way impact the status of market assessments, which will be done next year.

And I spoke to the secretary about this at length. His concern is you get the market assessments that are done next summer and by the time this gets going, those market assessments are out of date. That is his major concern. And actually, this will give us a time to push even further.

Look, this is a big undertaking. I totally get that. And you all know me well, and everybody at that dais I think does. I have said a thousand times, I would rather go slow and get it right than go quick and get it wrong, just like the Mission Act and everything else. So there is no rush, but I think waiting is not going to change.

And I appreciate your comments. I yield back.

The CHAIRMAN. Thank you, Dr. Roe. I now would like to recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman. Dr. Grant, have you actually looked at the requirements of the Cannabis Research Act we have today? There are some objections from the VA about the way the bill is written and the types of studies it would mandate. I think that is what Dr. Roe was asking about. Are you familiar with what the bill actually calls for?

Dr. GRANT. Yes. I have it here and I have read it. I don't say—I can't tell you I have memorized it, but I have it and I have read it. Yes.

Mr. LAMB. This isn't a pop quiz. I was just trying to get a feel for whether you, just as a physician doing research and practicing in this area, do you share the same concerns that the VA is telling us, which is that it sort of forces them to do too many things at once as opposed to earlier, smaller, more controlled trials?

Dr. GRANT. Well, as I said earlier, I think what is in this bill is very ambitious. It has a lot of elements to it. And as you know, in science, you never know exactly where things are going to go. You have to be positioned to move in different directions. It would be my personal preference that there be outlined, "Here are the things we want to have answers to," and then develop an approach to that.

But having said that, I will repeat what I said before, it is critically important to do this kind of work. And if this is the path forward and everything else will, you know, devolve into five years of discussion, then it is better to do this than to do nothing. But it would be preferred to have a more multi-pronged approach, slightly less prescriptive approach as a scientist.

Mr. LAMB. Thank you. That is very helpful. Now, in your testimony when you talked about the possibility that cannabinoids could have an opioid sparing effect and the need for further research in that area, could you explain maybe in a little bit more detail what is the state of knowledge or certainty as it exists now with respect to the potential for cannabinoids to have that effect? Have there been early initial studies? Is that what your comment is based on or is there still sort of an unknown?

Dr. GRANT. Well, first of all, there are pre-clinical studies, animal studies, that make it clear that there is a reduction in an animal's intake of opioid in pain models of various kinds when cannabinoids are administered simultaneously. So there is pre-clinical data.

I think the clinical data are still very preliminary and really relate a lot to these indirect surveys that you have read about where opioid use may or may not decrease in certain states where medical marijuana exists, and also the testimony of physicians in pain clinics that say that, "Gosh, I have a number of patients that I have not been able to wean off of these opioids because they are using medicinal cannabis." And that is certainly true at our center. But I don't consider that a definitive study.

Mr. LAMB. Right. Has that been true in your own experience or is that mainly reported to you by colleagues?

Dr. GRANT. Well, I am not a pain physician myself but one of the pain physicians who runs our pain clinic is part of our center and he has reported this, that he has been able to reduce opioid prescription and in some case discontinued totally, in people who have taken medicinal cannabis. Again, this is not a formal study, though.

Mr. LAMB. Right. Do you know if that is typically combined with other non-opioid methods of treatment or has that been—from what you know, has that been sort of solely attributable to the use of the cannabinoid?

Dr. GRANT. Well, again, I don't know about other clinics. In ours, it is a comprehensive program. It does also involve behavioral approaches and such things. But even adjusting for that, it seems like the cannabinoids may be helpful. Certainly, I think the pre-clinical data is very suggestive.

Mr. LAMB. Great. Thank you very much, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. Lamb. I now recognize Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Mr. Fuentes, can you please tell us why you believe it is important to prioritize SAH grants for veterans with serious illnesses such as ALS?

Mr. FUENTES. ALS is one of those conditions that deteriorate very quickly. And unfortunately, VA is limited to 30 grants per year today and the process takes a good long time as well. So not only does it progress really quickly, so we want to make sure those adjustments are done very quickly, it could also take years because they didn't get in before the 30 grants were approved.

Mr. BILIRAKIS. Okay, thank you. And I understand that, you know, we are raising the amount of grants anyhow overall under this legislation. But I am not sure whether the caps apply for ALS. But in any case, we actually covered this, Mr. Fronabarger, you actually covered this in your testimony, but it is definitely worth mentioning again. There is no question.

Why do you believe the reinstatement of SAH benefit ten years after the veteran's initial grant would be helpful to veterans?

Mr. FRONABARGER. Absolutely. And I appreciate that question, Congressman.

As many of you know, veterans normally do not just stay in one location. Specifically, our population, we deal a lot with the injured, ill, and wounded of today's generation. So we don't find it, I guess, normal for someone to adapt their first home and then stay there until they pass away, hopefully at a very, very old age.

So with every 10 years, that lines up with about the average house an American homeowner will own, anywhere between five and six. So if you get injured at 30, but by the time you are 90, you still have that benefit going on and you fall in line with the average American. So every 10 years is kind of how we came up with that and we feel that it is an equitable way to honor those veterans.

Mr. BILIRAKIS. Thank you very much. And another question for you, sir. How does the current three time usage limit or cap on the SAH grant impact a veteran's ability to adapt his or her home?

Mr. FRONABARGER. Thank you for that, Congressman. Currently the SAH grant has a three time usage cap, as you said. The benefit is up to \$85,000. So right—as now, the veteran can use—if they need \$20,000 to adapt their home, they can use that \$20,000 and they have two more usages up to that cap.

So for those that are injured but don't require the entire amount, changing that from three to six can help them because \$20,000 times three is \$60,000. They are not reaching the full potential of what they might need if they move. So we look at that as a beneficial way for veterans to utilize the full benefit—

Mr. BILIRAKIS. More flexibility?

Mr. FRONABARGER. Absolutely. Yes, Congressman.

Mr. BILIRAKIS. That is—yeah, very important. Thank you very much. And again, we have a lot of non-profits that do a wonderful job of building homes for vets, but raising the amount by 15 percent and giving the veteran the flexibility, as well. And then again, the 10 year rule under this bill is wonderful to have the full amount again after 10 years. It is just something that the veteran deserves. It is a quality of life issue. So I appreciate it and I would like to see the whole Committee co-sponsor the bill. I appreciate—for that matter, the whole House.

Thank you very much and I don't know if anybody wants the rest of my time, but if not, I yield back.

The CHAIRMAN. I will take it back. Thank you.

Mr. BILIRAKIS. All right. Take it back. You got it. You got it, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman. And I would like to thank my friend, Mr. Bilirakis, the Ranking member. I am honored to have the opportunity to help introduce this legislation.

And I wanted to begin by asking about it and then move to cannabis with the time I have remaining. I appreciated the testimony, as always, from all the VSOs today in sort of the discussion draft. Mr. Fuentes, in your written testimony, you talked about two difficulties. One was long wait times and the other was—we were talking about months, which is amazing, and the other is the requirements for contractors to meet.

Can you talk about the—kind of our understanding what is causing the roadblocks? Again, it can be up to many months.

Mr. FUENTES. The application process, you know, specifically when it comes to ALS and severe illnesses, these are illnesses that require immediate attention and it takes a lot—too long for VA to process the applications. The contractors, because of the require-

ments of exactly what needs to be met sometimes aren't familiar with those requirements, so then it takes time to find one that is not only familiar with it, but also willing to undertake the task.

Mr. LEVIN. Thanks for that. And the second difficulty again is finding contractors. Can you speak more to that, to the requirements for finding contractors, why that is such a difficult issue?

Mr. FUENTES. It comes, in terms of the requirements that VA has on how it must be completed and also the quantity of contractors that are out there as well, even though we do have a good amount who are willing to work and assist veterans. Because of the long process that it takes to get everything approved, some of them may not want veterans to go through the SAH process.

Mr. LEVIN. Thank you. I appreciate that and your continued support, working together with Mr. Bilirakis and my colleagues as we get this over the finish line.

I wanted to turn to cannabis, and Dr. Grant, I wanted to thank you for being here today. I represent UC San Diego. SO I am really honored that you are doing some of the leading research on this. It is a great honor. If you watch the Congressional baseball game next week, I will be proudly wearing the UC San Diego uniform.

In your testimony, you explain that research has confirmed the benefit of medicinal cannabis in cannabinoids for some chronic conditions, but further studies are needed to fully understand the effects of these drugs. And of course, we know about the supply constraints. And I wanted to ask you about that.

You are basically limited to the University of Mississippi and I wanted to understand from you, how did those supply constraints impact the work that you are doing?

Dr. GRANT. Yes, well, it is in several ways. First of all, the University of Mississippi program is doing its best. So this is not about dissing them. But they are one provider and they have a lot of difficulty, I think, keeping up with what is going on in the real world. So for example, up until a year or so ago, there were upper limits on how much THC was in a product, whereas on the street now, it is 15 percent and we have been studying 4 percent and 2 percent and such.

Now, it may be that those percentages are all you need medically. You need a lot more to get super looped, but maybe for the treatment benefit, you may need a much lower dose.

The other has to do with the types of formulations. As you know, a lot of people are taking edibles of various sorts. You know, if we had to study, say marijuana in brownies, we would have to bake them ourselves, literally. We would have to get the product from Mississippi and set up and we are not really equipped to do those kinds of things.

The other has to do with different mixes. So it may be the case that having a say 20 to 1 mix of CBD, the cannabidiol to THC, may be optimal for some things because it may be the CBD is cutting the effects of the THC and so forth. These are all theories, but we don't have those kinds of products.

So, you know, one option is to pursue importation because in Canada, they have a number of GMP facilities, manufacturing practice facilities. Maybe that could be expedited in some way while, you know, kind of we catch up in this country. The other is

the DEA a long time ago, a couple of years ago said they may license more manufacturers in the U.S., but as far as I understand it, nothing has happened with that process. So the supply is a real problem.

Mr. LEVIN. Thank you, Dr. Grant. I am out of time, but I want to thank you for your decades of good work at the medical school and the Department of Psychiatry at UCSD.

Dr. GRANT. Go Tritons.

Mr. LEVIN. Go Tritons.

The CHAIRMAN. Say, "Go Highlanders." Okay. Dr. Dunn, you are recognized for 5 minutes.

Mr. DUNN. Thank you very much, Mr. Chairman. I will be brief.

I noted at our VA Health Subcommittee hearing on April 30th that Federal laws and state laws often do not exempt VA physicians from criminal punishment were they to prescribe cannabis or any illegal substance to a veteran. It is our job as policymakers to protect both the physicians and the veterans before we go off and encourage them to prescribe or recommend any illegal substance as a treatment for any of the myriad of conditions that have been indicated for cannabis.

One way I personally support this is by looking into rescheduling cannabis into a Schedule 2 substance. The benefit of this is just that it facilitates serious scientific research. It makes it much easier to get the substrate that the good doctor mentioned.

And I think we have many divergent opinions regarding the utility and value of cannabis as a medicine, but I think we can all agree that we need more research, serious scientific research into this topic. And as a final comment, I would like to note that the research should be designed and directed by scientists and not policy makers.

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

The CHAIRMAN. Thank you, Dr. Dunn. Ms. Luria, you are recognized for 5 minutes.

Ms. LURIA. Thank you. And I would like to start by talking about the proposed H.R. 1647, Veterans' Equal Access Act proposed by Representative Blumenauer. And just to recap the summary of that is to authorize the Department of Veterans Affairs Health Care Providers to provide recommendations and opinions to veterans regarding participation and state medical marijuana programs. So in states where it is legal and accessible.

And I just wanted to address this question specifically to the VFW because your testimony states that your opposition to this, and I am just trying to quantify if this is the only reason for opposition, that it is unacceptable for VA providers to recommend a treatment that they are unable to provide for veterans. Thus, a treatment that the veteran would have to pay for at their own expense. Is that your sole reason for objecting to this particular item?

Mr. FUENTES. Yes, ma'am.

Ms. LURIA. So you otherwise support in states where cannabis is legal, VA providers being able to make those recommendations to patients?

Mr. FUENTES. We certainly fully support VA having that discussion with veterans. We would not like for VA providers and doctors to prescribe a medicine or any type of drugs that VA is unable to

provide to veterans. I don't know the cost of medicinal cannabis in those states, but it could pose a barrier for veterans and many of them are already struggling to meet VA's copays, certainly don't want to put the full cost of any of the medications that their doctor says they need on them.

Ms. LURIA. So in a scenario where potentially there could be a reimbursement, if it was anything other than the cost, you would not object to it?

Mr. FUENTES. Correct.

Ms. LURIA. Okay. And then I wanted to shift to the Iraq and Afghanistan Veterans of America and I have fortunately had the opportunity to speak to some of your colleagues and some of your members over the course of the last few months in looking across this legislation relative to cannabis, we have a very friendly chart here that shows red, yellow, or green based off of the level of support of the people who are going to be testifying so we can kind of understand the trend.

But the trend I see for you is that IAVA has support on every single one of these. Can you discuss kind of the demographics of your membership age-wise, and then the statistics you have amongst your members as a younger group of veterans, their perception of marijuana as a potential treatment for some of the things that they suffer from?

Mr. HERR. Yeah. We have a younger generation of veterans, as you mentioned, who are all post-9/11 veterans. In order to take our member survey, the stats I have been quoting, you have to be confirmed as deployed to Iraq or Afghanistan. And so to talk to some of those statistics that you mentioned, 90 percent support cannabis research. I think it is right around 80 percent that support full legalization of cannabis. 91 percent also state that they would take cannabis if it was available to them. And currently, as I mentioned, only 20 percent reporting are taking it, so that is a huge difference of people that could be affected and could benefit from this.

Ms. LURIA. SO if I interpret that data, this is a younger group of veterans who think that this is beneficial to them. And I would take that as they are asking us as Congress and lawmakers to find a way to make that happen: all the elements of that, be that research, be that all of the elements outside of the purview of this Committee, but you know, making it accessible, making it standardized, making production standardized, essentially. Just regulating the industry so it can become a product and a commodity that we can research and use safely. Is that what I would take away from this group of younger veterans? They want us to do something to make it available to them.

Mr. HERR. Yes, I believe that is fair. And I think we need to start with the research, which is why we are supportive of the Medicinal Cannabis Research Act. That is why it has been our centerpiece for our cannabis campaign, that we have been out and talking with offices like yourself about. So that is where we need to start. And I think once we have that data, once we have more good data from the VA, then we can go from there as far as what we need to do.

Ms. LURIA. Thank you. I yield back my time.

The CHAIRMAN. Thank you, Ms. Luria. Ms. Radewagen, you are recognized for 5 minutes.

Ms. RADEWAGEN. Thank you, Mr. Chairman. My question is for Mr. Fuentes. In your written statement, you commented that you oppose the change to the work study program because you believe VA just needs to do a better job processing claims. Given VA's poor track record of delivering education benefits in a timely manner, don't you think it may be time for a new approach?

Mr. FUENTES. Thank you, ma'am, we completely agree that VA needs to fix the work study program. It is preventing veterans from essentially meeting ends meet. They rely on this benefit to pay for housing for food. Right now, the difference is that VA pays the veteran directly, so the school simply just certifies that the veteran worked the number of hours that are required and then the—a similar program under the Department of Education pays the school or gives the school a certain amount of money and then the school pays the veteran.

The VA knows how to pay veterans. It does so for millions for disability compensation. It does so for the GI bill. We have confidence that VA can get it right and fix it, instead of changing a new process. We think that VA would probably better be able to fix the current process as a paper-based process than they would be at adopting a new business process.

That, again, we certainly refer to VA if they think that a better business—a new business process is easier for them to manage. At the end of the day, we will hold them accountable to it because these veterans need their payments now and as soon as possible.

Ms. RADEWAGEN. Thank you. Mr. Horr, can you please tell us why you believe using the way the Department of Education pays work study could be a better model than the way that VA currently pays benefits.

Mr. HERR. Yeah, the Department of Education model has been proven to where it can get work study payments on time. We understand that there have been issues with the VA's IT infrastructure, especially with the G.I. Bill payments and things like that. But using the Department of Education's model, which already exists, the VA can easily more restraining order that, in order to get these work study payments out on time. So, we believe that is how it can be easily integrated.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

I yield back.

The CHAIRMAN. Thank you, Ms. Radewagen.

Mr. Sablan, you are recognized for 5 minutes.

Mr. SABLAN. Thank you, Mr. Chairman. I have no questions at this time for this panel, but I thank everyone for being here.

The CHAIRMAN. Thank you, Mr. Sablan.

Mr. Barr, you are recognized for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman.

Thanks for our witnesses for your service and for your testimony here today. As you all can see, this Committee is very interested in the possible benefits of medical cannabis.

I have had an opportunity to listen to veterans of different eras—Post-9/11 veterans, Iraq-Afghanistan veterans—about their interests in the therapeutic benefits for post-traumatic stress, and anx-

xiety, sleep deficiency, and also Vietnam-era veterans in my veterans coalition, who have expressed an interest in us proceeding with this.

So, I am a co-sponsor of Dr. Roe's bill, H.R. 747, which does direct the VA to conduct medical cannabis research.

And I also want to thank Mr. Correa for the VA Medicinal Cannabis Research Act.

I share Dr. Roe's concern that Mr. Correa's bill may be a little bit too prescriptive, but I appreciate Dr. Grant's point that if that is our only opportunity to proceed with research, I would prefer that than nothing. So, I have a preference here and it is Dr. Roe's bill, but I do want to see us move expeditiously on the research because of the intense interest that the veteran's community has expressed to me.

Let me just ask any of you about that difference between the Roe version and the Correa version. Do we need to have an approach that lets the researchers, as Dr. Grant has expressed a preference for, direct this, as opposed to folks up here—and admittedly, I am not a physician and I don't have an expertise in this area—what is the best approach here, because maybe we can get a larger consensus to pursue this, and I invite anyone to offer an opinion on that.

Mr. ATIZADO. Mr. Barr, thank you for posing that question, and I do appreciate your comments and Ranking Member Roe's comments on the matter, as well.

