STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
HOUSE OF REPRESENTATIVES

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Good morning, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs' (VA or Department) programs and services. Joining me today is Ms. Catherine Biggs-Silvers, Executive Director, for Mission, Planning, and Analysis, Human Resources and Administration. Due to the timing of the hearing, VA is unable to provide views on the draft bill, to make certain improvement in the Health Professionals Educational Assistance Program of the Department of Veterans Affairs. These views are currently being drafted and we will forward them to you as soon as they are available.

H.R 93 Medical Services for Women Veterans

H.R. 93 would add section 1720H to Title 38, United States Code (U.S.C.), requiring the Secretary to ensure that gender specific services are continuously available at every VA medical center (VAMC) and community-based outpatient clinic (CBOC). It also would allow the Secretary to employ appropriate staff and enter into

such contracts as may be needed to meet current and expected future demand for these services.

We appreciate the intent of this proposal and would like to work with the Committee to further clarify the scope of this bill. We strongly believe that every Veteran should receive care specific to his or her needs, but we caution that the language as written could be broader than intended. For example, the term “gender specific services” is undefined, and could apply to both men and women Veterans. It is also unclear if this is intended to refer to gender-specific primary care services for women or more advanced services such as obstetrics and gynecology (for women) or urology (for men). We also note that the bill as written would require these services be continuously available at every VAMC and CBOC. This could potentially have significant resource implications depending upon the intended effect. We would greatly appreciate the opportunity to meet with the Committee further to discuss these and other issues to improve this legislation.

Given the unclear scope of the legislation, we are unable to provide a cost estimate for this bill at this time but note that it could have significant resource implications depending on the intended effect.

H.R 501 VA Transparency Enhancement Act of 2017

H.R. 501 would impose new reporting requirements on medical center directors and the Secretary. It would require each VAMC Director to file a quarterly report to the Secretary providing specific data related to surgical infections and cancelled or transferred surgeries. Within 60 days of the end of each calendar quarter, the Secretary

would be required to report to Congress and publish online the reports submitted by the VAMC Directors and a summary on those reports.

We do not support this bill because portions of it are unnecessary and others would be burdensome to implement. Currently, each facility collects data on surgical infections locally, but this information is not gathered nationally. The VA Surgical Quality Improvement Program (VASQIP) examines a portion of all surgeries (approximately 30 percent) completed within VA to identify surgical infections, and nationally, approximately 1.5 percent of VASQIP assessed surgeries result in infections within 30 days of the procedure. Examining all surgeries could significantly increase our demand for resources without generating an appreciable improvement in quality.

We are concerned about the intended result of the summaries of surgical infections, which could implicate patient privacy information. We would appreciate the opportunity to discuss this further with the Committee to resolve these concerns while ensuring the Committee has the information it needs to perform its oversight functions.

We currently collect information on cancelled surgeries (including both the number and the reasons for such cancellations) and can provide this information as needed, both locally and nationally. It would be more difficult to gather information on transferred surgeries, as our systems do not collect this information now. We note that section 2(a)(2)(C) directs VA to provide information on the number of additional days each such patient had to wait for surgery because of cancellation or transfer, but we caution that there are a number of reasons for cancellations and transfers, some of which are patient-driven and others that may be clinically necessary, and that this information would therefore not necessarily be helpful. Some surgeries may be

cancelled and never performed, either because they were elective or because of intervening circumstances. We would also like to discuss this provision further with the Committee to see if currently available information may satisfy the objective of this provision.

VA estimates the cost of the legislation would be $18 million in fiscal year (FY) 2018, $97 million over five years, and $209 million over 10 years.

H.R 1063 Veteran Prescription Continuity Act

H.R. 1063 would amend Section 715 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92) by adding a new subsection (c). The Secretary would be required to provide any pharmaceutical agent not included in the joint uniform formulary for VA and the Department of Defense (DoD) to an individual who is transitioning from receiving treatment from DoD to receiving treatment from VA, if a DoD health care provider determines that such pharmaceutical agent is critical for such a transition. VA would be required to furnish these pharmaceutical agents beginning on the date on which the individual enrolls in the VA health care system and ending on the date on which a VA provider determines the agent is no longer required by the individual.

