Critical Issues

Strengthen, Reform, and Sustain the VA Health Care System

Recommendations:

Working closely with veterans service organization (VSO) stakeholders, Congress must enact legislation, and VA must issue regulations and define policies, procedures, requirements, and responsibilities, necessary to create veterans community integrated health care networks, with VA serving as the overall coordinator and primary provider of care and community partners providing sufficient capacity to eliminate access gaps in each market.

Congress must ensure VA has the clinical and business capabilities to create and maintain a high-performing health care system, which must include interoperable electronic health records and modern tools for scheduling, billing, claims payment, and patient-centered navigation to interrelated veterans' health care benefits and services.

VA's highest priority must be to sustain its specialized services, which are essential and irreplaceable for millions of veterans and which rely on the support of VA facilities providing a full continuum of care for the ill and injured veterans who rely on them.

Veterans' access to care, including to non-VA community providers in the networks, should be based on clinical need and veteran preference, not arbitrary time or distance standards. Existing access standards for the Choice Program (30 days / 40 miles) should be phased out as VA's local integrated networks eliminate access gaps.

In consultation with VSO stakeholders, Congress should enact legislation, and VA should implement regulations, necessary to create a veterans rural-community extended health care network to address the special challenges facing rural veterans.

To further close gaps in access to a full spectrum of health care services, Congress must work with VA to enact legislation to provide veterans access to urgent care services, provide sufficient funding and authority for emergency care, and continue to aggressively expand telehealth and web-based medical services.

Congress must ensure VA is appropriated the resources needed to meet the true and full demand by enrolled veterans for medical care provided through VA facilities as well as by community partners.

Congress must authorize VA to increase utilization of public-private partnerships to construct and operate VA medical facilities.

Congress must provide VA the authority to allocate and reallocate VA medical care appropriations throughout the fiscal year according to veterans' health care needs.

In order to ensure that VA's resources are properly utilized, Congress must enact legislation to require a VA Quadrennial Veterans Review (QVR) planning process and establish a biennial independent audit of VA's budgetary accounts and the Enrollee Health Care Projection Model.

To improve veterans' health care outcomes and experiences, VA must move its patient advocates program into the new Veterans Experience Office, which should also be responsible for ensuring that all patient health care protections afforded under title 38 are fully applied and complied with by all community network providers, public and private.

Overview:

In the 114th Congress, the question of how to strengthen and reform the VA health care system was the dominant issue for VA, the House and Senate Committees on Veterans' Affairs, and the veterans' community. Since the access crisis was uncovered by Congress and the national media in the spring of 2014, a vigorous national debate has taken place about how best to provide timely, high-quality, comprehensive, and veteran-centered health care to our nation's veterans.

There have been dozens of congressional hearings, multiple internal reviews, numerous media investigations, enactment of temporary programs and laws, expert stakeholder input, an independent assessment, and finally last fall a comprehensive report with recommendations from the congressionally mandated Commission on Care.

Despite multiple perspectives and organizations engaged in this debate, by the end of 2016 virtually all of the major stakeholders had coalesced around a common long-term solution: the best way to transform veterans' health care is by creating an integrated network of VA and community providers, with VA serving as the coordinator and primary provider of care.

This evolutionary approach, which builds upon existing strengths, has been endorsed by *The Independent Budget's* veterans service organizations (DAV, PVA, and VFW), most major VSOs, VA Secretary Robert A. McDonald, key congressional leaders from both parties, and the Commission on Care. While all do not agree on every detail of this new paradigm, there is a remarkable convergence of views about how, when, and where injured and ill veterans should be able to obtain health care in this new system.

With the current veterans' Choice Program scheduled to expire this year, and millions of America's veterans continuing to choose and rely on VA for their medical care, it is time for Congress and the new administration to act and create the future VA health care system that America's veterans deserve.

History of Underfunding VA Health Care:

Since the catalyst that began this debate was lack of access, it is important to understand the true underlying causes of access problems facing veterans. While the problems today are significant, 14 years ago VA faced a much more serious crisis centered on access to VA health care, as hundreds of thousands of veterans—peaking at 310,000 in July 2002—were found to be waiting 6 months or longer just to receive an initial VA medical appointment. In May 2003, a bipartisan presidential task force (PTF) reported that in January 2003 "at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up—a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide required care." The PTF concluded that there was a "**mismatch in VA between demand for access and available funding.**"

A dozen years later, these same access problems created news again as tens of thousands of veterans were reported to be waiting for VA health care and a number of VA employees were found to have been involved in significant scheduling and waiting list manipulations in Phoenix, Arizona, and some other VA facilities. In order to examine the reasons for this latest VA access crisis and to offer recommendations for improvement, Congress authorized an "independent assessment" to be conducted. The resulting report issued by the MITRE Corporation, the Rand Corporation, and others in September 2015 reached findings that were remarkably similar to the PTF report from a dozen years earlier.

The independent assessment's first finding was a "**disconnect in the alignment of demand, resources and authorities**" for VA health care. Its first recommendation was the need to "address the misalignment of demand with available resources both overall and locally." In terms of access to care, it found that "increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care over the next five years," with a core recommendation of "increasing physician hiring." The report also identified the key barriers that limited provider productivity, including "a shortage of examination rooms and poor configuration

of space," and "insufficient clinical and administrative support staff," all of which would require additional funding for the VA health care system.

Furthermore, the assessment found that the "capital requirement for the Veterans Health Administration (VHA) to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen." It estimated this gap at between $26 and $36 billion over the next decade, although the report suggested several significant management strategies that could potentially lower the projected gap down to between $7 billion and $22 billion.

The findings of this assessment are fully consistent with the earlier PTF's conclusions and confirm *The Independent Budget* veterans service organizations (IBVSOs) have reported for more than a decade: the resources provided to VA health care have been inadequate to meet the mission of care for veterans. While there are many factors that contributed to the access crisis, it is a simple fact that when there are not enough doctors, nurses, and other clinical professionals or enough usable treatment space to meet the rising demand for care by enrolled veterans, the result will be waiting lists and access problems.

To be clear, the IBVSOs are not suggesting that simply increasing funding by itself—without making significant reforms in VA—will lead to better health outcomes for veterans over the next 20 years. However, history shows that no VA reform plan has any chance of success unless sufficient resources are consistently provided to meet the true demand for services, when and where they need them. With more and more veterans seeking out VA as it improves access, Congress will have to continue investing resources to allow VA to keep up with rising demand.