I think in my testimony I mentioned that we have to recognize a couple of things and that is, in fact, VA is not doing much in this space when there is a definite need that they need to be a leader in this area. I think the veterans have spoken. I think Congress is speaking to them.

I think it would be helpful if we can have members in Congress, some of the Veterans Service Organizations, and the scientific research community come together and find—and I don't want to use this as a way to slow the legislative process down. I want to help inform the two bills that are out there now and maybe Mr. Roe and Mr. Correa can craft the bill together, but with VA's definitive opposition, we need to get over that, because they are the ones that are going to have to execute on this, and that might be a way forward.

Mr. BARR. Well, thank you. Any other thoughts on that point?

Mr. HERR. Yeah, I think just to echo what DAV was saying, I think there is a concern that if VA is not explicitly told how to do it, that they will drag their feet and withhold this research or—

Mr. BARR. Well, maybe there is a middle road.

Mr. HERR. Yeah.

Mr. BARR. A mandate that they do it, but give the professionals and the scientists and the researchers a little bit of control in terms of setting the parameters for the research and providing some deference to the expertise of people like Dr. Grant. So, I am willing to step in and try to work on that compromise to help move this forward and not having the delay. And I look forward to working with the VSOs on that if I can be helpful.

In Kentucky, we have kind of led the way in de-scheduling industrial hemp, which is low THC/CBD and so, for Dr. Grant—and we

de-scheduled in the Farm Bill. I am interested in your research and what your research tells us about low THC/CBD and any therapeutic benefits that can provide separate and apart from the psychoactive THC substance in marijuana.

Dr. GRANT. Thank you. Let me see if I can address that. First of all, as you know, and as we have discussed, cannabidiol, which is a common ingredient in cannabis, in marijuana, is not thought to be psychoactive, but it may have antianxiety, anti-inflammatory, antiepileptic, and other qualities. So, clearly, this is a substance, first of all, that needs further study, but already in the area of epilepsy, we have seen that its benefits children. That drug, in my opinion, should not be on a schedule. There is no evidence that it is an addictive substance.

As for THC-containing things, it seems to be a more sensible approach would be something along the lines that we have used with codeine. So, low-codeine preparations are in Schedule 3, for example, and higher-codeine preparations are in Schedule 2, and that makes a lot of sense. If you give more or the higher potency, it may be more dangerous. And I think the THC products belong somewhere in that zone, personally.

Mr. BARR. My time, obviously, has expired and I have gone over and I am sorry. I appreciate the Chairman's indulgence.

I would just say that as we move forward with research on both the high-THC and the low-THC, that the researchers look at what CBD cannabidiol could do separate and apart from the higher psychoactive, higher-THC psychoactive parts.

And I yield back, and I appreciate the Chairman's indulgence.

The CHAIRMAN. Thank you, Mr. Barr.

Mr. Bergman—General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

And I see a lot of familiar faces out there—good to see you all again. And I know I have at least two Marines. Anymore? Okay. Well, you guys have already taken over the panel just by having two out of five, right? All right. Well, we are not going to talk about service cultures here.

You know, it is always very instructive to sit here and listen to people who have, both on the panel and my colleagues, who have got a lot of time and effort in researching and trying to figure out what the best way is to go forward to help our veterans, whether it be in pain management, addiction, or shall we say the kind of facilities that they get their care in that the VA has.

And let's talk about the asset review, first of all. You know, time is finite; once time is gone, it is gone. And I would suggest to you very strongly that the more we wait to kick off the asset review and to not speed up the timelines in a mission-oriented manner like we would do in the military, of prioritization and responding quickly, we have to move forward with the asset review and not waste any more time on that.

Twenty-five-year-old brain development, full brain development for the average male, is that—am I in the ballpark there?

Dr. GRANT. Some of us take longer.

Mr. BERGMAN. Well, some of us are still works in progress, as my wife would probably say.

Dr. Grant, we have a lot of our veterans who will serve honorably and complete a four-year enlistment by the age of 22. Any comments on what risks we might be accidentally assuming if we move forward with cannabis research with the target population, what parameters you might put on that so that we don't further potentially hinder a young veteran who has, you know, put their life on the line?

Dr. GRANT. You know, thanks for the question. And it is very complicated, as you very well know.

I think what I can say with some reasonable confidence is that marijuana in the strengths that it has been traditionally used—and I am going back now 4 decades—among adults is probably not harmful to the brain. There have been a number of kinds of retrospective studies that have looked at IQ and cognitive function and brain-imaging and so forth. But that is marijuana that was not very potent and that, typically, people are not using day-in and day-out and many times a day.

In terms of the developing brain, teenagers and young adults, we really don't have the answers. And I have to say I see practically every month some report saying, Oh, marijuana causes this and that terrible thing to happen to the brain, but, actually, when you look at the research, it is not that clear. That doesn't mean it isn't bad, but I don't think it is very definitive. And, certainly, we don't want to give chronically, in high doses, any drug that affects the brain because we don't know what is going to happen there.

Mr. BERGMAN. I just wanted to make sure that we, you know, didn't accidentally put a certain age group at risk moving forward with a good idea.

And I guess you mentioned something that kind of caught my attention, Doctor, on some of the things that Canada has to offer. Are there any other countries around the world who have already walked down this road with the research side that we can either partner with, model after, you know, have a list of dos and don'ts? Any other countries that stand out?

Dr. GRANT. Well, I think not to the kind of comprehensive extent of Canada, but, certainly, the Netherlands has had a fairly long history of some permissiveness, at least, in the marijuana area, and they have also done a lot of work on driving and those kinds of impairments.

Mr. BERGMAN. Has there been any outreach made to the Netherlands at all?

Dr. GRANT. Well, we certainly have consultations with those people, but no, I don't know the answer to that.

Mr. BERGMAN. Well, thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, General.

Mr. Meuser, you are recognized for 5 minutes.

Mr. MEUSER. Thank you, Chairman, and thank you Dr. Roe very much. Thank you very much all to you for being here with us and to the veterans on the panel, and all the veterans, thank you very much for your service.

I'd like to focus my questions on the draft legislation on the Specialty Adaptive Housing grant program. I do commend Chairmen

Levin and Bilirakis for this draft legislation that I do plan to be supportive of.

Mr. Fronabarger, do you hear from disabled veterans regularly on the housing issues and the need for adaptive specialty access?

Mr. FRONABARGER. Thank you for that question, Congressman.

We do. We have a program with—called the Independence Program. That project that we have going on actually assists critically injured, ill, and wounded servicemembers in home adaptation, caregiver services, and any other issues they might like. So, we do have about 500 individuals in that program right now.

Mr. MEUSER. Five hundred.

Describe briefly, if you would, the type of disability that someone would have in order to be eligible for this type of housing grant.

Mr. FRONABARGER. Absolutely. I would say you would see two primary kinds of individuals with bilateral amputees and also those with ALS. Those are relatively common, unfortunately.

Mr. MEUSER. So, those with loss of limb, normally, it was lost in the field in combat?

Mr. FRONABARGER. I couldn't break down specifically if it was combat or training, but most likely with this most current war, yes, I would—

Mr. MEUSER. Yes, great sacrifices.

And work is pretty difficult for those with these high level of disability?

Mr. FRONABARGER. It is. I mean, it is difficult to move from an injury like that into a normal civilian life.

Mr. MEUSER. Maybe part-time, just difficult to get there, even.

Mr. FRONABARGER. Correct.

Mr. MEUSER. In a normal home environment, how would they mobilize?

Mr. FRONABARGER. Well, that is a difficult question. A lot of it depends on the home itself. If there are stairs, that can be incredibly difficult for somebody who is lost both the lower limbs, obviously. If it is, you know, a long walk from the driveway up to the house, if there is not a garage on the front that leads straight into the house, all of those—

Mr. MEUSER. Typically very, very difficult.

Mr. FRONABARGER. Correct.

Mr. MEUSER. Very difficult.

Can you describe a project that was—comes to your mind and a veteran that has benefited by the current initiative for this type of specialty housing?

Mr. FRONABARGER. Absolutely. I [DF2]Captain Kules [DF3]right behind me used the program. He was able to purchase a house in D.C. And as you all know, D.C. homes are probably some of the least adapted homes possible; they were all built in the 1930s and older. So, he was able to take a house and add the things that he needed, including a ramp, to make that home fit his needs.

Mr. MEUSER. Okay. Great. Well, these projects are not only life-sustaining, I think they are life-changing. They are quite essential.

And Captain Kohls, thank you very much for your service.

And I don't have any further questions, so, Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Meuser.

That concludes, I think, our work with our second panel. So, you are all now excused. Thank you all very much for your testimony and for your answering our questions.

I would like to now invite Mr. Larry Mole, Chief Consultant, Population Health Services Patient Care Services of the Veterans Health Administration to come to the table.

And I will just take a note that we statements for the record from Ms. Thelma Roach-Serry of the Nurses Organization of Veterans Affairs; we have Mr. Eric Goepel also submitting a statement, Founder and CEO of Veterans Cannabis Coalition, VCC; Mr. Morgan D. Brown, National Legislative Director of Paralyzed Veterans of America; Mr. J. David Cox of AFGE; Mr. Randy Erwin, National President of the National Federation of Federal Employees; Mr. William Attig, the Union Veterans Council, AFL-CIO; Mr. Brett Copeland, Executive Director of the Veterans Healthcare Policy Institute; Mr. David Holway, National Association of Government Employees; and Mr. Justin Strekal, Political Director of the National Organization for the Reform of Marijuana Laws, otherwise known as NORML.

The CHAIRMAN. So, Mr. Mole, welcome. Thank you for testifying today. I will begin—oh, no, you need to do your 5 minutes of—go ahead. Five minutes—you have 5 minutes, Mr. Mole.

Dr. MOLE. And go Highlanders.

STATEMENT OF LARRY MOLE

Dr. MOLE. Good afternoon, Chairman Takano, Ranking Member Roe, and members of the Committee. Thank you for inviting us here today to present VA's views on a number of important bills covering cannabis policy, transitional care for women veterans, and ensuring that language is not a barrier to access to VA services.

We are unable to provide views on today's written testimony on four proposals that were added recently to the agenda, but we will follow-up with the Committee as soon as possible.

Regarding the bill to require continuation of Women's Health Transition Training Pilot Program, I am pleased to share that last week, the VA committed to a permanent women's health component to the Transition Assistance Program by 2021. In the interim, VA will provide the pilot activities currently in place for active-duty servicemembers. Although we have no objections to its enactment, we do not believe this bill is now necessary.

Concerning the bill, Making Fact Sheets Available in English and Spanish, VA agrees that it is important that we help ensure that language is not a barrier seeking care or other services from VA. VA publishes many critical materials in English and Spanish, including VHA enrollment forms and our annual guide to benefits.

More systematically, VA is implementing a language access plan covering all organizations to ensure as much as possible there are not language barriers for veterans and their advocates. Given the breadth and complexity of VA program, VA favors this more systematic and flexible approach, as opposed to a statutory mandate for one category of document. As a result, VA does not support this legislation. We are glad to discuss our current efforts with the Committee.

Next, I begin my discussion on the medical cannabis bills by setting out the current landscape. According to the National Conference on State Legislatures, 47 states, the District of Columbia, and 3 of 5 territories have some form of state or territory regulation on medical cannabis use. These laws permits various types of cannabis-derived products to cover various symptoms and conditions. These laws greatly vary from each other and conflict with Federal law which classifies cannabis as a Schedule 1 controlled substance. That complex legal landscape makes it important that legislation in this area receives a thorough airing and we appreciate the Committee's attention to these issues today.

It is critical for the Committee, veterans, and the public, to know that the veterans will not be denied VHA services solely because they participate in state-approved programs and that clinical staff may discuss marijuana use with their patients. But we should also be clear that VA cannot pay for state-approved marijuana products and VA providers cannot recommend, make referrals to, or complete forms or register veterans for participation in state-approved marijuana programs.

The Veteran Medical Cannabis Research Act of 2019 would require VA to conduct a large-scale clinical trial to examine multiple health outcomes among veterans with various diagnoses using multiple strains and formulations of cannabis. Typically, smaller early-phase trial designs would be used to advance our knowledge of benefits and risks associated with cannabis before moving to a more expansive trial. VA currently supports a VA clinical trial of cannabis for treatment of PTSD. Because we believe research on such a scale would be premature ahead of other related research, VA does not support this bill.

The VA Equal Access Act would require VA to authorize its physicians and other health care providers to provide recommendations and opinions to veterans who are residents of states with state-approved marijuana programs. While VA encourages its providers to discuss marijuana use with veterans, we cannot support this bill for the detailed reasons provided in my written statement; namely, that there are legal issues presented by the legislation that would require significant involvement of other agencies to resolve.

This VA Survey of Cannabis Use Act would require VA to enter into an agreement with a federally funded research and development center to conduct nationwide surveys to measure cannabis use by veterans. We have significant concerns detailed in our testimony, one of which is that we believe veterans and providers will not want to participate, despite the survey being anonymous; moreover, the survey results would likely only be meaningful if we knew where veterans lived and where providers practiced, information that could compromise the identity of the veterans and the providers. That is why VA cannot support this bill.

The bill, Training in the Use of Medical Cannabis for All VA Primary Care Providers would require VA to train these specific providers in the use of medicinal cannabis. We already make available to all providers, information sessions on cannabis, including the latest on marijuana use and side effects, treatment implications for veterans with PTSD, and on caring for patients who use marijuana at the end of life.

In addition, VA's academic detailing program provides resources for providers to have meaningful conversations on cannabis with their patients; as a result, we do not believe that this legislation is necessary.

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

[THE PREPARED STATEMENT OF LARRY MOLE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Mole.

I am going to call upon, as a courtesy to Dr. Roe, call on him first for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman. I have a phone call here in just a couple of minutes about some veterans' issues at home.

And just for clarification, Dr. Mole, the secretary testified multiple times before this Committee and before the Senate Committee on Veterans Affairs, expressing his desire for the AIR Commission to begin their important work as soon as possible and asking Congress for our helping in accomplishing that. Given that, is it fair to say that VA is supportive of H.R. 3083?

Dr. MOLE. I can answer that I don't think VA has put out its official position. I agree with you that the secretary has made statements in support of that and that is as far as I can comment, sir.

Mr. ROE. And the AIR act requires the VA—and I know because we wrote it on this Committee—to consult with VSOs as it conducts its market assessments. Explain VA's efforts, because we heard some objection to that—probably rightfully so—our plans to consult with VSOs as it conducts market assessments. Have you all decided how you will do that? I think that is a fair ask of the VSOs.

Dr. MOLE. Yeah, and I agree with you. I will need to take that back for additional information, because I don't know what that particular office is doing, but I can get that and bring that information back to you, sir.

Mr. ROE. We appreciate you doing that. And can you clarify for the record that the market assessments that are required for the AIR Commission are the same market assessments as Secretary Wilkie has testified will be completed by June, one year from now?

Dr. MOLE. Yes, they are.

Mr. ROE. Okay. So, in other words, what we will have a year from now are the market assessments across the country, and I think what I heard the secretary say multiple times—as a matter of fact I know what I heard him say multiple times is that if you wait a subsequent year, then you have got data that may not be accurate that you are making decisions on.

The other side of that is—and I have said it from the very beginning when I started the discussion in my office with the VSOs—that I would rather make sure that we get it right than fast. And I don't think this is a fast—and as a matter of fact, I don't think we have any choice but to do this. And whether it is the AIR Commission or some other commission, it is just not the way that VA provides health care anymore.

And if you look at what the VA is doing around the country, which I wholeheartedly applaud them for, is pushing more and

more of the care out into the community where the veterans actually live. That was the idea of the MISSION Act. So, if you are in Los Angeles where the traffic—I mean, it is horrific. I could drive to several states in the time I could get 30 or 40 minutes in downtown LA, to put that care closer to the veterans. That is the purpose of all of this.

And to repurpose those bills—and I have challenged every medical center that I have gone to in the last 3 years since—because we have done it at our own medical center at home in Mountain Home VA in Johnson City—start thinking about how you would like your medical center to look in 3, 5, or 10 years from now and what demands are being made. We know that the veteran population, the actual numbers are going down.

Hopefully, the number of veterans will go up. I hope the number of veterans that use the VA goes up and not down, and I think it will. So, with that in mind, I would think that we could get started with this with our partners in the VSOs. And it doesn't mean you are going to end any quicker—you aren't by law; you are just going to get started a little sooner is all. Am I correct in that?

Dr. MOLE. I think I am not—

Mr. ROE. —AIR Act.

Dr. MOLE. Yeah. I mean, I am not well enough connected to know the pieces to know how it starts once you get through the market assessments. I don't know all the other milestones, so that is hard for me to comment on, but, again, I can take that back, sir.

Mr. ROE. Thank you.

I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Roe.

I will now recognize myself for 5 minutes. Mr. Mole, have VA leaders recently spoken to the employees and veterans at the VA Medical Center in San Juan, Puerto Rico?

Dr. MOLE. I don't have an answer to that.

The CHAIRMAN. You don't know?

Dr. MOLE. Yeah.

The CHAIRMAN. What I wanted to know was whether the San Juan Medical Center has Spanish language materials they need to communicate with veterans and conduct training at the hospital. I don't imagine you would know that, either.

Dr. MOLE. I only know to some extent because of Spanish articles I have worked on historically, but what was mentioned earlier today about the MISSION Act and materials developed for Spanish, that is the first that I have heard of that.

The CHAIRMAN. Okay. Do you have any effort on VA's part to staff the Veterans Crisis Line so it can assist Spanish language speakers nationwide?

Dr. MOLE. Yeah, I don't know that. I can get that for you, sir.

The CHAIRMAN. Okay. Were you aware that Puerto Rico had created its own Spanish language Veterans Crisis Line and that it is not being answered?

Dr. MOLE. That, I did not know.

The CHAIRMAN. Okay. I just want to make sure that through you, the Department is aware of this—

Dr. MOLE. Yes.

The CHAIRMAN [continued]. —and can maybe address these questions.