We do not support this bill. When filling prescriptions, the Veteran's medical necessity drives the utilization of medications, not the formulary status of a medication. Fundamentally, we are concerned that the legislation would usurp a prescriber's professional responsibility to ensure a medication, whether a controlled substance or not, started by another provider continues to be safe and effective.

We have a long-standing practice of continuing medications that are clinically needed for transitioning Servicemembers, and we have strengthened this further with a policy articulating this requirement in 2015 (VHA Directive 2014-02, issued January 20, 2015). Further, as required by Congress, VA and DoD have developed a process for annually reviewing the Continuity of Care Drug List, and we recently completed this review earlier this summer. VA's Center for Medication Safety has collaborated with DoD and performed two studies that have validated that our policies are working and that transitioning Servicemembers and new Veterans are receiving the medications they clinically need. The VA Center for Medication Safety is assessing the financial impact of the Continuity of Care Drug List, as required by Congress.

DoD has no requirements in law to address the opioid crisis currently affecting the country. While section 715 required a joint formulary, there is no requirement for VA and DoD to adhere to the same protections and metrics for opioid prescriptions. We recommend that if Congress is interested in legislating in this area, this is an area that could produce significant improvements in the safety and well-being of Veterans and Servicemembers alike. We would be happy to work with the Committee on this initiative. We also recommend that Congress enact legislation requiring DoD to notify VA immediately for any patients on high-risk medications who are transitioning out of military service. There currently is no mechanism for sharing this information, which introduces the potential for gaps in clinical care and patient safety.

The bill is intended to ensure that patients maintain continuity of their prescription medications as they transition from DoD to VA, but as written, this legislation could obligate providers and pharmacists to furnish medications in ways that could violate

other provisions of law or professional responsibility. For example, if a Servicemember received a prescription for a controlled substance, and such a prescription requires either routine monitoring or additional screening, a VA pharmacist or provider could be forced to decide which law to comply with and which to violate. As another example, if a Servicemember received a prescription for a controlled substance, then sought additional prescriptions for the same substance from several private providers, a VA pharmacist would know this by checking the Prescription Drug Monitoring Program; ordinarily, VA pharmacists would not fill that prescription, but this bill could require them to do so. VA providers and pharmacists are trained to review prescriptions carefully to ensure that patient safety is the top priority, and we are concerned that this legislation, while well-intended, could impede that objective.

We note as a technical manner that, as written, proposed section 715(c)(2)(B) would require a VA health care provider to determine that the Veteran does not require a pharmaceutical agent. This would preclude a non-Department provider authorized to furnish care and services to Veterans from making this determination. Given the continuing discussion regarding the future of Care in the Community, we note this language may affect some Veterans differently based upon who furnishes their care.

We are unable to provide a cost estimate for this bill given the uncertainty regarding how many transitioning Servicemembers would be affected, which medications VA would have to provide, how much those medications would cost, and how long it would take for VA to make a clinical determination regarding the continued need for that medication.

H.R. 1066 VA Management Alignment Act of 2017

H.R. 1066 would require, within 180 days of enactment of this Act, the Secretary to report to Congress on the roles, responsibility, and accountability of elements and individuals within VA. In creating the report, the Secretary would be required to utilize the results of the Independent Assessment of the Health Care Delivery Systems and Management Process established by section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146), any study or report by the Commission on Care established by section 202 of Public Law 113-146, and other studies or reports. The Secretary's report to Congress would also have to specify clearly delineated roles and responsibilities to optimize the organizational effectiveness and accountability of each administration, staff office, or staff organization, their subordinate organizations, and key leaders of the Department.

VA supports the intent of this bill. The Secretary has made improving accountability within VA, including ensuring that the Department is well-organized and well-functioning, one of his highest priorities, and our current efforts are achieving the intended results of this legislation. We are not waiting for legislation to improve VA's organizational structure and internal management—we are taking aggressive steps now to ensure that VA is responsive to Veterans' needs while being a good steward of taxpayer dollars.

We do not expect this legislation would result in any appreciable costs.