Record of High-Quality Care

Another critical but often overlooked finding of the independent assessment confirmed what the IBVSOs, other veterans' service organizations, and most studies have shown: the quality of care provided by VA is high—equal to or better than the private sector. Specifically, the independent assessment found:

> *"In new analyses comparing VHA's (Veterans Health Administration) quality with non-VA providers, VHA performed the same or significantly better on average than the non-VA provider organizations on 12 of 14 effectiveness measures (providing recommended care) in the inpatient setting, and worse on two measures. On average, VHA performed significantly better on 16 outpatient Healthcare Effectiveness Data and Information Set® (HEDIS) measures of effectiveness compared with commercial health maintenance organizations (HMOs); on the 15 outpatient HEDIS measures of effectiveness that were available for Medicaid HMOs; and on 14 of 16 outpatient effectiveness measures compared with Medicare HMOs."*

When it came to "patient-centeredness" measures, the independent assessment continued:

> *"Our analyses indicated that average VA performance at the facility level is significantly worse than non-VA performance, notably on many of the patient experience measures for care in the inpatient setting and the 30-day all-cause risk-standardized readmission measures for heart attack, heart failure, and pneumonia. . . .*
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> *We also observed substantial variation in quality measure performance across VA facilities, indicating that Veterans in some areas are not receiving the same high-quality care that other VA facilities are able to provide. A high-priority goal for VA leadership should be narrowing these gaps to ensure that quality of care is more uniform across VA facilities so that Veterans can count on high-quality care no matter which facility they access."*

The MyVA initiative is using its Diffusion of Excellence Initiative to combat variability of quality among VHA facilities. This is reflective of an issue we consistently hear from our members across the country about their frustration with a system that needs to be more responsive to veterans' preferences, needs, and values. We

believe that implementation of the MyVA initiative has already made significant progress toward improving VA's patient-centeredness, the veteran's experience, and overall satisfaction with VA health care. The best path forward for a 21st century veterans' health care system must continue building upon the strengths of the VA, including its unparalleled expertise treating the unique conditions of injured veterans, while working to reform systemic problems hindering the timely delivery of care.

Implementing and Fixing the Choice Program

Enacted in August 2014, the Veterans Access, Choice, and Accountability Act (P.L. 113-146; also known as the Choice Act) ordered the independent assessment, as well as the independent Commission on Care, to develop recommendations for long-term solutions. However, the primary focus of the Choice Act was to rapidly provide new access through the creation of the temporary Choice Program. As approved by Congress, the Choice Program would allow certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for required care or to travel more than 40 miles to a VA facility to receive such care. The law required VA to stand up this nationwide program—which could potentially touch all 9 million enrolled veterans—in just 90 days.

Since its inception 2 years ago, the Choice Program has been beset with problems, some resulting from the flawed design of the law and others due to the unrealistic implementation schedule mandated by Congress. As the number of veterans using the Choice Program rose, so did the number of problems related to care coordination, appointment scheduling, and provider payments. Although the IBVSOs supported passage of the Choice Program as a necessary and temporary response to the access crisis, the law was neither intended to be nor supported as a permanent centerpiece of VA's future health care delivery model.

Within weeks of the Choice Program's commencement, both veterans and VA health care personnel reported confusion about how, when, and for what types of care the program was to be utilized. The law required VA to use third-party administrators (TPAs) to operate the program; however, this only added to the confusion and breakdown in communication between veterans, VA, and TPAs. Problems with scheduling, health record transfers, care coordination, doctor payments, and veterans' copayments all hindered usage of the Choice Program during its first several months. To address these and other technical and implementation challenges, Congress passed, and the president signed, two subsequent pieces of legislation (P.L.s 113-175 and 114-41) to address some of the major flaws in the Choice Program. Among the major changes were a redefinition of how to calculate the 40-mile distance criteria for Choice Program eligibility and removal of a requirement that medical records be returned to VA before provider payments were made. These adjustments, as well as additional training of VA personnel, slowly increased utilization of the program. From August 1, 2015, through July 31, 2016, VA and the TPAs created more than 3.2 million Choice Program authorizations for veterans to receive care in the community, an 11 percent increase compared to the prior one-year period.

At the same time, VA was also addressing its own capacity limitations by using funding in the Choice Act designed to hire thousands of new doctors, nurses, and other health care staff, as well as to expand treatment space through new leases and renovation of existing treatment space. As a result, according to VA, in August 2016, 96 percent of all requested appointments were within 30 days of the clinically indicated or veterans' preferred date; 85 percent were within 7 days; and 21 percent were same-day appointments. VA also reported that the average waiting time for primary care appointments was 4.7 days, 6.7 for specialty care, and 2.8 for mental health care. Although the number of veterans receiving care at VA and the total number of appointments have risen both inside VA and through non-VA community care programs, VA, VSOs, Congress, and independent experts are in agreement that it is time to reform the VA health system to ensure veterans receive high-quality, comprehensive, timely and veteran-focused health care.

VA's High Performing Network Plan

As mandated by P.L. 114-41, VA developed and submitted a plan to Congress in September 2015 to consolidate non-VA community care programs, including the Choice Program. VA's plan called for creating a "high-performing network" comprising both VA and community providers to create seamless health care access for enrolled veterans. In building its network, VA proposed first relying on the most cost-effective, compatible, and highest-quality community partners (particularly the Department of Defense [DOD], the Indian Health Service [IHS], and other federal health systems), then university hospitals that have existing academic affiliations with VA, and then the best of private providers. Under its plan, VA would serve as the coordinator and guarantor of care for veterans to ensure that no veteran falls through the cracks. Most enrolled veterans would get most of their care directly from VA, with network partners filling in gaps in access to care whenever and wherever they may exist.

Throughout 2016, VA further developed its plan and began taking actions under its existing authority to move forward with its Community Care Consolidation Plan. Throughout this process, VA has consulted with the IBVSOs and other stakeholders, and that collaboration remains critical to the success of this and other VA reforms. Among the most challenging questions yet to be resolved are how to build and operate the networks, how to coordinate the provision of care, and how to manage all the financial and logistical elements of working with private-sector providers. VA has already begun processes necessary to develop a formal request for proposal from qualified health care systems capable of providing and managing health care networks to provide the supplementary capacity VA requires to meet veterans' demand for care. However, until Congress takes certain legislative actions, including enacting new provider agreement authority with flexible payment authority to meet local market demands, VA's plan cannot be brought to fruition.