Has VA conducted any studies or collected data to determine whether Spanish-speaking or non-English speaking veterans are accessing benefits at the same rate as English-speaking veterans?

Dr. MOLE. Not to my knowledge, but I am not in that program office that would do that, but that is another one to be answered, yes.

The CHAIRMAN. I appreciate your getting back to my staff on that.

Dr. MOLE. Yes, sir.

The CHAIRMAN. Now, I want to turn to the medicinal cannabis.

Dr. MOLE. Uh-huh.

The CHAIRMAN. If the VA has concerns with the VA Medicinal Cannabis Act and how it could limit the design and research or clinical trials, would VA be willing to work with the Committee to address those concerns that VA can conduct objective research?

Dr. MOLE. Absolutely.

The CHAIRMAN. And you said that, really, that there were other research priorities that you didn't support this Act because there are other research priorities.

Dr. MOLE. The way that the bill is written—

The CHAIRMAN. Uh-huh.

Dr. MOLE [continued]. —it implies that a big, large clinical trial would be designed that would have many, many arms that would be studied all at once.

The CHAIRMAN. I understand.

Dr. MOLE. And we are kind of ahead of ourselves in doing it that way, because to some extent, we may not know some of the products that are being tested, whether they actually do any good or what the risks are of using those.

The CHAIRMAN. I see where you guys are coming from.

Dr. MOLE. Yeah.

The CHAIRMAN. So, I mentioned may be working with the VA in an approach that the VA would support. So, I see how you guys are thinking that this is too prescriptive for you.

In your previous testimony, you stated that VA has gone so far as to, "Encourage other research on possible medical uses for marijuana." Specifically, what steps has VA taken to encourage this type of research?

Dr. MOLE. So, I can give you a partial answer. Our research department would be the best to give you a full listing of everything they have done. But they hold seminars. They have done series on educating what you can and cannot do, with regards to research with cannabis, and actively participate with our regional experts in research to determine what they can do as a national program office to assist them and help them develop good, strong, scientific protocols to then submit for funding for research.

The CHAIRMAN. All right. Well, thank you, Mr. Mole. I am not going to use all my time, but I would like to now call on and recognize Mr. Barr if he has any questions.

Mr. BARR. Thank you, Mr. Chairman, again.

And Dr. Mole, thank you for your testimony here today. Just to further explore where the VA is, specifically, with its research on

medical marijuana and cannabis, I understand your concerns with the proposed legislation in this hearing that it is too prescriptive, and I note in your testimony that you would advocate or the VA would advocate for smaller early-phase, controlled clinical trials with a focused set of specific aims that are warranted to determine initial proof of concept for medical marijuana for a specific condition. And I appreciate the Chairman's overture to work with the VA on what the right framework should be going forward on this.

My question is, you heard the testimony from the earlier testimony, some of the VSOs, and the frustration with the delays or the concern that this might slow down the process. What could you reassure—how could you reassure the Committee that if it was structured in a way that made the criteria that it wouldn't slow things down?

Dr. MOLE. Well, I think the first thing would be that the VSOs have to be at the table when we are having conversations about a research plan and what a full research portfolio would look like. So, I would start there. There needs to be engagement. We need to educate each other on what each other's expectations are and then set what those expectations would be for that research plan.

I think some of the times we kind of cross-talk each other in terms of trying to explain what is involved in a research-type program and I think we just miscommunicate, and we need everybody at the table from the beginning on this.

Mr. BARR. Well, again, can you provide an update on the specific research that is ongoing now. If there is not a broad-ranging clinical trial that is going on, what, specifically, is happening?

Dr. MOLE. So, what I can comment on is the one study that is actually looking at cannabidiol in combination—and it is a double-blind, placebo-controlled study; it is actually out at UC San Diego—and they just enrolled their first patient last week. And they have a number of veterans lined up who wish to be involved in the clinical trial.

And so, that is really our first one that is being done specifically for PTSD, taking the standard of care and then determining whether or not there is an impact by having cannabidiol in that standard of care treatment plan.

Mr. BARR. That interests me, because as you say, it is cannabidiol—

Dr. MOLE. Right.

Mr. BARR [continued]. —so what is being tested is basically hemp; it is low-THC—

Dr. MOLE. Yeah. It is the refined available product that was previously mentioned by Dr. Grant.

Mr. BARR. Or I suppose CBD could also be derived from marijuana—

Dr. MOLE. Yes.

Mr. BARR [continued]. —but there is no THC in it or low THC in the substance that is being tested?

Dr. MOLE. That is correct, sir.

Mr. BARR. So, that is the baby-steps approach, I guess, on this.

Dr. MOLE. Right. And I want to point out that this is the one that is funded by VA. There are other VA researchers that are getting funding from other sources, as well as other university re-

searchers and so forth that are looking at this. So, I think when we are trying to assess what sort of work is going on out there, I think we need some sort of catalog or something to understand all of these different studies so when VA comes up with, here's the portfolio that we are going to do, it actually complements what else is going on.

Mr. BARR. Doctor, are there any preliminary findings so far with the CBD and PTSD?

Dr. MOLE. No, they just started enrolling patients.

Mr. BARR. Okay. Very good.

Finally question, could you describe some of the risks of requiring the training of VA providers in the use of medical cannabis in light of the fact that it remains a federally scheduled substance?

Dr. MOLE. I would have to defer to our colleagues over at the Department of Justice and what they decide they want to prosecute or not.

Mr. BARR. Yeah. I guess the reason—what motivates that question is some of the other legislation that is being considered here today on training, it appears to put the cart before the horse. I think we do need to come to a consensus on an expedited, good, thoughtful, research-driven, evidence-based approach to research. But training VA providers before we have all the evidence in seems to be a little bit premature.

So, with that, Mr. Chairman, thank you, and I yield back.

The CHAIRMAN. Thank you, Mr. Barr.

I now recognize Mr. Levin for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman.

And thank you, Doctor, for being here today. I am trying to understand the timeline and where VA really is on this issue. In 2017, there was a poll conducted for The American Legion, showed that support for medical cannabis and research on medical cannabis was high across veterans and caregivers, all age ranges, genders, political leanings, and geography showed 92 percent of all respondents supporting medical marijuana research, 82 percent of all respondents supporting legalizing medical cannabis.

Are you familiar with that poll?

Dr. MOLE. Yes.

Mr. LEVIN. And then in 2017, VA's Evidence-based Synthesis Program found, "Methodologically strong research in almost any area of inquiry is likely to add to the strength of evidence" regarding the benefits and/or harms associated with medicinal cannabis.

Also in 2017, VA sent this Committee a letter that stated that VA was unable to perform research into medical cannabis. Are you familiar with that letter?

Dr. MOLE. Yes.

Mr. LEVIN. And then after some back-and-forth in the media, your spokesman or VA's spokesman, a gentleman named Curt Cashour admitted that VA could, in fact, perform the research, but found pursuit of the research to be overly burdensome.

Are you familiar with that 2018 statement?

Dr. MOLE. Yes, I am.

Mr. LEVIN. So, then in 2019, VA met with staff where they expressed support for the need for research, but seemed to further

muddy the waters and confuse things. Can you clarify what the VA's position is on cannabis research?

Dr. MOLE. So, VA can do research. The research is initiated by our investigators across the field. They are to do research on cannabis. Given its schedule on controlled substance has some extra steps in the process. None of those steps are onerous, as evidenced by the fact that you see—as our San Diego site was able to set this up fairly quickly.

Once they get through their funding and once they started moving, actually getting product and bringing it in and working with it was relatively straightforward. And that investigator has made a nice training video for anyone else who needs to go through the process.

So, we can do clinical trials and the process it takes to bring the product in and then study it is doable.

Mr. LEVIN. So, when I go back to my district, which I do every weekend, which has UCSD in it, and I speak to veterans, which I do virtually every weekend, what am I to tell them when they ask, When is this actually going to happen? When is this research going to occur? When is the VA going to listen to the 92 percent of veterans across all political stripes and ideologies that want to see this done?

Dr. MOLE. I think you can start by hopefully proudly saying that your local VA actually has a study. They have begun enrollment. If any of those veterans are interested in actually participating in the study, they can go to clinicaltrials.gov and they can look up that study. They can just type in “veterans” and “cannabis” and they will get that study. And you may find that some of your voter's back home are really interested in participating or not.

But I think you can tell them that we have begun this process. We have gotten over these initial hurdles and we are going to continue to encourage VA investigators to investigate cannabis.

Mr. LEVIN. Thanks, Doctor. I appreciate that.

I wanted to shift for a minute, with the time I have left, to the Veterans Equal Access Act. In the 2009 guidance issued by the DOJ that you cited in your testimony, the agency accepts that in the Ninth Circuit, which includes my state of California, a physician's ability to recommend cannabis use to their patients is a right protected by the First Amendment.

What efforts has VA taken to allow physicians within these states to enjoy their First Amendment right to make these recommendations?

Dr. MOLE. The opinion that we requested back then from DOJ came to us as quoted in the testimony that what is the precedent as Federal employees, is the Controlled Substance Act. And to my knowledge, since 2008, I do not believe there has been another request to DOJ to revisit that opinion.

Mr. LEVIN. Okay. I appreciate your being here. I look forward to working together on this issue and others, and I will yield back the balance of my time.

The CHAIRMAN. Thank you, Mr. Levin.

This legislative hearing has been well-attended and very informative. Again, I would like to thank the witnesses.

I thank you, Dr. Mole, for appearing before us today. You are excused.

I would like to thank all the witnesses from our three panels for their testimony.

All members will have 5 legislative days to revise and extend their remarks and include extraneous material.

Again, thank you for appearing before us today, and this hearing is now adjourned.

[Whereupon, at 4:16 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Congressman J. Luis Correa

Chairman Takano and Ranking Member Roe, thank you for the invitation to speak on my bipartisan bill: H.R. 712, the VA Medicinal Cannabis Research Act.

I appreciate the chance to return to the House Veterans Affairs Committee, where I served in the last Congress, to speak on our urgent need for research on medical cannabis as a possible treatment option for our nation's veterans.

The U.S. Department of Veterans Affairs is uniquely positioned to pursue the necessary research on what cannabis can and cannot do for our veterans.

Our brave men and women return from military service in Iraq and Afghanistan, at times with psychological wounds as well as physical injuries.

Unfortunately, for many veterans with PTSD and chronic pain, the use of prescription opioids has been ineffective in providing relief.

Worse, the use of prescription opioids has led to addiction or even death.

Tragically, VA patients are almost twice as likely to die from accidental opioid overdoses than non-veterans.

In California, I have met with multiple veterans who use medical cannabis as an alternative to prescription opioids and other treatment methods.

The men and women that I meet back home vouch for the therapeutic benefits of medical cannabis and support further research into the issue.

In fact, according to the Iraq and Afghanistan Veterans of America, over 90 percent of their membership support medical cannabis research.

As more veterans use cannabis for medical purposes, it is important that doctors be able to fully advise on the potential benefits and effectiveness of medical cannabis.

Currently, VA doctors can discuss cannabis usage with patients, but they have limited federally approved research on which to base recommendations or clinical opinions.

For that reason, with my colleague and friend Congressman Clay Higgins of Louisiana, I introduced the VA Medicinal Cannabis Research Act.

The bill requires the U.S. Department of Veterans Affairs to conduct a double-blind clinical study on the safety and effectiveness of medical cannabis.

The legislation provides a framework for that research to ensure a scientifically-sound study on the issue.

Research on the safety and effectiveness of medical cannabis is timely, necessary, and supported by the veteran community.

I want to thank the Iraq and Afghanistan Veterans of America, Veterans of Foreign Wars, Disabled American Veterans, and many others for their support of the bill.

H.R. 712 is a pragmatic and sensible approach to the need for research on medical cannabis and could result in potentially lifesaving information.

I look forward to working with you all to move this bill forward.

Prepared Statement of Adrian M. Atizado

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the House Committee on Veterans' Affairs. 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. We are pleased to offer our views on the bills under consideration by the Committee.

H.R. 2676, the VA Survey of Cannabis Use Act

H.R. 712, the VA Medicinal Cannabis Research Act of 2019

DAV supports both the VA Medicinal Cannabis Research Act of 2019 and VA Survey of Cannabis Use Act based on DAV Resolution No. 023, calling for more comprehensive and scientifically rigorous research by the Department of Veterans Affairs (VA) into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans.

H.R. 2676 would require VA to partner with a federally-funded research and development center that will study how veterans use cannabis, their experiences and any side effects of use. It also requires VA to report to Congress on the results of the survey. H.R. 712 would allow the VA to engage in research on the safety and efficacy of medicinal cannabis use on health outcomes for veterans with chronic pain and post-traumatic stress disorder (PTSD). In addition, the bill would allow a long-term observational study of clinical trial participants and require VA develop a means of preserving data for future studies. The bill would also require VA to submit periodic progress reports to Congress not less frequently than annually.

DAV understands that use of cannabis for medicinal purposes is now legal in 33 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 medicinal cannabis for these purposes is beneficial.

DAV is a strong supporter of 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.

H.R. 3083 - AIR Acceleration Act

DAV strongly opposes H.R. 3083, the AIR Acceleration Act, which would eliminate the requirement that the Asset and Infrastructure Review Commission, a key element of the Asset and Infrastructure Review (AIR) Act, not be allowed to convene any earlier than 2022. This requirement was drafted to ensure sufficient time and opportunities for stakeholder engagement in the multi-step review and approval process that could result in substantial changes to VA's health care infrastructure. By removing the time constraints on the Commission, VA would be free to accelerate the AIR process, as the title of this bill reflects, which would undercut one of the key elements of the compromise that led to inclusion of the AIR ACT as part of the VA MISSION Act.

Mr. Chairman, when the original draft version of the AIR Act was presented to DAV and other VSOs in 2017, one of the major concerns we expressed was that its timeline was far too short for a truly deliberative process on something as critical as the future of VA's health care infrastructure. Further, we were concerned about the lack of mandated stakeholder engagement throughout the proposed AIR process. Finally, we argued that VA should wait until after new VA capacity enhancements were completed, and after new integrated networks created by the VA MISSION Act had been established and stabilized before beginning the process to decide which VA facilities would be necessary to most effectively deliver medical care to veterans.

In building a compromise on the proposed AIR Act last Congress, then-Chairman Roe, the bill's sponsor, worked closely with DAV and other VSO stakeholders to address numerous concerns raised about his bill. We greatly appreciated Dr. Roe's open and collaborative approach to developing the final language of the AIR Act, which reflected significant changes from the bill's original text. On October 30, 2017, in a letter to DAV, The American Legion, Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars (VFW), he wrote that:

"Based on the feedback you provided during those Committee meetings as well as in numerous meetings and conversations with me and my staff since, I have made a number of changes to the AIR Act to make it stronger, more transparent, and more veteran-centric. For example, at your request, the revised AIR Act would:

Greatly expand the entire AIR Act timeline to allow VA sufficient time to gather needed data, complete local capacity and commercial market assessments, and stabilize community care efforts."

It was with these and many other substantive changes made that DAV and other VSOs were able to support the inclusion of the AIR Act within what became the VA MISSION Act. However, if H.R. 3083 were enacted, and Secretary Wilkie were to accelerate the AIR process as he has repeatedly indicated his desire to do, it would fundamentally undermine the dynamic structure of the VA MISSION Act by forcing premature decisions on infrastructure before decisions on health care delivery have been finalized.

Although VA has already contracted for market assessments, and we understand that the first tranche have essentially been completed, it is important to understand that the MISSION Act had two separate sections requiring market assessments. Section 106(a) requires VA to undertake a Quadrennial Veterans Health Administration review, which would encompass comprehensive market assessments as the predicate for Section 106(b), which requires VA to deliver a Strategic Plan to Meet Health Care Demand not less than every four years. These market assessments and the strategic plan based upon them were due no later than June 6, 2019, the effective date for the new Veterans Community Care Program. These market assessments were not intended to inform the future Asset and Infrastructure Review. In fact, this market assessment process was already begun by VA prior to enactment of the MISSION Act, when inclusion of the AIR Act was far from certain.

Section 203(b)(3) of the MISSION Act, in the AIR Act section, requires capacity and commercial market assessments to be performed to guide the Secretary's recommendations for infrastructure realignment, which are due no later than January 31, 2022. These market assessments were intended to reflect the capacity and demand after the new Veterans Community Care Program had been implemented and reached a point of optimization and stabilization. Because the MISSION Act includes provisions to increase VA's capacity to deliver care through VA facilities, it would be premature to assess VA's capacity before the MISSION Act changes were fully implemented. The creation of new integrated networks, the expansion of telehealth and the creation of a new urgent care benefit will all impact how, when and where veterans will seek care in the future; however, these changes will not be known for at least a couple of years.

This was one of the key reasons then-Chairman Roe agreed with our request to "expand the entire AIR Act timeline to allow VA sufficient time to gather needed data, complete local capacity and commercial market assessments, and stabilize community care efforts."

In addition, the market assessments required under Section 203(b)(3) have mandatory requirements for VA to "consult with veterans service organizations and veterans." different than Section 106. However, we are unaware of VA engaging with DAV or any other VSOs in any meaningful way regarding either the process or methodology for conducting the current market assessments or in the field as they performed individual market assessments. It is our understanding that VA's contractor has effectively completed the first group of market assessments and we remain unaware of any efforts to contact VSOs locally or nationally to solicit input regarding veterans' needs or preferences for future medical care delivery.

Mr. Chairman, the AIR Act was included in the VA MISSION Act with the very clear understanding among all stakeholders that VA would not begin a process that could result in closures of VA health care facilities until after the new community care program had been fully established and stabilized. Decisions on how VA will ensure the delivery of health care to millions of veterans must be made first, and only after new demand patterns have stabilized should decisions be made about the future alignment of VA infrastructure to deliver that care.

Furthermore, because of the importance of ensuring that VSO stakeholders were fully engaged throughout the process, the MISSION Act included numerous specific consultation requirements. Such collaboration with VSOs is not only important to help ensure that VA's plans for creating integrated networks reflect veterans' needs and preferences, but robust engagement is essential to achieve the level of support from veterans that will be necessary to implement real reform and realignment of VA's health care infrastructure.