H.R 1943 Restoring Maximum Mobility to Our Nation's Veterans Act of 2017

H.R. 1943 would amend 38 U.S.C. § 1701 by adding a new paragraph (11) defining the term "wheelchair". This term would include enhanced power wheelchairs,

multi-environmental wheelchairs, track wheelchairs, stair-climbing wheelchairs, and other power-driven mobility devices. It would also add a new subparagraph (2) to 38 U.S.C. § 1712(c) to require the Secretary to ensure that each wheelchair provided under this title to a Veteran because of a service-connected disability restores the maximum achievable mobility and function in the activities of daily life, employment, and recreation for the Veteran. The Secretary would be authorized to furnish a wheelchair in order to restore an ability that relates exclusively to participation in a recreational activity.

We generally support the proposed changes to section 1701, but have concerns with a few of the types of wheelchairs identified. For example, track wheelchairs and stair-climbing wheelchairs are not currently cleared by the Food and Drug Administration (FDA) for use, and as a result, we do not believe it is appropriate to prescribe or furnish such equipment to Veterans. We currently furnish FDA-cleared wheelchairs, and in the event that other wheelchairs are cleared by FDA in the future, we would be able to furnish such wheelchairs at that time. Similarly, we are concerned about the breadth of the term “other power-driven mobility devices”, which could include any number of items that have no valid medical necessity.

Regarding the proposed changes to section 1712, we note that the language would limit eligibility to Veterans who are furnished a wheelchair because of a service-connected disability. VA currently provides wheelchairs to Veterans, regardless of their service-connected status, as long as they are enrolled in VA health care and the wheelchair is determined to be medically necessary. We do not distinguish between Veterans with service-connected disabilities and those without when making

determinations regarding which prosthetic devices the Veteran needs; we only consider their medical necessity. In this context, we do not believe these amendments are needed because we already furnish these services. We recommend that the language requiring the Secretary to ensure that each wheelchair restores the maximum achievable mobility and function in the activities of "employment" and "recreation" be removed, as this could potentially create an open-ended obligation. We believe it is sufficient for a Veteran's clinical needs that the wheelchair restore the maximum achievable mobility and function in the activities of daily life.

We note there is some ambiguity in terms of the intent and effect of the second sentence in proposed 1712(c)(2), and we would appreciate the opportunity to discuss this further with the Committee to provide any technical assistance that may be required.

Because the intended scope of the certain provisions of the bill is unclear, we cannot estimate the cost of this legislation to the Department but note that it could have significant resource implications.

H.R 1972 VA Billing Accountability Act

H.R. 1972 would amend sections 1710(f)(3) and 1722A, and add a new section 1709C to title 38, U.S.C., that would require VA to notify Veterans of their copayment requirements no later than 120 days after the date of care or services provided at VA medical facilities, and no later than 18 months after the date of care or services provided at non-VA facilities. If VA does not provide such notice, VA could not collect the copayment, including through a third-party entity, unless VA provided the

Veteran: (1) information on applying for a waiver and establishing a payment plan, and (2) an opportunity to make a waiver or establish a payment plan. The Secretary would be authorized to waive the copayment requirement in cases where notification to the Veteran was delayed because of an error committed by VA, a VA employee, or a non-VA facility (if applicable), and the Veteran received notification beyond the specified timeframes. H.R. 1972 would also require VA, no later than 180 days after enactment, to review and improve its copayment billing internal controls and notification procedures, including pursuant to the provisions of the bill.

VA supports the intent of H.R. 1972 to prevent delays in the release of copayment charges due to operational error, avoid undue burden to Veterans, and improve VA's copayment billing procedures. However, we are concerned that the 120-day time period proposed in the bill could adversely affect some Veterans. Further, it is not clear what specific copayment billing issues the bill would address.