IB Framework for Veterans Health Care Reform

Around the same time VA was developing its consolidation plan, the IBVSOs developed our own Framework for Veterans Health Care Reform based on a few core principles. First, we affirmed that our nation has a sacred obligation to make whole the men and women injured or made ill as a result of their military service to the United States—to, as President Abraham Lincoln famously said, "care for him who shall have borne the battle, and for his widow, and his orphan." Second, though there is much the private sector can contribute to honor this commitment, it is ultimately the responsibility of the federal government to ensure that veterans have proper access to the full array of benefits, services, and supports promised to them for their service. Third, America's veterans have earned and deserve high-quality, accessible, comprehensive, and veteran-focused health care designed to meet their unique circumstances and needs. Any health care system that does not meet these standards is not capable of providing veterans the care they require.

The IB Framework is based on these principles and builds on VA's existing strengths. It has many similarities to VA's Community Care Consolidation Plan, but it takes a more holistic approach by addressing barriers that were outside of the VA plan's limited scope. The IB's coauthors have leveraged historical expertise, extensive conversations with veterans around the country, and survey data to develop a new model of care centered on veteran perspectives and focused on the positives and negatives of the current VA health care delivery system. The IB's four-pronged Framework looks beyond the current organization and division between VA care and community care to create a seamless system that is best for veterans.

Restructure the Veterans Health Care Delivery System

The IB Framework calls for optimizing the strengths and capabilities of the VA health care system and supplementing it with other public and private health care providers to create veterans community integrated health care networks. VA would be responsible for organizing the networks and coordinating care and would remain the principal provider of care for veterans. Similar to VA's Community Consolidation plan, the IB Framework would utilize network providers as an extension of VA care to fill access gaps whenever and wherever they may occur.

The design and development of integrated networks should be locally driven and nationally guided and must begin with and continue to have regular, open, and active engagement of veterans stakeholders to ensure that the networks are and remain focused on veterans' needs and preferences. Further, VA must continually monitor and optimize local integrated community networks—particularly the allocation of funding for VA and community providers and the determination of location, capabilities, and capacity of VA health care facilities—in order to meet changing demographic patterns and accommodate veterans' preferences. Implementation of these local networks should be carefully coordinated and phased to ensure that care provided to veterans through any existing community care programs and providers is not disrupted. VA should regularly report to Congress on negative impacts on veterans, how to mitigate those impacts, and suggest recommendations for the continuation of existing non-VA care programs.

Under the IB plan, most veterans would continue to receive most of their VA-provided care directly from VA doctors and clinical staff; network providers would be utilized to ensure timely access to convenient care when VA is unable meet the demand or it is in the best interest of the veteran. In order to ensure that veterans who rely on VA for most or all of their care can continue to use VA as they desire—whether due to their highly specialized needs or personal preference—VA must have the ability to manage the work flow within the networks. VA must have a critical mass of veteran patients in its health care facilities to maintain both the quality of care and the cost-efficiency of delivering that care. Absent a critical mass, some number of VA facilities would be forced to eliminate some services or programs or might be forced to close or consolidate with other facilities, thereby reducing more convenient access for some veterans. In particular, VA's world-class specialty care programs—including its spinal cord injury/disease (SCI/D) system of care, visual impairment rehabilitation program, polytrauma system of care, as well as treatment for burn care, amputations, prosthetics services, and post-deployment mental health care, which are largely unavailable outside of the VA system—rely on robust, full-service VA health care facilities.

Furthermore, VA must maintain a critical mass to fulfill the other three missions of the VA health care system: to provide education and training of medical professionals, biomedical research to support clinical care, and backup support for the federal government during national emergencies. The loss of any of these missions would be significant not just veterans, but also for the entire nation. The VA health care system must also have sufficient capacity and capabilities to continue fulfilling its obligations to the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and other federal agencies and programs that work collaboratively to serve veterans.

VA must continually monitor and optimize the utilization of local community networks so that changes in demand, capacity, and capabilities result in appropriate adjustment of network funding allocation between VA and community providers, as well as in determination of the location and capacity of VA health care facilities. VA must continually engage directly with veterans and VSOs to determine their preferences for receiving care because utilization data is artificially skewed by current capacity and access constraints.

The IB Framework also calls for establishing a Veterans Managed Community Care program to ensure that rural and remote veterans have an option to receive veteran-centric and coordinated care wherever they live. Veterans whose homes are far from VA health care facilities, and often far from any health care providers, have special access challenges that will require more focus and flexibility to account for local circumstances. To accomplish this will require strengthening the Office of Rural Health, establishing a higher-level care coordination program that includes case management, allowing greater flexibility in terms of contracting and payment for community providers and allowing community partners to practice across state lines using federal preemption. VA must also continue to expand its telehealth and web-based health care services that not only increase access for rural and remote veterans, but also for any veteran who does not always have timely or convenient access to health care.

Redesign the Systems and Procedures That Facilitate Access to Health Care

Under the IB Framework, access to care, including decisions about access to community network providers, would be based on clinical determinations and veteran preferences, rather than based on arbitrary time (30 days) or distance (40 miles) standards. All enrolled veterans would be designated a primary care provider after consideration of their needs and desires, with VA-employed providers designated whenever reasonable. When veterans require specialized care, their primary care providers—including non-VA primary care providers in the local network—would refer them to specialty care providers within the network, again utilizing VA providers first whenever reasonable.

Veterans must be able to request reconsideration of either their designated primary care provider or specialty provider and should be accommodated whenever reasonable, based on medical need, accessibility, availability, preference, or other appropriate factors. When veterans are unsatisfied with their providers or treatment options, there must be a review process providing rapid reconsideration, as well as a more formal clinical review process than what exists today.

Veterans should expect to have the same experience when accessing care through either a VA provider or a community network provider, including the same methods for scheduling appointments, making copayments, and submitting other health insurance information. The MyVA initiative will be critical to achieving this uniform experience in the future VA health care system.