Mr. Chairman, throughout the development of the AIR Act specifically, and the MISSION Act in general, DAV and other key stakeholder VSOs were regularly engaged with this Committee, working closely with both sides of the aisle in the House and the Senate. Unfortunately, the implementation by VA has too often been done with little or limited engagement with VSO stakeholders, even when the law specifically requires such consultation.

For these reasons, while we recognize the good faith intentions of the bill's sponsor, Dr. Roe, throughout the development and passage of the MISSION Act, and particularly the AIR Act section, we strongly oppose this legislation. Accelerating the AIR process - which Secretary Wilkie has indicated is his desire - would run

contrary to clearly bipartisan and bicameral intentions of the MISSION Act compromise and could lead to a fundamentally flawed infrastructure review process.

H.R. 485, the Veterans Reimbursement for Emergency Ambulance Services Act

With our recommendation, DAV is pleased to support H.R. 485, based on DAV Resolution No. 075, calling on Congress to improve administration of the emergency care benefit for service-connected veterans. DAV believes access to emergency care is a necessary component of a robust and complete medical care benefits package.

This bipartisan bill would clarify the circumstances under which VA would be required to reimburse emergency transportation of veterans. Veterans seeking reimbursement for both emergency transportation and care have routinely been denied because VA does not consistently apply a standard definition of “prudent layperson understanding” in providing reimbursement for claims.

VA, like many other federal providers and payors, uses the prudent layperson standard created under the Emergency Medical Treatment and Labor Act (EMTALA) to define what constitutes a medical emergency. However, medical literature has shown that there are significant differences in perceptions of need for emergency care between laypeople and medical professionals—lay people are actually more conservative in applying the “emergency” label to some specific conditions than health care workers; however, they are also more likely to label conditions that affect ability to work, conditions that happen after business hours and any other conditions the patient believes is an emergency as “emergent” than health care workers.

H.R. 485 aims to clarify the language defining a medical emergency that qualifies for VA reimbursement for emergency transportation by requiring that a condition have a sudden onset; that the layperson believes that the emergency is an immediate risk to life or health; or that a delay in treatment will result in serious consequences to life or health. This reimbursement for emergency transportation would apply to veterans who were transported to the closest medical facility that can respond to the veteran’s needs.

We understand these more detailed requirements for approval of emergency ambulance reimbursement claims may provide better guidance for claims administrators and help standardize administration to the veteran’s favor; however, in light of VA’s inconsistent and lackluster performance in administering Section 1725, we urge the Committee include an evaluation and reporting requirement of VA’s performance in executing the intent of this legislation to be conducted by an entity independent of the Veterans Health Administration.

H.R. 2942

DAV strongly supports this measure introduced by Congressman Cisneros based on DAV Resolution No. 304, which urges the Department of Defense (DoD) and other transition partners including VA and the Department of Labor (DOL) to include VSOs in the program and ensure that service members are obtaining meaningful employment and making adequate progress toward their life goals in the period of time shortly following military service.

This bill would build from a successful ongoing pilot between VA and the Air Force, by establishing a pilot program to assist women who are transitioning from military to civilian life with obtaining appropriate health care.

DAV made this recommendation in our 2014 Report, *Women Veterans: The Long Journey Home*. This report found that the effectiveness of the Transition Assistance Program (TAP) has yet to be evaluated. Often upon returning home from deployment, service members are eager to return to their homes and loved ones. Focusing on problems they may encounter later on is not something they are prepared to address. DoD often conducts TAP immediately prior to separation, but our report recommends that DoD consider addressing employment, educational opportunities and gender-specific information through additional workshops 6–12 months after separation to ensure that veterans are adequately primed to receive and make use of the information they receive.

The report further recommends that DoD share contact information with VA and the DOL to ensure that outreach can be conducted and assess service members’ satisfaction with participation, the effectiveness of TAP for all separated service members and the outcomes of participation in the program by gender and race in terms of addressing service members’ need for education and employment opportunities.

DAV’s 2014 report also found that while there were many federal programs for women veterans, women were often unaware of the programs available to assist them and that there were many “gaps” between programs that transitioning service

members could fall between in ensuring their successful transition home. DAV often lauds VA for the “wraparound” services it provides to veterans with significant challenges such as homelessness or severe mental illness, yet veterans’ access to programs that may assist them are often dependent upon one discharge planner or case manager’s knowledge of them and often the crosswalks between VA and other federal agencies’ programs are not widely understood. We believe that VSOs are part of the answer to this challenge if they are included in transition planning activities.

As we have learned from both our 2014 report and 2018 Report, *Women Veterans: The Journey Ahead*, women transitioning from service often have difficult and different challenges to successful reintegration with families and communities than their male counterparts. Women are less inclined to have awareness of their veteran status, even after deployment. They are more prone to divorce and being single parents than male veterans. These factors often affect their economic stability and create or exacerbate the stress they have experienced during deployment. Likewise, more than half of the women veterans using VA services have a service-connected condition, use more VA mental health services than their male peers, have higher rates of suicide and homelessness compared to civilian women peers and a significant number report military sexual trauma all complicating their journeys to reintegration.

In a recent hearing of the House Veterans’ Affairs Subcommittee on Health, Representative Cisneros cited outcomes of the pilot to include: 99 percent of participants would recommend the program to other women veterans and 80 percent agreed to allow follow up. Dr. Patricia Hayes, the VA Women’s Health Program Director indicated that the program began because rates of suicide are high and growing among women veterans. She stated that the program allows women veterans to visit a VA medical center to dispel any stereotypes they believe may affect women’s understanding of the program. She also stated that the Navy had agreed to have Navy and Marine sites began participating in the program.

We believe this training may arm women veterans with information they need to prevent or minimize their challenges with transition by allowing them to acknowledge and obtain resources for addressing the residual health issues with which they are struggling in order to prevent health and mental health conditions from becoming more severe and chronic or leading to tragedies such as homelessness or even suicide, which too many of our veterans-both male and female-are lost to.

Discussion Draft, Specially Adaptive Housing

DAV does not have a resolution on VA’s grant program for Specially Adapted Housing and Special Housing Adaptation; however, DAV Resolution No. 055 speaks to another benefit under VA’s Special Housing Adaptation Program, the Home Improvement and Structural Alterations (HISA) grant program.

A HISA grant is available to veterans with service-connected disabilities or veterans with nonservice-connected disabilities and who have received a medical determination indicating that improvements and structural alterations are necessary or appropriate for the effective and economical treatment of the veteran for disability access to the home and essential lavatory and sanitary facilities.

Notably, a veteran may receive both a HISA grant and either a Special Home Adaptation grant or a Specially Adapted Housing grant. While this bill seeks to increase the grant amounts for Special Home Adaptation and Specially Adapted Housing, DAV’s resolution calls for a reasonable increase in the HISA benefit for veterans. Correspondingly, this bill seeks to increase the amount for Special Home Adaptation from \$12,756 to \$20,271, and Specially Adapted Housing from \$63,780 to \$101,350, which would help ensure the continued effectiveness of these grant programs.

We note this bill does not cure inherent weaknesses in VA’s Special Home Adaptation program. For example, the Specially Adapted Housing grant program differentiates between veterans who need this benefit based on when they were injured. A veteran suffering a loss, or loss of use of one or more lower extremities due to service on or after September 11, 2001, which so affects the functions of balance or propulsion as to preclude ambulating without the aid of braces, crutches, canes, or a wheelchair would be eligible. Yet a veteran who sustained a loss of or loss of use of both arms, or a loss of or loss of use of one leg and is blind in both eyes, or suffers from certain severe burns due to military service on or after September 11, 2001 would not be eligible. Moreover, a veteran who sustained these injuries due to military service before September 11, 2001 would be eligible. These different eligibility criteria appear as a fundamental problem of arbitrary versus responsible government but does little to encourage, if not belie, the recognition of military service regardless of when such sacrifice was rendered.

Mr. Chairman, this concludes DAV's testimony. Thank you for inviting DAV to testify at today's hearing. I would be pleased to address any questions related to the bills being discussed in my testimony.

Prepared Statement of Travis Horr

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

While I serve as the Director of Government Affairs at IAVA, I'm also a Marine Corps veteran. I enlisted in the infantry in 2007 and deployed to Southern Helmand, Afghanistan in 2010. The issues of the post-9/11 generation are my issues. I was exposed to burn pits on my small patrol base in Afghanistan, I utilized the Post-9/11 GI Bill to become the first person in my family to graduate college. I've seen first hand the positive impact that medicinal cannabis can have on my fellow veterans' lives once they transition out of the service. And I've lost too many of my friends to the suicide epidemic in the veteran community. These issues are personal to me and I'm proud to represent IAVA's views in front of the Committee today.

We thank the Committee for bringing forward important legislation that touches on a number of our Big Six priorities for 2019, which are: the Campaign to Combat Suicide, Defend Veterans Education Benefits, Support and Recognition of Women Veterans, Advocate for Government Reform, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veterans who Want to Utilize Medicinal Cannabis.

Support for Veterans Who Want to Utilize Medicinal Cannabis

For years, IAVA members have been supportive of medical cannabis. In IAVA's latest Member Survey, 83% of IAVA members agree that cannabis should be legal for medical purposes. And a resounding 90% believe cannabis should be researched for medicinal uses, an increase from 63% just last year. IAVA members are vastly in support of cannabis research, and support will continue to grow in the months and years ahead. It's time for the Department of Veterans Affairs (VA) to catch up.

IAVA members have set out to change the national conversation around cannabis and underscore the need for bipartisan, data-based, common-sense solutions that can bring relief to millions, save taxpayers money and create thousands of jobs for veterans nationwide. The veteran community has made it very clear that it supports research done on the use of cannabis as a treatment option.

However, this demand has not resulted in a change in policy. For these reasons, the VA Medicinal Cannabis Research Act (H.R. 712) is the centerpiece of IAVA's Campaign to Support Veterans who Want to Utilize Medicinal Cannabis. This legislation will advance research and understanding of the safety and effectiveness of cannabis to treat the signature injuries of war. At this time, we have limited evidence on cannabis' effectiveness to treat the injuries that impact huge swaths of the post-9/11 generation.

Without research done by VA surrounding cannabis, veterans will not have conclusive answers to ways cannabis might aide their health needs. This is unacceptable. VA houses some of the most innovative and best-in-class research this country has to offer. It should not be shutting its doors on a potentially effective treatment option because of politics and stigma. Our nation's veterans deserve better.

In IAVA's most recent Member Survey, a staggering 72% of veteran and military members reported suffering from chronic pain. Sixty-six percent report joint injuries, and over 50% report either PTSD, anxiety, or depression. Cannabis may be an effective treatment option for all of these service-connected injuries, but we must invest in the research to ensure it is. The VA Medicinal Cannabis Research Act will build on this evidence and provide further data to explore the effectiveness of cannabis as a treatment option. Without comprehensive cannabis research, we are unable to make policy decisions that could improve the lives of veterans.

One such veteran whose life was improved through medicinal cannabis was Army veteran and former IAVA intern, Julie Howell. Her story, in her own words, follows:

For years after I returned from Iraq I struggled to sleep through the night. As it turns out, I suffered from something known as maintenance insomnia. I would fall asleep but would wake for hours in the middle of the night and then fall back asleep right before needing to wake up. Thanks to California passing legislation regarding medicinal and recreational cannabis I now have access to a product that I ingest which contains a small amount of cannabis that helps me sleep through the night.

I do not use cannabis recreationally, I do not even smoke, but this product has allowed me to thrive. Without access to cannabis, I would never have been as successful in the pursuit of higher education. I am currently working through a masters degree in public policy with the hope of assisting veterans like me, to live their best lives.

In addition to Julie, over 100 IAVA members have shared the stories of their cannabis use, with dozens sharing how VA retaliated against or mishandled them and dozens more sharing that they flat out refuse to tell VA about their use. Left unchecked, this practice is harmful and dangerous. In fact, Julie herself, even after advocating on Capitol Hill and back home in California, still hasn't talked to her VA doctor about her cannabis use.

Julie isn't alone. Twenty percent of IAVA members report using cannabis for medicinal use and of those, only 31% have talked to their doctor about their cannabis use. Twenty-four percent either do not feel comfortable or only feel slightly comfortable talking about their cannabis use with their doctors. For the vast majority of those that use cannabis, they are not talking to their doctors about their cannabis use.

VA care is an earned benefit for our nation's veterans, they shouldn't feel that they have to hide and circumvent VA to access a standard of care their civilian counterparts access easily. Yet VA's policies inhibit realistic discussion and open conversations around cannabis. If veterans are unable to receive the care that they deserve, then they will go around it.

We must ensure that VA clinicians can have open and honest discussions with their patients, allowing VA clinicians to recommend cannabis to their patients when appropriate, and ensure VA clinicians can submit forms for state medical cannabis programs for their veteran patients.

For these reasons, IAVA is proud to support the Veterans Equal Access Act (H.R. 1647) that will allow VA clinicians to provide recommendations and fill out forms for state cannabis programs. IAVA is also proud to support the VA Survey of Cannabis Use Act (H.R. 2677), in order for VA to understand the scope and scale of veterans currently using cannabis. IAVA also supports H.R. 2677, which will allow VA physicians to undergo training to understand how to best use medicinal cannabis, where it is already available in state programs.

Reform VA for Today's Veterans

Millions of veterans rely on VA for both health care and benefits. Ensuring that the system is able and agile enough to accommodate the millions of veterans who use its services is paramount to ensuring the lasting success and health of the veteran population. About 48% of all veterans and about 55% of post-9/11 era veterans are enrolled in VA care. Among IAVA member survey respondents, 81% are enrolled in VA health care, and the vast majority have sought care from VA in the last year, 81% of these VA users rated their experience at VA as average or above average. IAVA members have been clear that access to VA care can be challenging, but once in the system, they prefer that care. Further, independent reviews of VA health care support that the care is as good, if not better than the private sector.

A bold approach to ensuring today's veterans have a system willing to bend and adapt to them will take the full coordination of the executive branch and Congress, along with stakeholder partners in state and local governments, and the private and nonprofit sectors. We need a system that leverages the use of new technologies to streamline processes and enables VA to take a more dynamic approach to respond to the needs of today's veterans. Even so, the best technology will not save a system if it is built upon outdated structures.

Because of these reasons, IAVA is proud to support the AIR Acceleration Act (H.R. 3083) which will remove a restriction of the AIR Act to allow the commission to be nominated, appointed, and start their important work as soon as possible. Modernizing VA needs to be a top priority, the longer we wait, the bigger the problem it will become.

The Veterans Reimbursement for Emergency Ambulance Services Act (VREASA) (H.R. 485) will expand VA's ability to reimburse emergency ambulance services. Typically, VA can reimburse ambulance services, however, there are still times when veterans are stuck with the bill. For instance, if a veteran experiences a medical emergency and a bystander calls for emergency services and it was later determined to not be life-threatening, then the veteran must pay for ambulance services, through no fault of their own. VREASA seeks to fix this loophole and aligns reimbursement to current law under Medicare and Medicaid. It is for these reasons that IAVA is supportive of the legislation.

H.R. 2943 would direct VA to ensure that all fact-sheets are produced in both English and Spanish. The US Military is a diverse organization and a cross-section

of the United States as a whole. I personally served with a large number of Marines who spoke English as a second language. All veterans should have equal access to information provided by VA in a language they are proficient in and it is for these reasons that IAVA is supportive of the legislation.

IAVA is also supportive of the draft legislation to address specially adaptive housing. We are pleased to see the expansion of this program, to include the increase in the amount of assistance given, the increased amount of applicants that can be approved, and the elimination of the cap on grants given out.

Recognize and Improve Services for Women Veterans

Data shows that women veterans, on average, do not seek support from the Veteran Health Administration (VHA) until 2.7 years after leaving the service, or until mental or physical health issues have manifested. On top of that, VA states that women veterans tend to face more health-related challenges than their male counterparts. And most importantly, since 2001, the suicide rate for women veterans has increased by 85.2%, while the suicide rate for males has increased by 30.5%.

It is because of those reasons that the VA Air Force Women's Health Transition Training pilot was created. It is aiming to provide servicewomen with a deeper understanding of women's health services within the VA health care system. The courses are all led by women veterans, and everyone has the opportunity to personalize their training.

The Helping Expand and Launch Transitional Health (HEALTH) for Women Veterans Act (H.R. 2942) is consistent with IAVA's groundbreaking She Who Borne The Battle campaign to recognize the service of, and fill gaps in care for women veterans. This legislation not only ensures the pilot program remains in place until 2020 but expands it across all services, and creates a feasibility study to make the program permanent. Women veterans are the fastest growing cohort of veterans and it is critically important that they receive the same care as their male peers. IAVA supports H.R. 2942.

Defend Military and Veteran Education Benefits

The Post-9/11 GI Bill can only go so far in ensuring the future success of today's fighting force. While an earned benefit, the Post-9/11 GI Bill is also an investment in America's next "Greatest Generation." Veterans are proven to be more productive and have higher retention rates once hired into a career, and ensuring they have the appropriate training and degrees is paramount to this success. This successful transition to the civilian workforce often begins on a college campus. In fact, according to Student Veterans of America and the Institute for Veterans and Military Families, 2.9 million post-9/11 veterans have entered higher education since transitioning out of the military and I'm proud to be one of them. This means that ensuring veterans are supported and successful on campus is of utmost importance to the long-term success of each veteran.

To this end, IAVA is supportive of the draft legislation that addresses and improves VA Work Study program. This bill will update the work-study program to mirror the already successful program used by the Department of Education (ED). By using previous years' data, VA will be able to give more timely work-study payments to students and ensure that they paid on time and in full. While we are all intimately aware that IT issues continue to be a problem at VA, we feel confident that by using ED as a model, VA will be able to make their work-study payments more reliably.

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

Prepared Statement of Carlos Fuentes

Chairman Takano, Ranking Member Roe, and members of this committee, 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 committee.

H.R. 485, Veterans Reimbursement for Emergency Ambulance Services Act

This legislation would decouple ambulance reimbursement from reimbursement for emergency room health care services. The VFW supports this bill and has a recommendation to improve it.