We note that copayments are automatically generated by VA's integrated billing system. Moreover, VA ensures that every Veteran is given the notice of rights and the opportunity to request a waiver or compromise, and to establish a repayment plan for copayment charges. This information is included with every copayment billing statement that VA sends to a Veteran. As a service to Veterans, VA holds copayment bills until a Veteran's other health insurance (OHI) is billed and either pays or denies the claim. This allows VA potentially to offset the Veteran's copayment charges with payment received from the OHI, reducing the Veteran's liability. When a Veteran has OHI, the copayment charge is placed on hold for 90 days while the OHI is billed. If no payment is received within 90 days, the charges will automatically be released and a

statement generated to the Veteran. If a balance remains after an OHI payment is applied to the copayment debt, the bill for the remaining balance is released to the Veteran and he or she receives it within a variable timeframe that ranges from 70 to 150 days depending on when the OHI payment is made – a timeframe that can exceed the proposed 120-day standard in H.R. 1972. Requiring all copayment bills to be issued within 120 days could adversely affect some Veterans whose OHI payments are delayed, as they would be notified of a copayment and billed when they would ordinarily not incur any personal liability. We note that less than 10 percent of copayment bills currently are submitted more than 120 days from the date of service, but in these cases, requiring copayment bills be issued could produce confusion among Veterans, result in greater out-of-pocket costs for these Veterans, and increase VA's administrative burden in implementing this change. VA financial policy for medical care debts specifies that Veterans who do not have OHI should have the opportunity to satisfy copayment obligations at the Agent Cashier's office prior to leaving the medical facility. Otherwise, the record of service is prepared and the copayment is released for billing on the Veteran's next scheduled monthly billing statement, which is normally received anywhere from 14 to 42 days after the date of service. The timeliness of OHI payments to VA is one of the biggest factors affecting the timeliness of copayment bills issued by VA to Veterans.

Copayment bills may also be generated following income verification under 38 U.S.C. § 5317, which authorizes VA to validate certain Veterans' reported income with the Internal Revenue Service (IRS) and Social Security Administration information. This validation begins 18 months after the calendar year in which that

income is reported due to receipt of data, upon completion of tax processing, from the IRS. If VA identifies unreported income, VA has authority to generate copayment billings as a result of this verification process. VA also refunds copayments, when appropriate, as a result of this income verification process. The timeframe associated with this process exceeds the 120-day standard proposed in H.R. 1972. We also note that private sector billing industry standards allow for billing up to 12 to 18 months after services are rendered – also exceeding the proposed 120-day timeframe.

H.R. 1972 does not specify what constitutes an error, what would justify a waiver, and whether the waivers and payment plans authorized under the bill would differ from those currently authorized in applicable statutes and regulations. VA has existing procedures under 38 U.S.C. § 5302 to waive collection in cases where the Secretary determines that recovery would be against equity and good conscience. In these instances, an application for relief must generally be made 180 days from the date of notification of the indebtedness.

We note that VA copayment requirements under 38 U.S.C. § 1710(f)-(g), 38 U.S.C. § 1722A, and 38 U.S.C. § 1710B (which is not referenced in H.R. 1972, but requires copayments of certain Veterans for extended care services) apply regardless of whether the care or services was provided in a VA facility or authorized by VA in a non-VA facility. Therefore, the 120-day timeframe that would be added in section 1710(f)(3)(G)(ii) and section 1722A(c)(2) by the bill may be read as applying to care or services in both VA and non-VA facilities.

We note that the Department is close to submitting its plan for the future of community care, the Veteran Coordinated Access & Rewarding Experiences (CARE)

Act, which will include proposed amendments to its practices concerning the recovery or collection of reasonable charges from other parties for certain care and services. We recommend the Subcommittee forbear further consideration of HR 1972 until VA has submitted the Veteran CARE Act and the Subcommittee can consider how this bill would be affected by the Department's proposal.

If copayment billings delayed beyond 120 days from date of service are waived, VA estimates a 5-year revenue loss of $282 million and a 10-year revenue loss of $562.8 million from the First Party Inpatient/Outpatient and Pharmacy Medical Care Collection Fund.