The IB Framework also calls for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care and reduce reliance on more costly emergency room care for non-life-threatening issues. The addition of urgent care services will also alleviate some of demand on VA's primary care providers. VA must increase its capacity to deliver urgent care at existing VA medical facilities and create additional capacity through private-sector urgent care clinics around the country to create new options between emergency care and primary care. In addition, to strengthen and clarify how VA offers emergency care services for enrolled veterans, Congress must provide sufficient funding and oversight, and VA must issue interim final rules for the VA emergency care benefit.

Realign the Provision and Allocation of VA's Resources to Reflect Its Mission

As noted above, unless there are sufficient resources provided to the VA health care system on a consistent basis, no reforms, including the IB Framework, will be successful in the long run. Next month, the IBVSOs will issue specific budgetary recommendations necessary to adequately support VA's for VA medical care programs and its capital and information technology (IT) infrastructure requirements. In addition to fully funding VA health care,. Congress must ensure VA has the clinical and business capabilities to create and maintain a high-performing health care system, to include interoperable electronic health records and tools for effective and efficient scheduling, billing, and claims payment, and patient-centered navigational tools to help veterans access various health care benefits and services.

In order to make more efficient use of whatever resources are provided by Congress, the IB Framework calls for expanding public-private partnerships and considering shared-use facilities with other federal, state, local, and community resources. VA must be required to engage community leaders to develop broader sharing agreements so it can plan infrastructure in a way that allows communities to share resources and invest in services the community lacks.

The IB Framework also calls for reforming the congressional appropriations process to ensure VA has the resources it needs and the flexibility to allocate them to provide the health care and services veterans demand, without unnecessary appropriations restrictions. For example, VA is currently precluded from using Choice Program funds to reimburse community providers engaged under the Patient-Centered Community Care (PC3) program and vice versa, even though both programs are intended to meet the same need. VA is also prohibited

from moving funding from community care accounts to increase VA's internal capacity, even if veterans' health care utilization patterns show increasing demand for care in VA facilities. Congress should work with VA to develop and approve legislation to ensure that the undersecretary for health has the authority to allocate funding for the medical care of veterans wherever it is needed throughout the fiscal year.

Further, to ensure that VA's resources are sufficient and properly aligned to fulfill its mission, the IB Framework calls for the establishment of a QVR process, similar to the Quadrennial Defense Review (QDR) performed every four years by the Department of Defense (DOD). A QVR would help VA to align its strategic mission with its budgets and operational plans and help provide continuity of planning across future administrations. VA should also develop a Future-Years Veterans Program (FYVP) detailing five years' of projected spending, as well as fully implement its Planning, Programming, Budgeting and Execution (PPBE) system to better ensure that funding is effectively used for its designated purposes.

Reform VA's Culture with Transparency and Accountability

In order to help change and engrain a new culture of transparency and accountability, the IB Framework calls for establishing a biennial independent audit of VA's finances to identify accounts and programs that are susceptible to waste, fraud, and abuse. The audit would also examine the development of VA's budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and the subsequent appropriations, including advance appropriations, in meeting requirements based on veterans' needs.

In addition, the IB Framework calls for strengthening VA's Veterans Experience Office by combining its capabilities with VA's patient advocate program. Veterans experience officers would advocate for the needs of individual veterans who encounter problems obtaining VA benefits and services. They would also be responsible for ensuring that the health care protections afforded under title 38 of the United States Code (USC), a veteran's right to seek redress through clinical appeals, claims under title 38, USC, section 1151, and the Federal Tort Claims Act, and the right to free representation by accredited VSOs are fully applied and complied with by all providers participating in the VA-community networks, including both private and public health care entities.

The IB Framework was presented in testimony to both the House and Senate Committees on Veterans' Affairs during the 114th Congress and has received strong support from many other veterans and military service organizations.

Commission on Care

In September 2016, the congressionally mandated and independent Commission on Care reported its recommendations to the Secretary of Veterans Affairs and to Congress. The commission had spent the prior year reviewing the findings of the independent assessment, engaging with stakeholders and other outside experts and developing its recommendations to improve the VA health care system for veterans. The commission examined a wide range of ideas and options, including the IB Framework and VA's Community Care Consolidation Plan. It also considered proposals to privatize or dismantle the VA health care system over the next two decades, but ultimately it rejected such radical ideas, instead reaching an overwhelming consensus on a series of recommendations to strengthen and reform the VA health care system.

The IBVSOs agreed with the majority of the commission's recommendations, including its primary one calling for establishment of "high-performing, integrated community-based health care networks." Similar to the VA and IB plans, the recommendation maintains VA as the coordinator and primary provider of care and views the use of community providers and choice as a limited means to expand access in circumstances in which VA is unable to meet local demand for care.

However, the IBVSOs do not support one aspect of the commission's recommendation—specifically, allowing veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care in a timely fashion. This open-choice option would result in fragmented care, worsen health outcomes, lower the overall quality of care, and result in significantly higher costs that could ultimately endanger the overall VA system of care that millions of veterans rely on, particularly veterans who were injured or made ill during military service.

As the commission's report states, "veterans who receive health care exclusively through VHA generally receive well-coordinated care . . . [whereas] . . . fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers." While veterans' individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high-quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the commission's report states, "well-managed, narrow networks can maximize clinical quality," while "achieving high quality and cost effectiveness may constrain consumer choice."

Furthermore, the commission's recommended option to allow every individual veteran to determine which VA or non-VA providers in the network they would use could affect access for other veterans and would lead to increased costs. The commission itself recognized the likelihood of higher costs for networks under its recommended option, cautioning that VA "must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources." In fact, the commission's economists estimate that the recommended option could increase VA spending by at least $5 billion in the first full year and that it could be as high as $35 billion per year without strong management control of the network. The commission also considered a more expanded choice option to allow veterans the ability to choose any VA or non-VA provider without requiring it to be part of a VA network. Economists estimated such a plan could cost up to $2 trillion more than baseline projections over just the first 10 years.

While we agree that the VA health care system must evolve by integrating community providers into networks, VA must retain the ability to coordinate care and manage workload within the networks. In general, the networks must have the ability to expand to include community providers if veterans face access challenges or VA is unable to provide sufficiently high-quality care. However, the size, scope, and design of local networks, as well as clinical work flow, must be directed by VA based on a predictive demand-capacity analysis and veterans' preferences in each market to assure quality and adequate access to care. It is essential for VA to be able to maintain the critical mass of veteran patients necessary to sustain it specialized care programs, which in turn rely on VA health care systems offering a full continuum of care to its patients.