The Department of Veterans Affairs (VA) emergency transportation reimbursement process is cumbersome and tends to take unreasonably long. VA must first adjudicate a claim for emergency room care before VA pays for the emergency transportation. In order to have a claim for emergency room services approved, VA must confirm the veteran experienced an emergency, whether the veteran has received VA health care within the past 24 months, if there is an acceptable reason a VA medical facility was not used, and whether the veteran notified VA of the emergency within 72 hours. When the emergency is for a non-service-connected condition, the veteran is required to exhaust all other health care insurance options before VA can cover the cost of transportation.

Veterans who believe they are experiencing an emergency must not be delayed or deterred from contacting 9/11 for emergency assistance because they are concerned VA will refuse to cover the cost of emergency transportation and leave them with crippling health care debt. This bill would rightfully authorize VA to pay claims for emergency room transportation without having to first process a claim for emergency health care.

This legislation would require that a veteran be taken to the closest and most appropriate medical facility as a prerequisite for reimbursement of emergency transportation costs. Ambulance services typically take patients to the nearest emergency room. VA must make certain emergency transportation services are doing their best to take veterans to VA hospitals when possible. Since veterans who are facing an emergency typically do not have the opportunity to influence where they are taken, the VFW would recommend this committee strike the requirement that they be taken to the “closest and most appropriate” medical facility. Doing so would ensure veterans are not forced to pay emergency room reimbursement bills out-of-pocket because VA and the ambulance service disagree on what constitutes closest and most appropriate.

H.R. 712, VA Medicinal Cannabis Research Act of 2019

This legislation would require VA to conduct a double-blind scientific study on the efficacy of medicinal cannabis. The VFW is proud to support this important bill and thanks this committee for its consideration.

Prescribed use of opioids for chronic pain management has unfortunately led to addiction for many veterans, as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of post-traumatic stress disorder, chronic pain, and substance use disorder because medical trials have found them to be effective. To reduce the use of high-dose opioids, VA must expand research on the efficacy of non-traditional medical therapies, such as medicinal cannabis and other holistic approaches.

Medicinal cannabis is currently legal in 33 states and the District of Columbia. This means veterans are able to legally obtain cannabis for medical purposes in more than half the country. For veterans who use medical cannabis and are also VA patients, they are doing this without the medical understanding or proper guidance from their coordinators of care at VA. Many states have conducted research for mental health, chronic pain, and oncology at the state level. States that have legalized medicinal cannabis have also seen a 15–35 percent decrease in opioid overdose and abuse. A comprehensive study by the National Academy of Sciences and the National Academic Press also concluded that cannabinoids are effective for treating chronic pain, chemotherapy-induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia—all of which are prevalent in the veteran population. While VA has testified that it has the authority to study Schedule 1 drugs, it has failed to do so and veterans are tired of waiting for VA. This bill would prevent VA from further delaying needed research.

VFW–Student Veterans of America Fellow Christopher Lamy, an Army veteran and Louisiana State University law school student, focused his semester-long research project and advocacy effort on this important bill. Chris’ research discovered that veterans experience chronic pain at 40 percent higher rates than non-veterans and if not properly treated, such chronic pain often leads to depression, anxiety, and decreased quality of life. Chris also found that states with medicinal cannabis programs have, on average, a 25 percent lower rate of death from opioid overdose than states without such programs.

Veterans Health Administration (VHA) Directive 1315, Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, provides protections for veterans who use medicinal cannabis. However, Chris found that veterans who discuss their use of medicinal cannabis with their doctors are ostracized and have their medications changed or discontinued. The fear of reprisal for medicinal cannabis prevents veterans from disclosing information to their VA

health care providers, which can lead to problems caused by drug interactions. This legislation would prohibit VA from making eligibility determinations for benefits based on participation in the study. To ensure veterans who participate in the study do not have their VA health care negatively impacted, the VFW recommends this committee amend the bill to prohibit VA from denying or altering treatment for veterans who participate in the study. Doing so would provide veterans peace of mind.

H.R. 1647, Veterans Equal Access Act

This legislation would authorize VA doctors to provide recommendations for participation in state-approved medicinal marijuana programs. The VFW agrees with the intent of this legislation, but cannot offer its support at this time.

The VFW agrees that veterans who rely on the VA health care system must have access to medicinal cannabis, if such therapies are proven to assist in treating certain health conditions. Without such evidence, VA would not have the authority to prescribe or provide medicinal cannabis to veterans. The VFW believes it is unacceptable for VA providers to recommend a treatment that they are unable to provide veterans and force patients to pay for the full cost of such care. If VA recommends a treatment plan, it must be able to provide required therapies or prescriptions. That is why the VFW supports H.R. 712, which would enable veterans to participate in medical cannabis research without having to bear the full cost of treatment.

H.R. 2676, VA Survey of Cannabis Use Act

The VFW supports this legislation, which would require VA to commission surveys of veterans and health care providers to measure cannabis use by veterans.

VFW members tell us that medicinal cannabis has helped them cope with chronic pain and other service-connected health conditions. Conducting a scientific survey of veterans and health care providers would assist in identifying the current landscape of medicinal cannabis use and measure its effectiveness. The VFW is pleased the survey would require anonymity, but it does not preclude VA from affecting the employment status of health care providers who participate in the surveys or prevent VA from denying or altering treatment or benefits for veterans who participate in the surveys. The VFW urges this committee to prohibit VA from doing so, which would ensure the fear of reprisal does not affect participation in the surveys.

H.R. 2677, to provide training in the use of medical cannabis for all VA primary care providers

The VFW supports this legislation, which would require VA to train its primary care providers on the use of medical cannabis. While VA health care providers are precluded from prescribing medical cannabis, it is important for them to understand its use and how it affects their patients.

H.R. 2942, to direct the Secretary of Veterans Affairs to carry out the Women's Health Transition Training pilot program through at least fiscal year 2020

The VFW supports this legislation, which would track participation in VA health care and Transition Assistance Program (TAP) courses developed specifically for transitioning women service members. The VFW believes more information about what programs within VA are being used and where there needs more attention is vital to improving the transition process for women veterans. The United States (U.S.) Air Force currently operates a pilot program which adds a voluntary program to the end of the TAP classes for women veterans. This bill would require VA to participate in the additional workshop for women veterans to help guide them toward VA health care and benefits.

H.R. 2943, to make all fact sheets of the VA in English and Spanish

This legislation would require all VA fact sheets to be published in English and Spanish. The VFW agrees that VA must address all barriers to access, including language barriers, but VA must first evaluate the need before it can devote time and resources to translating and publishing its outreach material in different languages.

The VFW represents veterans who live throughout the world and use VA health care and benefits. The VFW has posts in Cambodia, Saipan, France, Germany, Guam, Italy, Japan, Korea, Panama, Philippines, Puerto Rico, Taiwan, Thailand, and Australia. The primary language used by VFW members who reside in those U.S. territories or countries may not be English. The VFW also has many members who reside in the United States, but prefer to use their native language, such as veterans who were born in foreign countries, Native Americans, or Pacific Islanders.

Yet, VFW members have not indicated that fact sheets or outreach material written in English present a barrier for accessing the care and benefits they have earned. That is why the VFW cannot support this bill. To validate the need, this committee should commission a review of language barriers to accessing VA care and benefits before requiring VA to devote time and resources to translate and publish its fact sheets in Spanish.

H.R. 3083, AIR Acceleration Act

The VFW fully supported the Asset Infrastructure Review (AIR) portion of the VA MISSION Act of 2018. The intent of the review is to fully examine the physical infrastructure of VA's health care system and determine what changes are needed to continuously deliver high-quality care. We would, however, be very concerned with expediting the timeline for the AIR commission without further knowledge of the ongoing market area assessments and allowing for proper implementation of the new Veterans Community Care Program.

Secretary Robert L. Wilkie has stated VA would like to move up the timeline of the review because of the market assessments, but he has not provided veterans service organizations information regarding the outcomes of these assessments. Additionally, a significant change to community care was recently implemented, which is estimated to impact the landscape and demand on the VA health care system. It is vitally important VA implements AIR correctly. The VFW warns Congress not to rush the AIR process, because it may cause irrevocable harm to the care and benefits America provides its veterans.

Discussion Draft to improve the work-study allowance program administered by the Secretary of Veterans Affairs

The VFW supports the intent of this legislation, which is to improve and streamline the VA work-study program. This is a vital tool student veterans use to supplement their income. The VFW agrees that improvements are urgently needed to ensure veterans who use this program receive timely work-study payments.

VA's outdated paper-based payment process is negatively affecting students who have to wait several weeks or months to receive payments they need to make ends meet. This legislation would change how VA processes claims by authorizing the school to directly pay program beneficiaries. This would align the VA work-study program with a similar program administered by the Department of Education. The VFW recommends that VA analyzes the similarities and differences of the two work-study programs to glean best practices to improve the delivery of benefits, including alternative ways of delivering payments to student veterans.

However, we cannot support changing the current business practice. Instead, the VFW urges this committee to require VA to evaluate and address barriers that delay work-study payments to ensure bureaucratic processes do not impact the financial well-being of student veterans.

Specially Adapted Housing Discussion Draft

The VFW supports this draft legislation to expand the VA Specially Adaptive Housing Grant Programs (SAH), which help veterans with service-connected disabilities to live independently in a barrier-free environment by providing critical housing adaptations. The accessibility provided through this program greatly increases the quality of life for such veterans, but to qualify, the individual must endure a lengthy and cumbersome process.

This draft bill would allow for more eligible veterans to utilize this life-enhancing benefit and would also increase the maximum amount of each grant. The VFW is pleased this bill would quadruple the number of applicants VA is able to approve annually from 30 to 120. However, we do not think there is a need for a cap on the number of veterans who can use this important program. Every veteran who needs to adapt their home because of service-connected disabilities must have the opportunity to receive an SAH grant.

Common issues veterans face when seeking SAH grants are the timeliness of approvals and the difficulty in finding contractors who are familiar with the SAH grant process. In some cases, the approval may take months, which makes completing activities of daily living difficult. We are encouraged to see this bill would prioritize the application of those veterans who are seriously ill. Veterans with illnesses that progress quickly, such as amyotrophic lateral sclerosis, must be granted an opportunity to adapt their homes as soon as possible.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you or the members of the committee may have.

Prepared Statement of Derek Fronbarger

Chairman Takano, Ranking Member Roe, and distinguished members of the House Committee on Veterans' Affairs, thank you for inviting Wounded Warrior Project (WWP) to testify on these important legislative priorities.

Wounded Warrior Project's mission is to honor and empower wounded warriors. Through community partnerships and free direct programming, WWP is filling gaps in government services that reflect the risks and sacrifices that our most recent generation of veterans faced while in service. Over the course of our 15-year history, we have grown to an organization of nearly 700 employees in more than 25 locations around the world, delivering over a dozen direct-service programs to warriors and families in need.

Through our direct-service programs, we connect these individuals with one another and their communities; we serve them by providing mental health support and clinical treatment, physical health and wellness programs, job placement services, and benefits claims help; and we empower them to succeed and thrive in their communities.

We communicate with our warriors on a weekly basis and are constantly striving to be as effective and efficient as possible by matching our programs - and our advocacy before Congress - to meet warriors' needs. We use these weekly engagements, our yearly WWP Alumni Survey, and direct programming to inform us of our positions outlined in this testimony.

Draft Bill: Ryan Kules Specially Adaptive Housing Improvement Act of 2019

One of WWP legislative priorities is the passage of legislation that expands VA's Specially Adaptive Housing Grant program (SAH). These expansions are outlined in the draft bill titled the Ryan Kules Specially Adaptive Housing Improvement Act of 2019. Ryan Kules is a bilateral wartime amputee who works at Wounded Warrior Project and helped highlight many of the program's deficiencies.

One aspect of this legislation that WWP is supportive of is the full reinstatement of the SAH benefit every ten years. As younger veterans age, get married, and have families, their needs in an adaptive home may change drastically. This is also true for those whose disabilities get worse over time. A veteran with a prosthetic leg might be fine to walk around their home when they are in their thirties, but they might require a wheelchair when they become senior citizens. We want warriors to thrive in their work and personal lives. Often, they must move to take advantage of opportunities to improve their socioeconomic conditions. It is not reasonable to expect a veteran to buy a home and never leave. This benefit is reserved for those catastrophically injured and who deserve our assistance throughout their entire life, not just one portion of it.

This bill also increases the total grant amount from \$81,080 to \$98,492, increases the total amount of applicants into the "expanded" SAH grant program from 30 to 120 a year, and increases the times a veteran may use the grant from three to six. These were all identified as deficiencies in the program that needed updating.

The VA Specially Adaptive Housing Grant assists the most critically ill, injured, and recognizes that Wounded Warriors find solitude in their homes as they transition from service into the civilian world. Wounded Warrior Project supports this Draft Bill as written and considers this piece of legislation a major priority for WWP during the 116th Congress.

H.R. 2942: To Direct the Secretary of Veterans Affairs to Carry Out the Women's Health Transition Training Pilot Program through at Least Fiscal Year 2020, and for other purposes

There are currently around 2,000,000 women veterans in the United States, which comprise 10% of the entire veteran population. Women veterans are the fastest growing cohort which is expected to double by 2045¹. Transition from military to civilian life is a critical touch point for VA and DoD. While women veterans are more likely to attend college, they are also more likely to be homeless over their male counterparts with a homelessness rate of 7.1 percent versus 5.3 percent². Understanding the unique challenges that women veterans face during transition is critical in ensuring success among this population. The Women's Health Transition Training Pilot Program helps transitioning women servicemembers by informing them of women's health and mental health care services available through the Vet-

¹ <https://www.pewresearch.org/fact-tank/2017/11/10/the-changing-face-of-americas-veteran-population/>

² <https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf>

erans Health Administration, along with other tools that may be of use during their transition from military service.

We support H.R. 2942, which would expand the Women’s Health Transition Training Pilot Program through fiscal year 2020.

H.R. 2676, H.R. 2677, H.R. 712, H.R. 1647: VA Survey of Cannabis Use Act, To Require the Secretary of Veterans Affairs to Provide Training in the Use of Medical Cannabis for all Department of Veterans Affairs Primary Care Providers, VA Medical Cannabis Research Act of 2019, Veterans Equal Access Act

Several emerging and alternative therapies have reported some initial results that are promising for the management and treatment of the invisible wounds of war, including post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). A debate surrounding veterans’ rights to access medical cannabis has emerged as a popular topic of discussion in the context of alternative therapies.

Choosing an alternative treatment method is a personal decision that should be made between each warrior, his or her family, and his or her medical team. Wounded Warrior Project encourages warriors to make informed decisions in pursuing the treatment options that are most relevant to their circumstances under guidance from their health care providers. Wounded Warrior Project supports evidence-based and evidence-informed therapies, as well as complementary and alternative therapies that have proven to be successful in rehabilitation and recovery.

While our position is limited in scope, we are using our annual survey to try to better understand how warriors are using cannabis. The 2018 WWP Alumni Survey reveals that around 18 percent of our alumni indicate they have used marijuana; 4.7 percent of those used marijuana less than once a month and 8.4 percent of them used marijuana more than twice a week, with the remainder falling in between³. To better inform our position on the use of medical cannabis, we added additional questions to our 2019 WWP Alumni Survey. While 2019 data is not published yet, we did find that 17 percent of our warriors indicated they use cannabis to treat a mental or physical condition and 49 percent of warriors know a veteran who is using cannabis to treat a condition.

H.R. 2676

Wounded Warrior Project supports legislation to expand research, evidence-based, and evidence-informed therapies. One avenue to help understand the “whole picture” of an issue is survey-based data gathering. We routinely do this with our WWP Alumni Survey and, to this end, support H.R. 2676 as it will require the Secretary of Veterans Affairs to partner with a federally funded research center to conduct surveys to measure cannabis use by veterans. We would recommend a change on page 6, line 5, to strike “not later than one year after the date,” and replace this with “not later than two years after the date” as we have found that surveys take a considerable amount of time to develop, disseminate, and analyze. We do not think one year is long enough for VA to conduct a suitable survey on this topic.

H.R. 2677

H.R. 2677 requires VA to establish a training program to inform primary care providers on the use of medical cannabis. While we do not have a position on H.R. 2677, we are concerned with the lack of clarity on what training VA primary care providers would receive under this proposal and whether the fact that they are federal employees limits their ability in any way. We think that before VA can start training health care providers on the usages of medical cannabis, there must be additional studies on the effects of this drug on this population and the risks regarding the usage of a schedule I drug for veterans while it remains categorized as such.

H.R. 712

Much like H.R. 2676, WWP supports legislation to expand research, evidence-based, and evidence-informed therapies. H.R. 712 would require the Secretary of Veterans Affairs to carry out a clinical trial of the effects of cannabis on certain health outcomes of adults with chronic pain and PTSD. While we support the intent of the bill, we do have some concerns regarding the ability of VA to implement this research study. Specifically, page 5, line 4 through 13, requires the VA to use varying forms of cannabis to include, full plants and extracts, at least three different

³ <https://www.woundedwarriorproject.org/media/183005/2018-wwp-annual-warrior-survey.pdf>

strains of cannabis, and varying methods of cannabis delivery. Currently, the University of Mississippi is the only institution with DEA approval to grow cannabis for research purposes. This is also the only institution that the federal government may purchase cannabis from for a federal study. Reports from former federally funded researchers have indicated that the University of Mississippi is limited in what they grow, which would hamper this proposed research study. If this bill were to pass, VA could possibly be put in a position to perform a study on cannabis strains that may not currently be available to the federal government.

While we support the intent of H.R. 712, we recommend reviewing page 5, line 4 through 13, to avoid a failure in the study due to lack of appropriate cannabis availability.