H.R 2147 Veterans Treatment Court Improvement Act of 2017

H.R. 2147 would require VA to hire additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved Veterans. Specifically, H.R. 2147 would require that VA hire not less than 50 VJO Specialists and place each such VJO Specialist at an eligible VA medical center (VAMC). The bill would require that the total number of VJO Specialists employed by the Department not be less than the sum of (a) the VJO Specialists employed on the day before the enactment of this provision; and (b) the number of VJO Specialists to be hired under this bill. The bill would require that the Secretary prioritize placement of the VJO Specialists at facilities that will create an affiliation with a Veterans treatment court that is established on or after the date of enactment of the bill, or one that was established prior to enactment but is not fully staffed with VJO Specialists. The bill would require the Secretary to submit a report to Congress on the progress and effects of

implementing these provisions within one year, with new reports submitted annually after that. The bill would also require the Comptroller General to submit to Congress a report on the implementation of this authority and the effectiveness of the VJO Program. The bill would authorize to be appropriated $5.5 million for each of fiscal years 2017 through 2027, and would require the Secretary to submit to Congress a report that identifies such legislative or administrative actions that would result in reduction in expenditures by the Department that are equal to or greater than the amounts authorized to be appropriated.

VA supports the intent of this bill and is already working to hire more than the 50 additional VJO Specialists within the next year. However, the bill could ultimately result in a reduction of $5.5 million in funding to other programs (including possibly programs for homeless Veterans). Because of this potential reduction in funding, VA does not support the legislation as drafted. Demand for VJO Specialists has grown considerably over the past several years, partly as a result of the adoption of the Veterans Treatment Court model in new jurisdictions. Limited VJO staff resources have affected VA's ability to partner effectively with Veterans Treatment Courts, especially those newly established.

We note that provisions of section 2(e) of the bill concerning the authorization of appropriations may not accomplish the intended objective. We understand this provision is intended to ensure that the Secretary identifies offsets to fund the program required by this bill. However, this provision would violate the Recommendations Clause, U.S. Const. art. II, § 3, by requiring the Secretary to recommend legislative actions regardless of whether the Secretary judges such legislation "necessary and

expedient." To comply with the Constitution, such recommendations should be discretionary rather than mandatory. Moreover, the bill only requires the Secretary to report to Congress on legislative or administrative actions that would result in a reduction of expenditures equal to or greater than $5.5 million. To the extent that the Secretary identifies legislative actions that would result in a reduction of expenditures, there is no guarantee that Congress would take such actions. We further note that the offsets would likely affect adversely VA's ability to implement and run other programs, which could result in delays in the provision of benefits, healthcare, and other critical services to Veterans and other beneficiaries. Ultimately, we do not believe this is an appropriate mechanism for funding the program required by this section.

We also note that the definition of "local criminal justice system" in section 2(f)(3) of the bill would not include Federal courts. We understand there are some Federal district courts that have Veterans treatment courts, and these would not be supported under this bill.

While we estimate the hiring of 50 additional VJO Specialists would cost $5.5 million in FY 2018, because the bill would require VA to identify offsets, we believe the ultimate cost would be $0 in FY 2018 and over both 5 and 10 years, if these offsets, some of which may require legislation, can be implemented. We again caution that the costs for implementation would involve reductions to other VA programs.

H.R 2225 Veterans Dog Training Therapy Act

H.R. 2225 would require the Secretary, within 120 days of enactment, to commence a 5-year pilot program under which the Secretary enters into a contract with one or more non-government entities for the purpose of assessing the effectiveness of

addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through a therapeutic medium of training service dogs for Veterans with disabilities. The bill would require the Secretary to enter into contracts with non-government entities located in close proximity to a minimum of three and not more than five VA medical centers. The bill requires that the non-government entities be certified in the training and handling of service dogs and have a training area that meets certain enumerated specifications.

The bill would require each pilot program site to employ at least one person with clinical experience related to mental health, and to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training. In addition, the bill would require VA to collect data to determine how effectively the program assists Veterans in various areas such as reducing stigma associated with PTSD, improving emotional regulation, and improving patience. Not later than one year after the date of commencement of the pilot program and annually thereafter, VA would be required to submit to Congress a report regarding the number of participating Veterans, a description of the services carried out by the pilot program, the effects of pilot program participation in various areas relating to the participating Veterans' health and well-being, and recommendations with respect to extension or expansion of the pilot program.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R. 2225 because VA has significant concerns about the

proposed legislation. Although anecdotal evidence has been offered to show the benefits of participating in such a dog training therapy program, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically or that such a resource-intensive program is any better than other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be duplicative of a DoD study of this same therapy program at the Uniformed Services University of Health Sciences. In addition, the service dog training therapy program currently in place at the Palo Alto VAMC is organized as part of an integrated set of services provided for their in-patient Trauma Recovery Program and is not offered as a stand-alone program or as an outpatient service. VA has no prior experience in offering or managing such a program as an outpatient program.

