FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

National Service & Legislative Headquarters
807 Maine Avenue, S.W.
Washington, D.C. 20024-2410
Phone (202) 554-3501
Fax (202) 554-3581
www.dav.org

STATEMENT OF
ADRIAN M. ATIZADO
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 20, 2019

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 be 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.