H.R. 1647

While WWP supports legislation on medical cannabis that is researched-based, we are concerned regarding legislation that could be detrimental to veterans and VA employees due to complications regarding federal and state cannabis laws. Currently, cannabis is a schedule I drug, but many States have laws legalizing medical or recreational cannabis. H.R. 1647 is concerning as it will authorize VA federal employees to recommend and give their opinion on a possible State-level approved medical cannabis treatment alternatives. While medical cannabis is legal in some States, it is still deemed illegal by the federal government. Given that veterans receive medical advice and treatment across different states, it is plausible that a federal employee would recommend medical cannabis to a veteran who resides in a state where it is not legal. This could lead to unnecessary legal action against the veteran due to confusion regarding Federal versus State medical cannabis laws. Additionally, there are insufficient protections in place for veterans regarding employment when using medical cannabis. Lastly, there is no protection for federal employees who recommend the usage of a federally scheduled I drug. This could lead to legal troubles for medical providers who recommend medical cannabis to a veteran as an alternative treatment. These fears lead us to oppose H.R. 1647 until such a time where these concerns can be addressed.

H.R. 3083: AIR Acceleration Act

Wounded Warrior Project acknowledges that VA needs the ability to alter its footprint to become more focused and better aligned with today's ever-changing veteran population. The Asset & Infrastructure Review (AIR) Act was passed in order to assess current resources and allow for a more focused and better-aligned infrastructure that will be designed to support the care to veterans where they might need it. Additionally, this legislation includes stakeholder involvement and other safeguards in the review process to ensure that the final result of the AIR Act is what the community would approve of. With this in mind, we support H.R. 3083 as it would accelerate the implementation of the AIR Act but recommend adding language that clearly states that this bill will be implemented after the market assessments have been completed.

H.R. 2943: To Direct the Secretary of Veterans Affairs to Make all Fact Sheet of the Department of Veterans Affairs in English and Spanish

Wounded Warrior Project does not have a position on this piece of legislation at this time.

H.R. 485: Veterans Reimbursement for Emergency Ambulance Services Act

Wounded Warrior Project does not have a position on this piece of legislation at this time.

Draft Bill: To Improve the Work-Study Allowance Program Administered by the Secretary of Veterans Affairs

Wounded Warrior Project does not have a position on this piece of legislation at this time.

Closing Remarks

In closing, we would like to acknowledge the bipartisan and inclusive spirit that guides the work of these committees. We share a sacred obligation to ensure that our veterans and their families get the support and care they have earned, and the success they deserve. At Wounded Warrior Project, we are committed to that mis-

sion, and we are constantly striving to be as effective and efficient as possible in the life changing programs we provide, as well as our advocacy efforts. We appreciate the committee inviting WWP to comment on these pieces of legislation and the work each member has done on behalf of veterans across the country.

Prepared Statement of Igor Grant, M.D.

Good afternoon,

My name is Igor Grant. I am a physician, neuropsychiatrist and Professor at the University of California San Diego where I direct the Center for Medicinal Cannabis Research (CMCR). During my career I also served for 3 decades as a Staff Physician at the VA San Diego Medical Center where I oversaw the opening the hospital's first mental health outpatient clinic in 1972. Therefore, I have some familiarity with the mental health needs of our veterans.

Some of the prevalent health problems of our veterans include chronic pain, posttraumatic stress disorder (PTSD), certain inflammatory disorders, as well as sleep disorders. Our veterans have not always found the treatments that we offer them to be fully beneficial and they therefore sought recourse outside the VA medical framework including with medicinal cannabis in states where it has been legalized.

I am here today to provide you with my medical opinion based on our experience with the Center for Medicinal Cannabis Research as to the state of current knowledge on medicinal cannabis. Clearly, this is a controversial area, but there are important facts that are emerging. The Center for Medicinal Cannabis Research at University of California San Diego was established in 2000 by legislation of the State of California. The establishment of the Center followed the passage in 1996 of an initiative called the Compassionate Use Act which made California the first state to authorize use of medicinal cannabis. The legislators wished to be provided with more scientific evidence in regard to that initiative.

Since our establishment we completed 8 different short-term clinical trials with cannabis provided to us by the NIDA Drug Supply Program. As you may know, the only legal source of cannabis for medical research is through NIDA which has a contract with the University of Mississippi to grow cannabis.

Our studies found that tetrahydrocannabinol (THC) containing cannabis ranging in strength from 2% to 7% in the several studies showed benefit in a type of chronic pain called neuropathic pain, which can be a complication of HIV/AIDS, diabetes, and certain kinds of injuries; a pain that is sometimes difficult to control through traditional pain medicines. We also found that patients with severe muscle spasticity due to multiple sclerosis derived benefit. Our results dovetailed with emerging data from other investigations, and also were consistent with the report of the National Academies of Sciences, Engineering and Medicine in 2017. That report noted that there was "conclusive evidence" for cannabis and/or cannabinoid benefit in terms of management of certain types of pain, muscle spasticity, as well as nausea control. That report also noted modest evidence for benefit in improvement of certain sleep conditions, particularly when pain was a component, as well as possible evidence for anxiety control, including PTSD. More recently the non-psychoactive cannabinoid cannabidiol (CBD) has been shown to be effective in control of certain uncommon forms of severe intractable epilepsies of children. There are studies that have been initiated to determine whether either THC or THC/CBD mixtures or CBD alone may be helpful in the treatment of some symptoms of PTSD, psychosis, anxiety, autism, essential tremor and sleep disorders.

Another area of increasing interest is the possibility that cannabinoids may have an "opioid sparing" effect. What this means is that it may be possible that the administration of cannabis or cannabinoids may reduce the requirement for opioids for patients with severe chronic pain problems, and it might in theory be possible to entirely eliminate the opioids. If research shows that these benefits are there, then this would be a step forward in combating the morbidity and mortality associated with chronic opioid use in our patients.

In summary, what I would recommend to you is that the area of medicinal applications of cannabis and cannabinoids has matured to a level that it is now clear that these drugs can be helpful for some chronic medical conditions, including conditions that are found in moderately high prevalence among our veteran population. As such, it is my opinion that the VA would be benefitting our veterans by:

1)Assuring that VA physicians and other medical staff receive education on both the potential value of medicinal cannabinoids as well as their side effects and possible harms, as well as what remains unknown;

2)Encouraging VA health providers to provide unbiased, authoritative information to veteran patients on medicinal cannabis and cannabinoids if the veteran's medical condition might be benefitted from these based on emerging scientific consensus, such as articulated in the National Academies 2017 report and subsequent analyses;

3)That in medical marijuana legal states, VA physicians be allowed to recommend use of medicinal cannabis if the emerging scientific evidence indicates there may be benefit;

4)That in States that permit medicinal cannabis use, veterans who receive medicinal cannabis in a manner compliant with State law not be subjected to any adverse action in regard to their VA treatment or other benefits as a consequence;

5)That the VA collaborate with Medical Boards in Medicinal Cannabis states to develop protocols and decision trees to guide medicinal cannabis and cannabinoid administration based on the emerging science.

This leads me to my final comment and that is it is essential that high quality medical studies continue to be done in this area. I recommend that the VA work closely with academic universities that have expertise in this area, to pave the way to a better understanding of indications, cautions, factors that might affect benefit and risk in special populations, such as the elderly or persons with substance use disorders, values of specific cannabinoids and their combinations, pharmacology related to routes of administration, interactions with other medicines, and optimal duration of treatment.. Many years ago, when I was training as a psychiatrist, I learned about the VA's landmark role in determining the value and limitations of antipsychotic medicines in the treatment of schizophrenia. I believe the VA, with its academic partners, can be at the forefront again of creating a better understanding of the place of cannabis and cannabinoids in addressing the health needs of our patients.

Thank you for your attention.

Prepared Statement of Larry Mole, PHARM.D.

Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services, including H.R. 712, H.R. 1647, H.R. 2676, H.R. 2677, H.R. 2942, and H.R. 2943. Due to the delay in notification regarding H.R. 485, H.R. 3083, the draft Specially Adapted Housing Improvement bill, and the draft Work-Study Allowance Program Improvements bill, we are unable to provide views on those bills at this time, but will follow up with the Committee as soon as possible. With me today are [TBD].

H.R. 712 - VA Medical Cannabis Research Act 2019

H.R. 712 would require VA conduct a clinical trial of a size and scope to include multiple strains of cannabis compositions and multiple administration methods on covered Veterans with multiple medical diagnoses and a multitude of clinical outcome measures.

VA has a rich history of scientifically driven contributions that have advanced health care through planning and implementing high quality clinical trials so that we can all better understand the results and potential for changing clinical practice when trials are complete. VA's Office of Research and Development has a program in place to fund clinical trials that are submitted to our expert peer review system for evaluation of scientific merit based upon the rationale, design, and feasibility of a proposal. Such trials could include the topic of medical uses of cannabis for conditions that impact Veterans. Clinical trial applications must detail the underlying rationale for the use of an experimental intervention such as cannabis for use in humans.

The proposed legislation with the mandated requirements is not consistent with the practice of scientific design for randomized clinical trials nor is it possible to conduct a single trial to obtain the information desired. The specification in the legislation of the multiple requirements such as type and content, administration route, diagnostic specifications representing potential inclusion and exclusion criteria, and outcome measures are not consistent with the current state of scientific evidence, which suggests that smaller, early phase controlled clinical trials with a focused set of specific aims are warranted to determine initial proof of concept for medical marijuana for a specific condition. Any trial with human subjects must in-

clude evaluation of risks and benefits/safety and include the smallest number of participants needed to avoid putting subjects at risk unnecessarily. In any study, the size of the experimental population is determined statistically so that the power or ability to detect group differences (between control and experimental groups) is based on known effects that can be shown using a specific outcome measure. For a cannabis trial, some of these effects are not known, thus a circumscribed approach to determine dose, administration modality, and best outcome measure(s) must still be studied or shown in a proof of concept approach to ensure the research would have the ability to detect the impact of the intervention in a controlled way. Typically, smaller early phase trial designs, instead of the extremely large study suggested in legislation, would be used to advance our knowledge of benefits and risks regarding cannabis before moving to the type of more expansive approach described in this proposed legislation, which is more akin to a program of research than a single clinical trial. The requirements to simultaneously address different modes of administration, different compositions, and different medical diagnoses without consideration of underlying rationale and mechanisms would not be a good use of taxpayer money, and in fact would not engender a favorable scientific peer review evaluation or regulatory approval. A plan forward to determine the legislative mandate should start with a scientific query or review of what is known for diagnostic categories of interest and what is logically called for in exploring next level clinical investigation.

VA is actively exploring pathways to contribute to the overall understanding of the possible contribution of medical cannabis to Veterans' health care. VA is reviewing the clinical state of the evidence regarding medical marijuana, which concluded more research is needed, especially related to clinical trials. VA is currently supporting a clinical trial of cannabidiol for posttraumatic stress disorder (PTSD) based upon a strong design and rationalized mechanism in a trial that will assess risks and benefits. VA has also encouraged other medical marijuana research. For all these reasons, VA is not supportive of this proposed legislation.

H.R. 1647 - Veteran Equal Access Act

This bill would require VA to authorize its physicians and other health care providers to provide recommendations and opinions to Veterans who are residents of states with state-approved marijuana programs regarding participation in such programs and to complete forms reflecting such recommendations and opinions.

The Veterans Health Administration's (VHA) policy prohibiting VA providers from recommending or making referrals to or completing paperwork for Veteran participation in state marijuana programs is based on guidance provided to VA by the United States Drug Enforcement Administration (DEA), the agency with authority to interpret the Controlled Substances Act (CSA).

Under CSA, marijuana is presently a schedule I controlled substance. VA defers to the Department of Justice (DOJ) to determine the legal effect of the phrase "notwithstanding any other provision of law" on the enforcement of CSA against VA providers who might assist Veterans in participating in state-approved marijuana programs.

VA encourages its providers to discuss marijuana use with Veterans who are participating in state-approved marijuana programs, but we do not support this bill. Though research studies are in progress, the scientific benefit of most products derived from the marijuana plant is still not proven, and VA must provide consistent, safe, science-based care for all Veterans. Further, the marijuana industry is largely unregulated, and products are often not accurately labeled, so providers cannot ascertain the strength and levels of active ingredients in the product being used by a particular patient, complicating medication management and treatment.

H.R. 2676 - VA Survey of Cannabis Use Act

H.R. 2676 would require VA to enter into an agreement with a federally-funded research and development center to conduct nationwide surveys to measure cannabis use by Veterans. The center selected by VA would have to have: (1) an in-depth knowledge of all state medicinal marijuana programs and the ability to tailor the required surveys accordingly; and (2) expertise and a record of independent, peer-reviewed publications with respect to behavioral health research and conducting independent evaluations of mental health programs using multidisciplinary methods. In conducting the surveys, the center would have to survey Veterans who are enrolled for VA health care and those who are not, collect information from VA health care providers and be conducted in a manner that ensures the anonymity of the individual being surveyed. The surveys of Veterans would have to cover 12 different topics, and the surveys of providers would have to cover 7 different topics.

Not later than 1 year from the date of the enactment of this bill, VA would have to submit a report to Congress on the results of these surveys.

We do not support this bill. The legislation would prescriptively define how the surveys would be conducted, but it does not provide the purpose, goals, or objectives for the surveys. We have significant concerns that Veterans will not want to participate, despite the survey being anonymous. The survey of providers would be difficult to complete because it is asking for both overall impressions of cannabis use among Veterans and specific documentation for patients using cannabis. This would produce a significant burden on providers, requiring a review of charts for their patient panels. It is very likely that the response rate would be low, both because of this burden and because of the anonymity of responses (which would make it impossible to identify and follow up with non-responding providers). Moreover, the survey results would likely only be meaningful if we knew where Veterans live and where providers practice, given the variability of state laws, but submitting information on the state could reduce the anonymity of the survey as well (particularly in small states). Finally, we note that the survey of Veterans might be subject to the Paperwork Reduction Act (44 U.S.C. 3501 et seq.), and compliance with the requirements of this Act could delay VA's implementation of this survey beyond the 1-year period the bill would permit.

H.R. 2677 - Training in the Use of Medical Cannabis for All VA Primary Care Providers

H.R. 2677 would require VA, within 1 year of the enactment of the bill, to provide an initial training for all VA primary care providers in the use of medical cannabis. VA would be required to provide supplemental training, as necessary. In developing this training, VA would be required to enter into partnerships with medical schools that have incorporated education on medical cannabis into their curricula.

VA does not support this bill. We do not believe there is sufficient scientific study and research findings to support a comprehensive training program. Marijuana potency is highly variable, and state laws governing medical marijuana are inconsistent, which would further complicate our ability to develop training for all providers, ultimately making it difficult to construct a curriculum that provides recommendations for a standard of care without a sufficient evidence base. Additionally, we are concerned that the bill requires partnering with medical schools who have incorporated medical cannabis into their curricula. A medical school's curriculum in this area likely reflects the applicable state laws, but any national training VA provided should not be state specific. This would, again, make it difficult to adapt any single school's curriculum to the Federal level. We further note that VA already makes available to all providers information sessions on cannabis, including a course on caring for patients who use marijuana at the end of life, a review of current findings and clinical considerations regarding cannabis use and PTSD, and the latest on marijuana use, effects, and treatment implications for Veterans. VA's Academic Detailing Program also provides resources for providers to have meaningful conversations with their patients. Finally, VA has tried to limit the amount of mandatory training directed at clinical providers. Instead, we have used other mechanisms to spread awareness and information about key clinical issues. Each hour of mandatory training takes over 20,000 doctors, 80,000 nurses, and thousands of other practitioners away from direct patient care duties. This is not only expensive but reduces access to vital services for Veterans.

H.R. 2942 - Women's Health Transition Training Pilot Program

H.R. 2942 would require VA to carry out the Women's Health Transition Training pilot program until at least September 30, 2020. VA and the Department of Defense would be required, by September 30, 2020, to jointly submit a report to Congress on the pilot program including a number of specified elements.

Carrying out this pilot program until at least September 30, 2020, is favored by VA for the reasons stated below, and while we do not believe this bill is necessary in order to do so, we do not oppose the bill. Our authority to operate the pilot program is not limited; VA is conducting the pilot under the direction of the VA/Department of Defense Health Executive Committee. The pilot program is currently funded through December 2019 for an additional 24 face-to-face training sessions and initial virtual training sessions. VA will plan to continue the pilot through 2020 to ensure additional face-to-face sessions are conducted for statistically-meaningful results on the efficacy of the pilot program. Currently, the vast majority of the pilot program participants have been from the Air Force. Extension of the pilot program through Fiscal Year (FY) 2020 will allow for greater inclusion of transitioning Servicewomen from the Navy, Marine Corps, and Army. We anticipate that robust participation from these services could help achieve sample size requirements and greatly inform

the full-scale implementation of this program. We also will need until September 2020 to be able to account for at least half of our current cohort's outcomes. We expect that continuing this program through 2020 will allow us to answer questions about the program's efficacy, participant satisfaction, and the impact on participant awareness; it will also provide an opportunity to collect a wealth of qualitative information for women across various Service branches. Understanding the needs of Servicewomen across military branches can help inform future VA health education and training programs, including and beyond women's health. We believe that completing the pilot program at the end of FY 2020 would allow VA to submit a report to Congress by the end of that calendar year.

H.R. 2943 - Making Fact Sheets Available in English and in Spanish

H.R. 2943 would require VA to make versions of all VA fact sheets in English and Spanish.

We agree with the intent of this legislation, but we do not support the bill because it is unnecessary as VA currently has the authority to produce materials in English and in Spanish, and our efforts already meet the goals of the legislation. Initially, we note that VA is committed to ensuring no individual is subject to discrimination because of national origin. In March 2016, VA adopted a Language Access Plan to ensure equal access to services provided by VA to individuals with Limited English Proficiency (LEP). The Plan aims to eliminate or reduce, to the maximum extent practicable, LEP as a barrier to accessing VA benefits and services. The Plan establishes detailed policies and processes, including the use of bilingual employees in telephone and face-to-face encounters. For written materials, the Plan leaves VA discretion concerning what steps it should take regarding translation of documents into Spanish or other languages. We believe this discretion is necessary given the huge variety and volume of written materials produced by VA. We note that the legislation only refers to "fact sheets," but does not define that term, which could make implementation of this bill difficult if it were enacted. We would be glad to discuss with the Committee VA's efforts toward ensuring all Veterans and beneficiaries are able to access the benefits and services for which they are eligible.