We note the bill would require this program be carried out through the Center for Compassionate Innovation of the Veterans Health Administration (VHA) of the Department of Veterans Affairs. We recommend against including such specific language identifying a particular organization as the lead for implementation, particularly given the nature of this work and the involvement of multiple offices within VHA.

The bill would require that each contract entered into under subsection (a) shall provide that the nongovernmental entity shall employ at least one person with clinical experience related to mental health. It is unclear what role this person is intended to fill.

The bill would also make a number of restrictive stipulations regarding the structure and operation of the pilot program. For instance, contractor service dog

trainers would be required to be certified, but there is currently no national certification program for service dog trainers. The bill would require the contractor to preferentially hire Veterans who have graduated from a PTSD or other residential treatment program and received "adequate certification in service dog training." However, programs at the Palo Alto VAMC and DoD sites do not provide adequate training to qualify a Veteran as a dog trainer, and they focus on basic commands rather than the advance tasks required by service dogs. The legislation would also require establishing a VA director of therapeutic service dog training who is experienced in teaching others to train service dogs in a vocational setting, has a background in social services, and has at least one year of experience working with Veterans or active duty military members with PTSD in a clinical setting. These criteria would severely reduce the number of eligible candidates.

VA also notes that, if any service dogs successfully trained through the program for Veterans with disabilities are to be eligible to participate in VA's service dog medical benefit program, the non-government entities chosen would have to be accredited by Assistance Dog International. Thus, the number of potential non-government entity partners who could produce dogs eligible for VA's service dog medical benefit program would be relatively limited.

VA estimates this bill would cost $3 million in FY 2018 and $14 million over five years.

H.R 2327 PAWS Act of 2017

H.R. 2327 would require the Secretary to carry out a pilot program under which the Secretary provides a $25,000 grant to an eligible organization for each Veteran referred to that organization for a service dog pairing. Grantees would be required to provide for each participating Veteran and service dog coverage of a commercially available veterinary health insurance policy; hardware, or repairs or replacements for hardware, that are clinically determined to be required by the dog to perform the tasks necessary to assist the Veteran with the diagnosed disorder of the Veteran; and payments for travel expenses for the Veteran to obtain the dog. If the Veteran is required to replace a service dog provided pursuant to a grant, the Secretary would be required to pay the travel expenses for the Veteran to obtain a new service dog, regardless of any other benefits the Veteran is receiving for the first service dog.

To be eligible to receive a grant, an applicant would have to be a nonprofit organization certified by Assistance Dogs International (ADI), provide one-on-one training for each service dog and recipient for 30 hours or more over 90 days or more, provide wellness verifications from licensed veterinarians, ensure all service dogs pass the American Kennel Club Community Canine test and the ADI Public Access test prior to permanent placement, while also meeting other requirements. VA would review and approve Veterans to participate in this program based upon their application, and VA would have 90 days to make an approval determination. Veterans would have to: be enrolled in the VA health care system; have been treated and have completed an established evidence-based treatment for PTSD; receive the recommendation of a VA provider or team that the Veteran may potentially benefit from a service dog; and agree to successfully complete training provided by an eligible organization. Veterans would

have to see their provider at least every six months to determine, based on a clinical evaluation of efficacy, whether they continue to benefit from a service dog. Any improvement in symptoms as a result of participation in the pilot program could not affect the eligibility of the Veteran for any other benefit under the laws administered by the Secretary.

The Secretary would be required to develop metrics and other appropriate measurements to determine the efficacy of the program. Within one year of enactment, the Comptroller General would be required to brief Congress on the methodology established for the pilot program. Ten million dollars ($10,000,000) would be authorized to be appropriated for the period of FY 2018 through FY 2023 to carry out the pilot program, and the amounts otherwise authorized to be appropriated for VA's Office of Human Resources and Administration would be reduced by the same amount over the same time period. The pilot program would terminate on the date that is 5 years after the date of the enactment of this Act, and any eligible Veteran in possession of a service dog furnished under the pilot program as of the termination of the pilot program may keep the service dog after the termination of the program for the life of the dog.