The IBVSOs also strongly disagreed with the commission's recommendation to eliminate the VA secretary's control of the VA health care system and give it to an unelected, independent board of directors that would be less accountable to the president, Congress, veterans, and the American people. Separating veterans' health care services from other veterans' benefits and services would result in less comprehensive and coordinated support for veterans, particularly those injured or ill from their service. Inserting another layer of bureaucracy between veterans and the VA health care system would create more problems than solutions. We appreciate the commission's interest in recommending greater stability and continuity of leadership; however, we believe better means are available to accomplish these goals without undercutting VA's uniquely integrated system of services and benefits.

As discussed above, the IBVSOs believe that the establishment of strategic planning mechanisms such as a QVR, an FYVP, and a PPBE system could provide VA stability and continuity in a more practical, effective, and feasible manner than trying to establish a semi-independent governance board.

In addition, the IBVSOs believe that consideration should be given to extending or overlapping the terms of the undersecretary for health and other senior VA leaders beyond presidential elections to provide additional stability and continuity and to further insulate them from political influence.

A New Consensus on Veterans Health Care Reform

After two years of spirited debate about the future of veterans' health care, the IBVSOs believe there is a new and growing consensus on how to strengthen, reform, and sustain the VA health care system. Despite beginning from vastly different perspectives, the IBVSOs, other veterans' leaders, the VA, bipartisan leaders in Congress, and most recently the independent Commission on Care are all in agreement on the key to fixing the access problem and ending long waiting times, while maintaining a high-quality, comprehensive, and veteran-focused health care system. All are proposing the same basic policy solution: create local integrated health care networks that combine the strength of the VA system with the best of community care, whenever and wherever gaps in coverage exist.

There is still more work to be done to flesh out all of the necessary details to move in this new policy direction, and there must be significant new investment to provide the IT systems and capital infrastructure necessary to build and operate the networks. But after more than two years of debate, there is finally agreement about how to best meet the health care needs of veterans today and over the next 20 years. It is imperative that the 115th Congress quickly move forward from debating to creating the future VA health care system veterans deserve.

Resolve Budget Constraints that Negatively Impact Veterans Programs

Recommendations:

Congress must end sequestration.

The congressional appropriations process must be reformed to ensure VA has the resources it needs to provide veterans timely access to high-quality health care.

VA must establish a QVR process.

Congress must establish a biennial independent audit of VA's budgetary accounts.

Background and Justification:

The Budget Control Act of 2011 set arbitrary budget caps to reduce the federal budget's discretionary spending by $1.2 trillion over nine years—equally divided between defense and nondefense programs. The federal budget would be further reduced by 10 percent across-the-board cut, if federal agencies exceed these budget caps. Since the budget caps were established in 2010 and were not based on actual or projected needs for affected agencies, they no longer reflect the realities of demand on federal programs.

As a result, these arbitrary budget caps have significantly limited VA's ability to carry out programs that have seen spikes in demand, such as the program of comprehensive assistance for family caregivers, hepatitis C treatment, and overall outpatient care. Sequestration has a significant impact on our nation's ability to fulfill its promise to the brave men and women who have worn her uniform. Despite nearly universal congressional opposition to such haphazard budgeting, Congress has opted to simply renegotiate outdated budget caps instead of ending sequestration.

This leaves VA with a misalignment between the resources it is given and the demand on its programs. In fact, the CMS Alliance to Modernize Healthcare emphasized in its report *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* that VA's ability to meet its promise to veterans is limited by the resources it receives from Congress and that VA would need increases over the next five years to meet expected demand.

The potential impact of this misalignment was seen in fiscal year (FY) 2015 when VA's medical services appropriations account was funded at nearly $2.0 billion short of the IB's FY 2015 recommendations. Less than six months after receiving its FY 2015 appropriations, VA reported a $2.6 billion budget shortfall in its medical services accounts that would have forced the department to shutter VA medical facilities if Congress were unable to provide additional funds. Fortunately, VA was authorized to use the non-budgetary account to offset the shortfall. However, that account is set to expire by the end of FY 2017, and more budget shortfalls are likely in the future.

In fact, VA faces a potential funding crisis by the end of FY 2017 and into FY 2018. With the Choice Program set to expire in August 2017 and its funding possibly running out before then, VA will have to address the new community care demand it has fostered without necessary resources. Moreover, the FY 2018 advance appropriations levels recommended by the administration and approved by Congress are woefully inadequate to meet the ever-increasing demand for services both inside and outside the VA health care system. VA admitted to underestimating the advance appropriations request in February 2016, insisting that the next administration would have to adjust for that fact. And yet Congress knowingly provided insufficient funding—projected to be anywhere between $5 billion and $12 billion short. If this problem is not addressed immediately, VA faces an access and service delivery problem the likes of which it has never encountered.

That is why the IBVSOs agree with the independent assessment's finding that the congressional appropriations process does not provide VA the flexibility it requires to meet the demands on its health care system. While the IB was at the forefront of efforts to enact advance appropriations to relieve the pressures of a broken appropriations process on the VA health care system, we believe that consideration should be given to new proposals that might optimize the funding process.

To ensure VA's budget requests are accurate and properly aligned with the health care needs of the veterans population, the IBVSOs believe it is also important to reform VA's current planning methodology, budget forecasting, and resource allocation systems to align them with veterans' changing demographic and health care needs. Similar to DOD's QDR, VA would benefit from a QVR which would serve as the benchmark for the future-year veterans programs and take a long view of the prospective resource needs based on demand for health on the entire VA health care system.

While ensuring VA has the resources it needs to meet demand is important, it is also critical that VA continue to serve as a good steward of federal resources used to provide timely, quality care to veterans. To support this point, the IBVSOs believe an independent audit of VA's budgetary accounts could identify line items and programs that are susceptible to waste, fraud, and abuse. Such an audit could also examine the development of the budget requests, including oversight of the Enrollee Health Care Projection Model, to ensure the integrity of those requests and subsequent appropriations, including advance appropriations.