Conclusion

This concludes my statement. I would be happy to answer any questions you or other Members of the Committee may have.

Prepared Statement of Representative Scott R. Tipton (CO-03)

Chairman Takano, Ranking Member Roe, and distinguished Committee Members, thank you for considering H.R. 485, the Veterans Reimbursement for Emergency Ambulance Services Act or VREASA, during today's legislative hearing.

Costs associated with emergency ambulance services to non-VA facilities are a huge financial burden for our nation's veterans, and one that those who have earned healthcare benefits through their service to this nation should not be required to pay.

VREASA is bipartisan legislation intended to address Department of Veterans Affairs' (VA) regulations that could unfairly burden veterans with the costs of emergency ambulance services to non-VA facilities.

Historically, some veterans have been denied their reimbursement claims for emergency ambulance services to non-VA facilities primarily because of how the VA was interpreting its regulations. Unfortunately, the VA's interpretation would leave these veterans to pay for these ambulance bills out of pocket. VREASA would clarify that veterans' expenses for emergency ambulance services to non-VA facilities are authorized to be reimbursed by the VA. In addition, VREASA ensures that the prudent layperson standard will be applied to emergency ambulance services to non-VA facilities.

I was pleased that the VA promulgated a regulation as an attempt to remedy this problem. However, to better ensure that our nation's veterans will be reimbursed by the VA for their emergency ambulance services at non-VA facilities, Congress should codify this requirement since administrations are free to change regulations. VREASA achieves codification giving our nation's veterans certainty, stability, and peace of mind to know that should the unforeseen occur where they need emergency ambulance services to a non-VA facility those expenses will be reimbursed.

Again, I thank the Committee for its consideration of VREASA today and look forward continuing to work in a bipartisan manner with the Committee to advance VREASA through the legislative process and toward final passage in the House.

Prepared Statement of David Cox, Sr.

The Honorable Mark Takano Chairman
House Committee on Veterans' Affairs
B234 Longworth House Office Building
Washington, D.C. 20515

The Honorable Dr. Phil Roe
Ranking Member
House Committee on Veterans' Affairs
3460 O'Neill House Office Building
Washington, D.C. 20024

June 18, 2019

Dear Chairman Takano, Ranking Member Roe, Members of the Committee,

On behalf of the more than 700,000 federal and D.C. government employees represented by the American Federation of Government Employees, AFL-CIO (AFGE), including the 260,000 frontline Department of Veterans Affairs (VA) employees represented by our National VA Council (NVAC), I write to register strong opposition to

H.R. 3083, the "AIR Acceleration Act," a bill that would authorize the Asset and Infrastructure Review Commission to begin its operations on an earlier schedule than that which was included in the VA Mission Act.

This Mission Act's provision for this Commission was modeled on the Defense Department's Base Realignment and Closure (BRAC) process, and there has never been any doubt that its purpose is to reduce the number of VA medical centers and clinics. AFGE strongly opposed this section of the Mission Act and opposes accelerating the dismantlement of VA through H.R. 3083.

From the beginning of the debate surrounding the MISSION Act, AFGE has warned against the negative consequences that closing VA facilities will have on patient care and the capacity of VA to meet veterans' demand for services. Make no mistake: the Asset and Infrastructure Review Commission will not result in improved infrastructure, it will serve to facilitate the closure of VA facilities.

Once the closures begin, veterans will no longer have the "choice" of VA's world-class integrated healthcare system. Their only choice will be private care. Privatized care will be the only care.

A closure commission for VA takes away Congressional responsibility - and authority - for VA's infrastructure decisions. The default position is that the Commission's recommendations will advance unless Congress explicitly overrides a Commission decision. It is unconscionable to leave the future of VA hospitals and clinics - whether they will be built, renovated, or closed and sold - to an unelected group of political appointees. To allow H.R. 3083 to become law would be a terrible abdication of responsibility on the part of the Congress.

Please also be aware that BRAC-style closures do not result in cost savings. In particular, when healthcare provided in VA facilities is replaced by care purchased from providers in the private sector, costs will rise substantially. Costly and unaccountable private care does not meet the promises our nation has made to veterans.

In the strongest possible terms, AFGE urges you to oppose H.R. 3083. We ask instead that the Committee focus its attention toward requiring the VA to fully staff its hospitals and clinics and fill its more than 50,000 open positions so that veterans can obtain the world-class, veteran-centric care at the VA that they have earned. If you have questions regarding AFGE's position on H.R. 3083, please contact Matt Sowards at Matt.Sowards@afge.org.

Sincerely,

J. David Cox, Sr. National President

Prepared Statement of Eric Goepel

Chairman Takano, Ranking Member Roe, and Members of the House Committee on Veterans' Affairs,

The Veterans Cannabis Coalition would like to thank you for the opportunity submit a statement for the record to the Committee concerning veterans and cannabis issues currently under consideration. We would especially like to thank the Com-

mittee for its continuing work to address the needs of veterans for effective, low-risk treatments. The staggering rate of veteran deaths by suicide and overdose (an outcome that is too often ignored) is indicative of the ongoing crisis in our community. We know what veterans need to be successful, because they are the same basic components every citizen needs for success: patient-centered healthcare, housing, and gainful employment.

Overview:

The House Committee on Veterans' Affairs has several bills related to cannabis and veteran issues currently before the body. Collectively, these bills seek to address the friction that exists between federal and state law and better understand cannabis and how veterans use it medicinally. The underlying issue of prohibition is beyond the scope of the Committee, but there are still many ways to serve veterans by addressing specific concerns that have arisen.

Current Legislation

H.R. 2676 - VA Survey of Cannabis Use Act (Moulton)

Position: **Support.** We appreciate the intent to establish the shape and extent of cannabis use among veterans but would add that a survey of this kind would create the opportunity to collect important information about veterans current and past pharmaceutical and drug use. There is an immediate need to establish a clear picture of how substances are impacting veterans and we should be looking at the full range of substance use: alcohol, tobacco, pharmaceuticals (of particularly interest is non-steroidal anti-inflammatory drug (NSAID) opioid, benzodiazepine, and antidepressant use), and illicit drugs.

H.R. 2677 - To require VA to provide training in the use of medical cannabis in conjunction with medical schools that have incorporated education on medical cannabis into their curricula. (Moulton)

Position: **Support.** VA physicians are not unique in lacking substantive knowledge about cannabis, cannabinoids, or the endo-cannabinoid system (ECS)-this lack of knowledge is reflected in the larger medical community. This particular point was highlighted recently in an op-ed in the Journal of the American Medical Association. While the need for primary education is apparent, we would suggest that conditioning VA participation on the actions of an independent party (a medical school, in this case) leaves too much room for delay.

Past statements have made it clear that if cannabis remains a Schedule I substance, VA will not support changes to how they interact with cannabis beyond some narrow adjustments. Simultaneously, the Department has boasted that some 70% of the country's doctors receive professional training at VA facilities-this would suggest that VA is uniquely equipped in leading the development of cannabis education for providers, has the resources necessary, and therefore should do so with all haste.

H.R. 712 - VA Medicinal Cannabis Research Act (Correa)

Position: **Strongly support.** The VA Medicinal Cannabis Research Act is a much needed, directed effort to jump start VA cannabis research. The Department has publicly disclosed two cannabis research studies and identified one specifically at the University of California San Diego. Our concern is that the UCSD study uses a limited form of cannabis (synthetic cannabidiol (CBD) isolate), is still recruiting for a target sample of 136, and is scheduled to be completed in 2023. It costs \$1.6 million, which is a rounding error in a Department with a \$200 billion budget.

VA has demonstrated that, as mentioned before, they do not intend to support changes to the status quo without a change in cannabis' schedule. This is, frankly, a shirking of responsibility to veterans, of which 1-in-5 surveyed by the American Legion and Iraq and Afghanistan Veterans of America (IAVA) self-report using cannabis for their service-connected injuries. It is especially striking in light of rampant veteran suicide and overdose, a noted lack of urgency or results from the VA in stemming or reversing these outcomes, and the link many veterans have reported between attempted suicide and legal pharmaceutical use. One of the answers to this inertia and a status quo that sees at least 6,000 veteran dead by suicide and overdose a year is a robust, funded, and coordinated research initiative lead by VA that explores the potential of cannabis.

H.R. 1647 - Veterans Equal Access Act (Blumenauer)

Position: **Strongly support.** The language in this bill has been introduced for the third Congress in a row and represents a basic concession to the needs of veterans who use the VA as well as closing an obvious gap in continuity of care. The fact that this effort is still not in law, that it is still opposed by VA, and is still being

asked for by veterans is another demonstration of the disconnect between those charged with providing the best care possible and those they serve.

Conclusion:

The sheer number of bills introduced in the 116th Congress dealing with veterans and cannabis demonstrates both an immediate need for reform and a critical lack of progress at the VA's current self-directed pace. Congress and the VA both have a historic responsibility to veterans that has devolved into endless rounds of delays, denials, and unfulfilled promises while veterans die at a staggering pace, day after day, year after year. As advocates, we see how this grind is damaging our community on a regular basis and see few solutions being offered and fewer still being acted on. It is far past time for members of Congress to listen to veterans themselves and do everything in their power to deliver on the promise the nation makes to every man and woman who serves in uniform.

Respectfully,
 Eric Goepel
 Founder & CEO
 Veterans Cannabis Coalition
 Bill Ferguson
 Co-founder
 Veterans Cannabis Coalition

Prepared Statement of Randy Erwin

The Honorable Mark Takano
 Chairman
 House Committee on Veteran Affairs
 B234 Longworth House Office Building
 Washington, D.C. 20515

The Honorable Phil Roe
 Ranking Member
 House Committee on Veteran Affairs
 3460 O'Neil House Office Building
 Washington, D.C. 20024

June 18, 2019

Chairman Takano, Ranking Member Roe, Members of the Committee,

On behalf of the more than 100,000 federal workers and the employees of the Veterans Affairs Department (VA) represented by the National Federation of Federal Employees (NFFE), I write to you today to urge you to oppose H.R. 3083, the "AIR Acceleration Act." This legislation, should it become law, would authorize the Asset and Infrastructure Review Commission to meet earlier than the agreed upon timelines established in the VA MISSION Act. While the commission is called "asset and infrastructure review" it is nothing more than a Base Realignment and Closure (BRAC) style panel for VA facilities. NFFE unequivocally opposes this section of the law and, without question, opposes this legislation.

From the beginning of the debate surrounding the MISSION Act, NFFE has sounded the alarm on this proposal and the negative affect it will have on patient care generally and the world-class VA system broadly. The commission will result in the closure of VA facilities. That, coupled with the MISSION Act's extremely broad access standards, will mean the VA's increased reliance on private providers for veterans' healthcare needs - privatization of the VA.

What is especially troubling about this commission is that it will take away Congressional authority involving the building, renovating, and closing of VA facilities. The way this commission is designed, Congress would have to pass a resolution of disapproval in order to override a decision made by the commission. Congress should be responsible for overseeing the funding and the maintenance of the VA's physical plant, not unelected political appointees in Washington, D.C.

Once VA facilities are closed, every veteran in that area will then be issued a voucher and forced to the private sector. Given the continuing problems of VA private sector care and standards, under no circumstances should we speed up this process by allowing the Commission to meet earlier than the agreed upon timelines as H.R. 3083 would do if enacted.

NFFE strongly urges you to oppose H.R. 3083; rather, and support the world-class, veteran-centric institution that is the VA, employing and caring well for America's veterans.

Sincerely,

/s/ Randy Erwin

Randy Erwin, National President

Prepared Statement of Thelma Roach

June 19, 2019

The Honorable Mark Takano
Chairman
House Committee on Veterans' Affairs
420 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Takano:

On behalf of the nearly 3,000 members of the Nurses Organization of Veterans Affairs (NOVA), we would like to provide comments to the Committee in opposition to H.R. 3083, The AIR Acceleration Act, legislation that would accelerate the timeline on the Asset and Infrastructure Review Commission. If anything, we believe the timeline of the AIR Commission should be slowed down or eliminated entirely.

P.L 115-182, Sec 202(d) of The MISSION Act, established an external Asset and Infrastructure Review (AIR) Commission to evaluate all Veterans Health Administration facilities with respect to utilization. On final recommendations, the AIR Commission will recommend closure, expansion or replacement of VA facilities. Unlike the Department of Defense BRAC Commission on which it is modeled, Veterans receiving care at a closed facility would not transfer to another VA. Instead, Veterans would automatically be moved into the Veterans Community Care Program (VCCP).

As NOVA has asserted in the past, Veterans are served better at a VHA facility than in outside communities. Data collected by RAND and Dartmouth researchers have confirmed that the quality of VA's healthcare in regional markets is as good as, and in many instances superior to that of non-VA facilities. Veterans receive care in an environment where healthcare professionals are better trained to provide the right kind of care for service-connected injuries and illness like TBI, PTSD, spinal cord injuries, toxic exposures, military sexual trauma and suicide.

VA remains the expert in treating these health concerns.

NOVA also would like to remind the Committee that closing a facility and sending Veterans into the fee-for-service private sector is likely to add, not reduce, overall spending. And timely access to care is less likely since VA's Access Standards ensure that VA facilities' wait times are monitored and enforced, but there are no set expectations of timeliness for care of Veterans in the community.

Finally, we would like to point out that Members of Congress will have limited authority to alter the final proposed recommendations. H.R .3083, and in fact any plan to close VHA facilities, must be met with a thorough assessment of the many ramifications - cost, quality and timeliness of care, research, employment opportunities - and an understanding of the vital services that VA Medical Centers provide to our Nation's Veterans.

Sincerely,

Thelma Roach-Serry, BSN, RN, NE-BC
President
Nurses Organization of Veterans Affairs (NOVA)

CC: Ranking Member, Dr. Phil Roe

Statements For The Record

PARALYZED VETERANS OF AMERICA (PVA)

Morgan Brown

Chairman Takano, Ranking Member Roe, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of care provided by VA better than PVA's members-veterans who have incurred a spinal cord injury or disorder. Several of these bills will help to ensure veterans receive timely, quality care and benefits. PVA provides comment on the following bills included in today's hearing.

H.R. 485, the "Veterans Reimbursement for Emergency Ambulance Services Act"

VA is authorized to reimburse the cost of emergency transport for veterans but often denies emergency ambulance claims due to improper interpretation of its own regulations, leaving tens of thousands of veterans to pay these bills out of pocket. No eligible veteran should ever have to worry if VA is going to reimburse a transportation company for transporting them to the closest and most appropriate medical facility capable of treating their emergency. Therefore, PVA supports H.R. 485 which seeks to make reimbursement for emergency ambulance services consistent with how VA reimburses for other emergency medical services.

H.R. 712, the "VA Medicinal Cannabis Research Act of 2019"

There is a growing body of evidence that cannabinoids are effective for treating conditions like chronic pain, chemotherapy induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia. H.R. 712 directs the VA Secretary to carry out a clinical trial of the effects of cannabis on health conditions like these as well as post-traumatic stress disorder. PVA supports evidence-based alternative treatments, including research into the efficacy of medical cannabis. A series of clinical trials on the use of medicinal cannabis would help to determine if it could provide any medical benefits for veterans.

H.R. 2942, the "Women's Health Transition Training Pilot Program"

PVA supports this legislation, which would extend and expand an ongoing pilot program jointly run by VA and the US Air Force to educate transitioning service-women about women's health care at VA. Despite being the fastest growing cohort in our military community, many servicewomen are still unaware of the benefits and services available to them. Early indicators suggest this approach may be effective. Continuing the pilot program and expanding it to women veterans of other services should provide the Department of Defense and VA the data it needs to assess the feasibility of making this program permanent along with the prospects of offering it in an online version or using it to auto-enroll participants in VA health care.

H.R. 3083, the "AIR Acceleration Act"

PVA opposes any legislation that seeks to accelerate the comprehensive review of VA capital assets directed by the VA MISSION Act of 2018 (P.L. 115-182). The timeline established in P.L. 115-182 was carefully formulated to ensure proper assessment of VA's facilities and infrastructure, nomination of commission members, and consultation with veterans service organizations were completed prior to any official meetings by the commission. Accelerating this timeline for commission meetings as allowed under H.R. 3083 would effectively allow VA to short-circuit this process. We are concerned that such a decision would undermine the protections put in place to ensure VA's Asset and Infrastructure Review (AIR) process is conducted in a fair and impartial manner, and that the commission has accurate data to work with.

Discussion Draft, the "Ryan Kules Specially Adaptive Housing Improvement Act of 2019"

PVA gives its strongest endorsement to this proposed legislation which raises the number of times veterans can request specially adaptive housing grants and directs VA to prioritize Specially Adapted Housing (SAH) claims for veterans with a terminal illness. It also raises the overall amount for SAH grants to \$98,492 and Spe-

cial Housing Adaption (SHA) grants to \$19,733, and provides a supplementary grant in case the veteran moves.

VA's specially adaptive housing grant programs help veterans with certain service-connected disabilities to live independently in a barrier-free environment by providing critical housing adaptations. Many PVA members have benefited from the SAH grant program and the accessibility they gain through it greatly increases the quality of life for these veterans.

Annual increases for VA's specially adaptive housing grant programs are tied to the Turner Building Cost Index but these small rises do not take into account for geographical costs associated with construction. For example, the cost of an accessibility ramp for a house in western New York is far less than it would cost here in the National Capitol Region. The one-time increases for SAH and SHA benefits that this bill provides will help to accommodate some of these differences.

The bill will also increase the number of times that the grant can be accessed. Currently, veterans can access their specially adaptive housing benefit a maximum of three times up to the maximum amount of the grant. Unfortunately, there are occasions where severely disabled veterans who previously used specially adaptive housing grants to modify a home were left without assistance after their disability became worse. For example, a patient with Multiple Sclerosis who was able to ambulate with an assistance device used the specially adaptive housing grants three times to adapt two homes at different periods of his life now requires a wheelchair to move as the disease has progressed. The veteran needs to make additional modifications to his residence to accommodate the use of a wheelchair, but the current cap on use forces him to pay for these adaptations out of his own pockets. Increasing the number of times a veteran can access the benefit will help ensure veterans are able to utilize their maximum specially adaptive housing benefits.