As we previously stated, VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, we do not support the specific provisions in H.R. 2327 because VA has significant concerns about the proposed legislation. Again, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically, or that such a resource-intensive program is any better than other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven

therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be duplicative of an existing VA research study on the effectiveness of service dogs and emotional support dogs for Veterans with PTSD.

We have several other concerns with this legislation. We note that the bill refers in certain places to "severe" PTSD, but there are no established diagnostic criteria to distinguish levels of severity of PTSD.

In section 2 of the bill, Congressional findings are presented concerning Veteran suicide, mental health disorders, and substance use disorders. However, we note that there is no evidence to support that the presence or possession of a service dog would result in the reduction of any of these conditions or events. VA strongly agrees with the need to focus on reducing Veteran suicide and in treating Veteran's mental health conditions, but we do not believe the proposed bill would be the best use of resources to that end. VA is aggressively pursuing efforts to end Veteran suicide, but we cannot rely on the assumption that service dogs will ensure the well-being of Veterans.

Under section 3(a) of the bill, grantees would receive $25,000 for each Veteran referred to that organization for a service dog pairing. We note that it is possible some organizations may be able to furnish these services for less than $25,000. We recommend the language be revised to state that grants may not exceed $25,000 to ensure that Federal resources are not wasted. We would appreciate the opportunity to conduct a cost analysis to ensure that we are the best stewards of taxpayer dollars and that we maximize the potential use of our resources.

Section 3(c)(1)(A)(ii) of the bill would require an organization to provide, on average, one-on-one training for each service dog and recipient for 30 hours or more over 90 days or more. If this refers only to the pairing, this may be an appropriate amount of time, but if this is intended to cover all of the training of the dog, this would be inadequate.

The 90-day approval period for VA to determine a Veteran's eligibility under section 3(d)(1) could present challenges in implementation given the number of consultations or clinical visits that may be required for some Veterans.

We are concerned about section 3(d)(2)(A), which could provide an incentive for failing treatment and could interfere with other forms or guidelines for evidence-based mental health treatment. Regarding section 3(d)(2)(B), there is no clinical basis in existence for providers to make a determination about whether a Veteran may benefit from a service dog. This could make implementation more difficult and result in variation across the system. We have similar concerns about the requirement in section 3(d)(3) for the ongoing evaluation every 6 months to determine the clinical efficacy of whether the Veteran continues to benefit from a service dog, as there are no recognized means for making such determinations. In section 3(d)(4), the bill clarifies what happens if the Veteran is no longer able or willing to care for the service dog, but does not address what would happen if the service dog were no longer able to fulfill its function.

We strongly oppose section 3(i) of this bill, which would reduce the amounts authorized to be appropriated for VA's Office of Human Resources and Administration (HRA) by $10 million between FY 2018 and FY 2023. This reduction would have a

devastating impact on our mission. HRA's budget funds missions that are statutorily driven. A reduction of this nature would have a cascading impact on all of the organizations in VA, including health care delivery. HRA's budget funds staff office rent for 10 buildings, security, U.S. mail, and other operational costs for VA's Central Office campus. These are non-negotiable fixed costs, and account for roughly half of the funds allocated to HRA as part of the General Administration appropriation. The remaining funds are allocated to payroll. Most of the services HRA provides to VA are provided through Federal employees. VA has already conducted a comprehensive review of HRA's organizational functions to reduce or eliminate activities not required by law, and as a result, there are no further programs that could be stopped based on a further reduction in funds.

Under section 3(j), the authority to operate the program would end 5 years from the date of enactment. This length of time would further limit the efficacy of this program. VA would be required to publish regulations for this program (see 38 U.S.C. § 501(d)), and in addition, it takes on average approximately 18-24 months to train a service dog. This would result in very little time in which Veterans could receive service dogs and would likely not produce very many service dogs that could be provided to Veterans.

We estimate the bill would cost $2 million in FY 2018 and $14 million over 5 years, but note that certain provisions in this legislation could result in continuing costs beyond that time period.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to answer any questions you or other members of the Subcommittee may have.