Reform the Claims and Appeals Process

Recomendations:

Comprehensive legislation to modernize, streamline, and reform the benefit claims' appeals process that was developed and agreed to in 2016 by senior leaders of VA, the Board of Veterans' Appeals, VSOs, and other stakeholders must be enacted, fully funded, faithfully implemented, and aggressively monitored to ensure it achieves its intended purposes while fully protecting veterans rights.

Congress should enact legislation requiring VA to provide due deference to private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes. VA should be required to fully consider completed Disability Benefit Questionnaires (DBQs) from private health care professionals and to fully consider medical opinions from private health care professionals when those opinions are competent, credible, and probative to the issue at question.

Congress should enact legislation to effectively eliminate unnecessary evidentiary burdens, such as those contained within title 38, USCUSC, section 5108, "new and material evidence," and reject similar proposals such as "new and relevant evidence."

Congress must carefully and continually oversee VA's IT initiatives to ensure that quality, accuracy, and timeliness of claims and appeals processing remain top priorities when considering workload management. VA's claims and appeals processing IT infrastructure must be planned, developed, resourced, implemented, and integrated properly to keep pace with current processing demands and those occurring when work processes and priorities change.

IT systems such as the Veterans Benefits Management System (VBMS), the National Work Queue (NWQ), and the Stakeholders Enterprise Portal (SEP) must have efficient interoperability. Seamless electronic transmission of compensation, pension examinations, DOD service treatment records DOD, other government agencies, and private businesses and organizations throughout all VA systems is vital to efficient claims and appeals processing.

> *"IT systems such as the Veterans Benefits Management System (VBMS), the National Work Queue (NWQ), and the Stakeholders Enterprise Portal (SEP) must have efficient interoperability. Compensation and pension examinations and records from the DOD, private businesses and other government agencies must flow seamlessly in this electronic environment."*

VA must ensure these IT systems have features built in to capture information that can be used to improve quality, consistency, and accountability. Design, development, and implementation of these systems must provide stakeholders with adequate information, access, and functionality needed to properly serve those we represent.

Introduction

In July 2012, VBA was facing a significant backlog of claims for disability compensation. At that time there were 883,930 claims pending, and the inventory was growing. It seemed as if there was no solution. In response to this crisis, VBA set out to transform and modernize its systems and procedures for processing veterans' claims for benefits.

VBA created and implemented a new claims-processing organizational model for its VA regional offices (VAROs), developed and then rolled out a new Fully Developed Claims process to speed simpler claims, and collaborated with VSOs to create new standardized medical evidence forms, called DBQs, to streamline the

rating process. VBA also designed, tested, deployed, and now operates essential IT systems, including VBMS, SEP, and e-Benefits, which together have revolutionized the electronic filing and processing of claims. VBMS associated with veterans' new e-folders facilitates simultaneous review by all VBA offices, 168 VA medical centers (VAMCs), and VSOs who represent veterans. VBA now processes nearly all claims electronically and receives nearly half of their compensation claims as Fully Developed Claims (FDCs).

At the end of 2016, just over four years from VBA's peak disability claims inventory, itit has managed to drive down the number of claims pending to 379,000; 74,500 pending claims (or roughly 20 percent) are considered backlogged, meaning they have been pending longer than 125 days. VBA continues to process claims in record numbers each year. It completed over one million claims in 2014 and 2015, and in 2016 processed more claims than the preceding two years. This is a significant achievement accomplished through a blend of people, technology, resource-specific allocation, and mandatory overtime.

These accomplishments are in fact deserving of praise, but much more work lies ahead for VBA, Congress, and stakeholders. The resources available to VBA today must be maintained and enhanced, and they must evolve to ensure veterans receive accurate, fair, and timely decisions without compromising the non-adversarial, pro-veteran, and due-process safeguards of the system that benefits veterans today.

Disability compensation claim processing is only one facet of VBA's responsibilities. While VBA was driving down claims in the ratings inventory, its appeals inventory and non-disability ratings inventory were steadily rising. At the end of 2016, there were over 460,000 appeals pending at various stages. Within VBA alone, there were close to 380,000 appeals pending action. The remaining 80,000 appeals are pending action by the Board of Veterans' Appeals (the Board).

The appeals backlog is of significant concern to the IBVSOs. These injured and ill veterans, their dependents, and their survivors are waiting upward of three years for decisions on their appeals. Without significant reform, proper resources, and planning in the 115th Congress, the time it takes to get a decision on an appeal will simply get longer and longer.

These delays are unacceptable. Congress must enact legislation and provide VBA with the resources needed to process all claims and appeals timely and accurately.

Legislation to Reform the Claims and Appeals Process

The current backlog, dysfunction, and resource needs for the appeals process the major impetuses for urgent fundamental reform. Much of the dysfunction within the appeals process relates directly to inadequate resources to efficiently process both claims and appeals simultaneously. VBA's overall demands simply outpaced their capacity.

Despite past failed attempts to modernize its claims-processing systems over the past two decades, VBA made a critical decision to transform its paper-based systems and replace it with modern IT systems and business processes. During this transformation and modernization initiative, then VA Secretary Eric Shinseki announced ambitious aspirational goals for transforming the claims system, promising that by 2015, VBA would decide all claims for disability compensation within 125 days and decisions would be completed with 98 percent accuracy. At the conclusion of FY 2016, VBA reported that disability claims processing averaged 123 days at 95 percent accuracy.

This production and quality goal has continued to guide VBA, but it may need to reexamine its goals and aspirations that focus more on timeliness of appeals and non-disability claims, accountability, the overall claimant experience, and continued emphasis on quality. To truly fix its claims and appeals processing systems, VBA must foster a work culture focused on these facets. Establishing arbitrary and artificial metrics such as the one in place currently can lead to unintended consequences such as backlogs in other critically important areas.

There must also be a partnership with stakeholders when considering goals and objectives. VSO stakeholders have intimate familiarity with VA's myriad benefits and services and have gained tremendous experience and knowledge through decades of providing representation to veterans, their dependents, and their survivors.

Much of VBA's efforts and energy over the years were keenly focused on driving down the disability claims backlog. To its credit, it has managed to drive down and manage the disability compensation claims inventory, also known as the ratings inventory. Its ability to bring down the claims backlog is attributable to increased staffing, enhancements to its IT systems, implementation of mandatory overtime, the FDC program, and reassignment of appeal processing personnel to work on claims.