Additionally, in cases where a veteran has exhausted all of his or her benefit, this bill would authorize VA to provide a supplementary grant to eligible veterans. This would be particularly beneficial for veterans who are in a position to relocate. If a veteran is offered a job and has to move, historically the veteran would be forced to pay for any modifications to her new residence if she has exhausted her benefit. By having a supplementary grant, these veterans would now have the ability to move to a new residence and receive monetary assistance for modifications.

Finally, since VA first established Amyotrophic Lateral Sclerosis (ALS) as a presumptive condition in 2008, PVA has represented the majority of veterans who have claimed service-connection for this disease. ALS manifests itself very quickly and it is imperative that benefits needed to enhance quality of life are approved once a veteran is diagnosed with it. Prioritizing SAH benefits for terminally ill veterans, such as those with ALS, is simply the right thing to do and we appreciate its inclusion in this legislation.

We urge Congress to pass this important legislation as quickly as possible.

Discussion Draft, "Improvement to Work-Study Allowance Program"

This draft legislation would grant VA the authority to provide to educational institutions an annual amount for the school to use in paying work-study allowances to veterans enrolled at the institution. PVA supports this proposal which would increase educational opportunities for veterans pursuing non-traditional means of education to start a new career and facilitate an easier transition from the military to civilian life.

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

VETERANS HEALTHCARE POLICY INSTITUTE

Chairman Takano, Ranking Member Roe, and Members of the Committee:

The Veterans Healthcare Policy Institute (VHPI) would like to thank you for the opportunity to submit a statement on the record regarding H.R. 3083, The AIR Acceleration Act. We appreciate your bipartisan recognition that all Americans deserve to know their tax dollars are being used efficiently to ensure the highest quality and availability of veterans' health care.

We strongly urge caution when reviewing The AIR Acceleration Act (H.R. 3083), which would accelerate the timeline for the Asset and Infrastructure Review Commission. As we document in this analysis, there are harmful secondary consequences of a Veterans Health Administration (VA) facility closure that must be

very thoroughly studied. Closure will likely increase overall costs and divert critical funds away from the national VA healthcare system. Beyond costs, shuttering any VA facility will erode the care of veterans, reduce the availability of clinicians with veteran-specific expertise, decimate healthcare education/research, harm local economies and diminish emergency preparedness.

Overview

Pub.L. 115–182, The VA MISSION Act of 2018, Sec. 202 established an Asset and Infrastructure Review (AIR) Commission to evaluate all VA facilities' utilization patterns and infrastructure needs, and recommend whether to close, replace, expand or repurpose them. Congress will have no authority to alter the final set of the Commission's recommendations. Instead, Congress may only approve or disapprove of the recommendations in their entirety, within a tight time frame. Because there will be no ability to walk back the Commission's proposals, it is critical that Commissioners and Members of Congress be thoroughly aware of the far-reaching repercussions of any recommended closures.

This document analyzes the severe economic, healthcare, training, and research consequences of a VA facility closure. As the nation debates the future of its largest and only publicly-funded, fully integrated healthcare system, it is critical to understand the vital role these medical centers play in their communities and the breadth and depth of the services they deliver to veterans.

Following is a summary of the major adverse consequences that **closing a VA facility will**:

- 1. Increase overall costs and drain funds from remaining VA facilities, ultimately eroding the availability of care throughout the system,**
- 2. Diminish veterans' access to veteran-specific, high quality, comprehensive and integrated care in their community,**
- 3. Increase wait times for veterans and non-veterans at non-VA facilities,**
- 4. Eliminate veterans' choice if they prefer to receive their care in the VA,**
- 5. Decimate residency and fellowship training programs at the affiliated medical and health professional schools,**
- 6. Diminish the number of graduates who enter the local network of healthcare providers to treat veterans and the non-veteran public,**
- 7. Impede efforts to recruit providers at other VA facilities,**
- 8. Reduce VA research projects that benefits veteran rehabilitation and health care for all Americans,**
- 9. Hamper local governments' ability to respond to national emergencies and natural disasters.**
- 10. Layoff employees, which would significantly impact the local economy. (Veterans make up a third of VA employees and many will find it difficult to secure employment).**

SPECIFIC ADVERSE IMPACTS OF A VA FACILITY CLOSURE

1. Impact on the VA Budget

Costs associated with closing a VA facility will be higher than keeping it open because:

- The number of veterans whose care is financed by the VA will increase. Of the approximately 19.6 million veterans, 32% were enrolled in the system and had some VA or Community Care paid by the VA last year; 14% were enrolled but did not have any care paid by the VA, and remaining 54% were not enrolled for VA-paid care¹.

¹“Avery Dennison Template - VA.gov.” <https://www.va.gov/vetdata/docs/pocketcards/fy2019q1.PDF>.

	A	B	C	
	Enrolled, some VA paid care in the last year	Enrolled, no VA paid care in the last year	Potentially eligible for VA paid care, but not enrolled	Total
Approximate % of U.S. veterans	32%	14%	54%	100%
Approximate total # of U.S. veterans	6.34M ^e	2.81M ^e	10.45M	19.60M ^e

^eVet Data Pocket Card^d

For as long as a VA facility remains open, the VA pays for VA facility or community healthcare only for veterans in column A. But if a facility is closed, VA will automatically issue vouchers for the Veterans Community Care Program (VCCP) to all local veterans in columns A and B, plus to those veterans in column C who decide to enroll (because it is advantageous for these veterans to do so). According to a 2016 report², the total systemic cost of a proposal to allow community care for veterans could increase usage and outlays nationally by \$96 to \$179 billion a year.

- Health care procedures are more costly in the fee-for-service private sector, which has a built-in incentive to over treat. One example is end of life care for veterans whose illnesses are terminal. VA's utilize more palliative and hospice care, while the private sector is more likely to use aggressive, expensive treatments, even if they are unlikely to significantly increase time and quality of life remaining.
- Additional VA administrative staff will be needed for oversight and reimbursement of veterans' private sector care in the entire affected region.

2. Impact on the Quality of Clinical Care Provided to Veterans

If a VA facility were to close, the overall quality, comprehensiveness and integration of care provided to veterans would decline.

Independent RAND³ and Dartmouth⁴ analyses - among many others - continually affirm that the quality of VA's healthcare in regional markets is as good as, and in many instances superior to that of non-VA facilities.

VA healthcare settings provide the best (and arguably only) environment for providers and trainees to attain proficiency in treating veteran-specific issues. Veterans are at higher risk for particular conditions, including combat-related injuries (e.g., gunshot, blast, and shrapnel injuries), traumatic brain injury, heterotopic ossification, musculoskeletal injuries, spinal cord injury, toxic exposures, PTSD, military sexual trauma and suicide. Not only do VA trained personnel know how to treat these conditions, they recognize which potential sources to investigate. A non-VA practitioner is less likely to explore PTSD as the cause of chronic insomnia or the impact of traumatic brain injury on mood and decision-making. Non-VA practitioners would be less likely to know that conditions such as asthma, prostate cancer or Type 2 diabetes may be the result of toxic exposures, including Agent Orange, contaminated water or burn-pits. RAND's Ready or Not?⁵ study reported that a majority of private sector providers do not screen for specific health concerns that are common among veterans.

Private sector providers may, therefore, misdiagnose or ineffectively treat these critical conditions, order inappropriate diagnostic tests, and fail to collect information that registries need for veterans to quality to receive compensation.

RAND's Ready to Serve⁶ study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or DoD, "a psychotherapist selected from the community is unlikely to have the skills necessary

²"Commission on Care - Amazon S3." <https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care-Final-Report-063016-FOR-WEB.pdf>.

³"Comparing Quality of Care in Veterans Affairs and Non ... - NCBI." 25 Apr. 2018, <https://www.ncbi.nlm.nih.gov/pubmed/29696561>.

⁴"Veterans Health Administration Hospitals Outperform Non-Veterans" 19 Mar. 2019, <https://annals.org/aim/fullarticle/2718687/veterans-health-administration-hospitals-outperform-non-veterans-health-administration-hospitals>.

⁵"Assessing the Capacity of New York State Health ... - RAND Corporation." 1 Mar. 2018, https://www.rand.org/pubs/research-reports/R_R2298.html.

⁶"Community-Based Provider Capacity to Deliver ... - RAND Corporation." 12 Nov. 2014, https://www.rand.org/pubs/research-reports/R_R806.html.

to deliver high-quality mental health care to service members or veterans with these conditions.”

VA social workers connect patients to veteran-specific follow up resources, including VA and other community resources that provide home health services, legal services, transportation, community living and housing. Such wrap-around services help mitigate homelessness and other social determinants of disease progression and prevalence of suicide. Veterans being discharged from the VCCP inpatient facilities to VCCP outpatient care would not receive the kind of VA expertise and systematic planning that links them to the array of veterans’ resources they need.

As the Commission on Care Final Report⁷ acknowledged: “Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.” Compared to VA’s best practice integrated model, healthcare delivered in the community lacks integration or coordination of veterans’ care. The VA, as a unified system, has superior ability to implement and monitor adherence to assessment and treatment standards.

3. Impact on the Timeliness of Clinical Care Provided to Veterans

VA’s Access Standards ensure that VA facility’s wait times are monitored and enforced. There are no set expectations of timeliness for care of veterans in the Community Care Network.

If a VA facility is closed, veterans will struggle to get care in an overburdened private sector healthcare system. Delays for outpatient, inpatient and emergency room care for veterans and non-veterans in the local area would increase.

At present, private sector average outpatient wait times for primary care, cardiology, and dermatology (though not orthopedics) are 68% longer⁸ than wait times at the VA.

Our nation faces an intractable physician shortage, especially in primary care. A report⁹ by the American Association of Medical Colleges warns that by 2030 the U.S. will be short 14,800 to 49,300 of needed primary care doctors. Non-primary care medical specialties predict additional shortages of 33,800 to 72,700 physicians. In geriatric care, an area in which the VA specializes and the private sector is drastically undersupplied, less than half of geriatric fellowship positions¹⁰ even filled last year.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only 12 % of PCPs are working in rural areas (and only 8% of other specialties)¹¹, and these provider numbers are actually declining. Sixty percent of counties¹² - all rural—lack a single psychiatrist. Between 2010 and 2019, 95 rural hospitals closed¹³ and an additional 21% (=430) are at high risk of closing.

4. Impact on Veterans Having “Choice” for Where to Receive Healthcare

Explicitly, the MISSION Act was developed to offer greater healthcare choices to veterans. When a facility is closed, veterans who prefer to receive their care in the VA will no longer have that option.

Forty-six percent of all veterans are enrolled in VA healthcare, and 17% utilize it as their primary source.¹⁴ VA utilizers are more likely to be black, younger, female, unmarried, less educated and have a lower income.

Further, many veterans prefer to receive care in a VA facility because of the opportunity for peer contact. A third of VA employees are veterans. The VA has 1,100

⁷ “Commission on Care - Amazon S3.” <https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care-Final-Report-063016-FOR-WEB.pdf>.

⁸ “Comparison of wait times for new patients between ... - JAMA Network.” 18 Jan. 2019, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917>.

⁹ “New research shows increasing physician shortages in both primary” 11 Apr. 2018, <https://news.aamc.org/press-releases/article/workforce-report-shortage-04112018/>.

¹⁰ “SAP Crystal Reports - 2017 SMS - NRMP.” <http://www.nrmp.org/wp-content/uploads/2018/02/Results-and-Data-SMS-2018.pdf>.

¹¹ “Rural America Faces Shortage of Physicians to Care for Rapidly Aging” <https://www.asaging.org/blog/rural-america-faces-shortage-physicians-care-rapidly-aging-population>.

¹² “The Silent Shortage - New American Economy.” <http://research.newamericaneconomy.org/wp-content/uploads/2017/10/NAE-PsychiatristShortage-V6-1.pdf>.

¹³ “2019 healthcare outlook - Navigant.” <https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant2019healthcareoutlook.pdf>.

¹⁴ “US Veterans Who Do and Do Not Utilize Veterans Affairs ... - NCBI.” 17 Jan. 2019, <https://www.ncbi.nlm.nih.gov/pubmed/30677266>.

Peer Specialists who are veterans in successful recovery from mental health challenges, integrated in mental health care programs and uniquely suited to engage veterans and instill hope. Closure takes that away.

5. Impact on Training of Medical/Healthcare Professionals

If a VA facility were closed, required residency/fellowship rotations would not be available, core funding would be eliminated, leading to shrinkage and in some cases collapse of the local university residency training programs.

There are 135 allopathic medical schools and 30 osteopathic medical schools that are formally affiliated with VA's. The residency/fellowship programs housed at local VA's include, but are not limited to: epilepsy, gastroenterology, geriatric medicine, hematology/oncology, infectious disease, hospice/palliative medicine, internal medicine, interventional cardiology, nephrology, neuromuscular medicine, nuclear medicine, ophthalmology, orthopedic surgery, pain otolaryngology, medicine, anatomic pathology, plastic surgery, psychiatry, psychosomatic medicine, pulmonary disease, radiology, rheumatology, sleep medicine, general surgery, thoracic surgery and urology.

In addition education would be curtailed for other trainees who rotate part or full time at VAMCs, such as medical and nursing students, psychologists, and trainees in more than 40 other health professions.

6. Impact on the Number of Doctors and Other Healthcare Professionals Providing Healthcare in the Local Area

Medical schools are a seedbed for training the next generations of doctors. Graduating residents tend to remain in their local area to live and work. A loss of hundreds of physician and other health care profession residency positions means that year by year there will be incrementally fewer healthcare providers settling in the community to treat patients, including the very veterans being automatically placed in the VCCP.

7. Impact on Recruiting a Workforce Committed to Veterans

Training programs are the single best mechanism for the recruitment of VA health professionals, including those that relocate from other geographic areas. Positive experiences of treating veterans as well as being mentored by renowned experts in veterans' healthcare issues are, for a substantial number of trainees, the biggest determinant in their decision to seek VA employment. Roughly 60% of current VA physicians (and even higher percentages of some other professions) participated in VA training programs.

Closure of a facility means fewer residents, fellows, medical students and other health profession trainees would train at VA's. That will diminish this recruitment tool, and VA's in other regions will be less able to attract physicians and other healthcare professionals committed to veterans.

8. Impact on Research on Veterans

Over the past 70 years, VA researchers and clinicians have worked together, along with scientists at academic institutions and the DoD, to develop innovative treatments that have benefited not only the nation's veterans, but also patients throughout the country and the world.

Take, for example, the San Francisco VA Medical Center, which has over 800 current research projects that would cease if the facility were closed. These include the study of basic neuroscience and neuroimaging of combat-related brain and spinal cord injuries, posttraumatic stress disorder (PTSD), fracture/ polytrauma, neurological combat-related injuries, rehabilitation after stroke and traumatic brain injury, Parkinson's disease, fracture repair, heterotopic ossification after polytrauma, prostate cancer, tinnitus, oncology, hypertension, stroke, cardiovascular disease, breast cancer, musculoskeletal disorders, hepatitis C, HIV, renal dialysis, epilepsy, cardiac surgery, mental health and substance use disorders. Closure of a VA would shut its lines of research that are unfeasible to transfer elsewhere.

The VA has a stable population that can be followed over the long-term, enabling researchers to make big data breakthroughs on emerging veteran-specific healthcare problems. That will be impossible if veterans' care becomes scattered across the private sector in which communication is fragmented. Closure of any VA facility weakens the VA's ability to identify, diagnose and develop innovative treatments for the next PTSD or Agent Orange.

9. Impact on Readiness for Emergencies

The Fourth Mission of the VA is to support national, state, and local emergency management, public health, safety and homeland security efforts for veterans and

non-veterans in the event of war, terrorism, national emergencies, and natural disasters. VAMCs are federal emergency response sites.

In the event of an emergency, there will be fewer ER and inpatient beds. It will also be more difficult to set up the kind of command center that the VA's routinely organize to track and assist veterans who are affected by such emergencies.

10. Impact on the Local Economy

Each VA medical center has thousands, and smaller CBOCS have hundreds, of employees who generate revenue for the local economy. When a VAMC or CBOC is closed, those employees are laid off. For many of them, especially those in support roles, finding gainful employment will be difficult. Veterans on compensated work therapy will likely face insurmountable challenges. Any decision about closing a VA facility must also consider how job losses impact the local economy.

The Veterans Healthcare Policy Institute thanks the Committee for the opportunity to provide this statement for the record.

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BILLS FOR THE RECORD (Upon Request)

1. H.R. 2943 - To direct the Secretary of Veterans Affairs to make all fact sheets of the Department of Veterans Affairs in English and Spanish. (Cisneros)

2. H.R. 2942 - To direct the Secretary of Veterans Affairs to carry out the Women's Health Transition Training pilot program through at least fiscal year 2020, and for other purposes. (Cisneros)

3. H.R. 2676 - VA Survey of Cannabis Use Act- This bill requires VA to enter into an agreement with a federally funded research and development center to conduct surveys nationwide to measure cannabis use by veterans. (Moulton)

4. H.R. 2677 - To require VA to provide training in the use of medical cannabis in conjunction with medical schools that have incorporated education on medical cannabis into their curricula. (Moulton)

5. H.R. 712 - VA Medicinal Cannabis Research Act (Correa)

6. H.R. 1647 - Veterans Equal Access Act (Blumenhauer)

7. H.R. 3083 - To authorize the Asset and Infrastructure Review Commission of the Department of Veterans Affairs to meet in years other than 2022 and 2023. (Roe)

8. H.R. 485 - To amend title 38, United States Code, to provide for the circumstances under which the Secretary of Veterans Affairs shall provide reimbursement for emergency ambulance services. (Tipton)

9. Discussion Draft - Specially Adaptive Housing

10. Discussion Draft - Work Study