But with its attention fixated on the claims backlog, appeals became a peripheral matter for VBA. Appeal-processing personnel were often tasked to work claims in an all-out effort to reduce the claims backlog. This included re-tasking staff to work claims during mandatory overtime.

This illustrates VBA's reliance on people to do the work. As a consequence of shifting its workforce around to address disability rating claims, the appeals inventory and non-rating claims inventory rose steadily and are nearing a crisis point.

For the past several years, VBA has issued over one million rating decisions. At the end of FY 2015, it completed 1.4 million claims; at the end of FY 2016, it completed 1.3 million claims. On average, VBA can expect to receive 10 percent of those decided claims as appeals. Therefore, VBA can expect to receive about 130,000 appeals, based on claims work decided for FY 2016.

The Appeals Backlog

At the end of 2016, there were over 460,000 appeals pending at various stages. Within VBA alone, there were close to 380,000 appeals pending action. The remaining 80,000 appeals are pending action by the Board.

Appellants face significant delays when they choose to appeal a decision made by VBA. For appellants seeking further review of their decisions before the Board, they can expect to wait upward of three years for a decision on their appeal. Of the 130,000 appeals expected to enter the system about 65,000, or half, will continue to the Board. This is5 percent of the total number of claims filed.

Despite its best efforts, the Board has been unable to keep pace with incoming appeals. It has been decades since the Board has managed to achieve a zero-sum year where its output matched the number of appeals received, because many appeals require supplemental processing. Therefore, its work continues to mount.

In FY 2015, the Board managed to issue 55,713 decisions with roughly 647 full-time employees (FTEs). In order for the Board to address its current appeals inventory and what it expects to receive, the administration requested funding for an additional 242 FTEs, which Congress approved for FY 2017.

The 2017 FY budget submission also projected the appeals inventory could top one million if the status quo is maintained without fundamental reform legislation. The delay associated with resolving an appeal is unreasonable and unacceptable. If comprehensive claims and appeals reform is not accomplished soon, appellants will endure even longer wait times for resolution of their appeals.

Legislative Reform Efforts

It is critically important that, when VA begins to implement reforms and plans to address the current backlog of appeals, strong protections in place today (such as duty-to-assist requirements, due-process rights, and the non-adversarial construct of the system) are not compromised by being forced into the new system for the sake of simply reducing the overall number of unresolved appeals. Congress and stakeholders must ensure

that reforms to the claims and appeals process keep the veterans' best interests at the forefront of any decision, never compromising the veteran-centric spirit that is an integral component of VA's sacred mission.

In the 114th Congress, significant claims and appeals-reform legislation was introduced. The legislative language contained within H.R. 5083, H.R. 5620, and S. 3328 reflected significant efforts of a working group formed in March 2016 that consisted of the IBVSOs, other VSO stakeholders, and leaders within VBA and the Board.

The original task before the working group was to solve the appeals dilemma, but the working group quickly realized the intrinsic nature of the claims process and how it affects the appeals process; these two facets are in fact symbiotic. Therefore, the working group determined that an effective fix would also have to consider additional changes to the claims process. Of note, support for current reform efforts appears strongest among the IBVSOs and other VSO stakeholders that regularly provide substantial and direct services to claimants and appellants.

A New Framework for Veterans' Claims and Appeals

The working group agreed that decision notification letters must be clear, easy to understand, and easy to navigate. Notice letters must convey not only VA's rationale for reaching its determination, but also the options available to claimants after receipt of the decision. The legislation required that in addition to an explanation for how veterans can have the decision reviewed or appealed, all decision-notification letters must contain the following information to help them in determining whether, when, where, and how to appeal an adverse decision:

- a list of the issues adjudicated
- a summary of the evidence considered
- a summary of applicable laws and regulations
- identification of findings favorable to the claimant
- identification of elements that were not satisfied leading to the denial
- an explanation of how to obtain or access evidence used in making the decision
- if applicable, identification of the criteria that must be satisfied to grant service connection or the next higher level of compensation for the benefit sought

Understanding the benefits and weaknesses of the current system, the working group developed a new framework that would protect the due-process rights of veterans while creating multiple options to receive favorable decisions more quickly. A critical factor was developing a system that would allow veterans to protect their earliest effective dates while allowing them opportunities to introduce new evidence without having to be locked into the long and arduous formal appeals process at the Board. In general, the framework provided three main options for veterans who disagree with their claims decision and want to seek redress of VBA's determination. Veterans would have to elect one of these three options within one year of a claims decision.

First, there would be an option for readjudication and supplemental claims when there is new evidence submitted or a hearing requested. Second, there would be an option for a local, higher-level review of the original claims decision based on the same evidence at the time of the decision. Third, there would be an option to pursue a formal appeal to the Board—with or without new evidence or a hearing.

The central dynamic of this new system was that a veteran who received an unfavorable decision from one of these three main options could then pursue one of the other two appeals options. As long as the veteran continuously pursues a new appeals option within one year of the last decision, he or she would be able to preserve his or her earliest effective date, if the facts so warrant. Each of these options, or "lanes" as some call them, have different advantages that allow veterans to elect what they and their representatives believe will provide the quickest and most accurate decision on their appeal.

For the first option—readjudication and supplemental claims—veterans would be able to request a hearing and submit new evidence that would be considered in the first instance at the VARO. VA's full "duty to assist" would apply during readjudication, to include development of both public and private evidence. The readjudication would be a de novo review of all the evidence submitted both prior to and subsequent to the claims decisions until the readjudication decision was issued. If the veteran was not satisfied with the new decision, he or she could then elect one of the other two options to continue pursuing his or her appeal.

For the second option—the higher-level review—the veteran could choose to have the review done at the same local VARO that made the claim decision or at another VARO, which would be facilitated by VBA's electronic claims files and the NWQ's ability to instantly distribute work to any VARO. The veteran would not have the option to introduce any new evidence or have a hearing with the higher-level reviewer, although VBA indicated it would allow veterans' representatives to have informal conferences with the reviewer in order for them to point out errors of fact or law. The review and decision would be de novo, and a simple difference of opinion by the higher-level reviewer would be enough to overturn the original decision. If the veteran was not satisfied with the new decision, he or she could then elect one of the other two options to pursue resolution of his or her issue.

For the third option—Board review—there would be two separate dockets for veterans to choose from: an "expedited review" that would allow no hearings and no new evidence to be introduced and a more traditional appeal that would allow both new evidence and hearings. Both of these Board lanes would have no duty-to-assist obligation to develop any evidence submitted. For both of these dockets, the appeal would be routed directly to the Board. Statement of the Cases, Supplemental Statement of the Cases and VA Form 9's would no longer be required.

The working group established a goal of having "expedited review" appeals resolved within one year, but there was no similar goal for the more traditional appeals docket. While eliminating introduction of evidence and hearings would naturally make the Board's review quicker, it is important that sufficient resources be allocated to the traditional appeal lane at the Board to ensure a sense of equity between the two dockets. Legislative language should be added to ensure the Board does not inequitably allocate resources to the expedited review lane.

For the traditional Board appeal lane, veterans could choose either a video conference hearing or an in-person hearing at the Board's offices in Washington, DC; there would no longer be travel hearing options offered to veterans. New evidence would be allowed but limited to specific time frames: if a hearing is elected, new evidence could be submitted at the hearing or for 90 days following the hearing; if no hearing is elected, new evidence could be submitted with the filing of the Notice of Disagreement (NOD) or for 90 days thereafter. If veterans are not satisfied with the Board's decision, they could elect one of the other two VBA lane options, and if they file within one year of the Board's decision, they would continue to preserve their earliest effective date. The new framework would impose no limits on the number of times veterans could choose one of these three options, and as long as they properly elected a new one within a year of the prior decision, they would continue to protect their earliest effective date.

If the Board discovered a duty-to-assist error occurred prior to the original claim decision, the Board would (unless the claim can be granted in full) remand the case back to VBA for it to correct the errors and readjudicate the claim. Again, if the veteran was not satisfied with the new VBA claim decision, he or she could choose from one of the three options available, and as long as the election is properly made within one year of the decision, the earliest effective date would continue to be preserved.

One additional option becomes available after a Board decision: the appellant would also have the opportunity to file a Notice of Appeal to the Court of Appeals for Veterans Claims (the Court) within 120 days of the Board's decision, which is the current practice today. Decisions of the Court would be final.
The legislation also included an amendment to title 38, USCUSC, section 5104A, to require that any finding made during the claims or appeals process that is favorable to the claimant would be binding on all subsequent

adjudicators within the department, unless clear and convincing evidence is shown to the contrary to rebut such favorable finding. In the new structure in which appeals can move back and forth from the Board to VBA, veterans must be reassured that favorable findings cannot be easily overturned by a different adjudicator or reviewer during this process. The IBVSOs also found this provision to be beneficial to claimants.

Overall, the new framework embodied within those bills could provide veterans with multiple options and paths to resolve their issues more quickly, while preserving their earliest effective dates to receive their full entitlement to benefits. The structure would allow veterans quicker "closed record" reviews at both VBA and the Board, but if they become aware that additional evidence was needed to satisfy their claim, they would retain the right to next seek introduction of new evidence or a hearing at either VBA or the Board. If implemented and administered as envisioned by the working group, the new claims- and appeals-processing system could be more flexible and responsive to the unique circumstances of each veteran's claim and appeal, leading to better outcomes for many veterans.

Remaining Issues and Questions Related to Appeals-Reform Legislation

Notwithstanding broad support for the new claims- and appeals-processing system and accompanying legislation, there is a uniform concern regarding the current appeals inventory, appeal equitability, planning, and implementation. Due to the complexity of the system and the scope of the changes proposed, some stakeholders are naturally cautious about such sweeping claims and appeals reforms. Transition to a new processing system will require adjudicating new appeals differently than those filed before the change in law.

The IBSVOs continue to work with Congress, the Board, and VBA to resolve and clarify a number of issues, further improving the proposed new appeals structure. There are still some critical issues that need to be further explored to ensure there are no unintended negative consequences for veterans.

One of the most critical questions is how the introduction of new evidence will be treated by VBA and the Board and how duty-to-assist requirements will apply. For the higher-level review, no new evidence is allowed; however, there is an informal opportunity for the veteran's representative to attend a conference with the reviewer to point out errors. If during this conference the representative identifies evidence not yet submitted as part of the discussion, how will the higher-level reviewer acknowledge or treat this information? Will the claim be referred back to the readjudication option as a supplemental claim, indicating there is evidence that needs to be developed? Will the reviewer inform the representative or the veteran directly that if there is new evidence that may affect the decision, the veteran should file a supplemental claim for readjudication to present that evidence directly or through a hearing?

Similarly, there are questions that need to be answered about how the Board will handle new evidence introduced outside the limited opportunities allowed at and 90 days after the filing of a NOD or a Board hearing. What happens if a veteran elects the Board option with a hearing and submits new evidence to the Board prior to the hearing date? Will the Board hold the evidence until the hearing and then consider it, or will the Board return or ignore the evidence?

In addition, since there is no duty-to-assist requirement after the NOD filing, what if evidence properly submitted indicates that additional evidence exists that could affect the decision? Will the Board ignore that evidence or inform the veteran that there was additional evidence that could have changed the decision but that it was not sought nor considered? Will or should the Board remand the appeal back to VBA for readjudication to allow for full development of all evidence? In each of these circumstances, and others that may arise, VA places the greatest weight on providing veterans the maximum opportunity to support their appeals in order to receive favorable decisions, rather than seeking to limit the workload of its employees.

There are also two critical operational concerns that will affect whether the new appeals structure can be properly implemented as envisioned. First, the Board and VBA must develop and implement a realistic plan to address the almost 460,000 appeals currently pending, most of which are still within VBA's jurisdiction.

Until these pending appeals are properly resolved, no new appeals structure or system can be expected to be successful. While we have been in discussion with VBA and the Board about how best to address these legacy appeals, we have yet to agree on formal plans to deal with its current backlog of appeals. We need Congress to perform aggressive oversight of this process to ensure a proper outcome.

Furthermore, since appeals that are filed today can take years to complete, some will last more than a decade. How will VBA and the Board operate two different appeals systems simultaneously, each with separate rules for treating evidence and the duty to assist? How will new employees be trained under both the old and new systems so that there is efficient administration of these two parallel appeals systems? How will the CAVCCAVC view the existence of two different standards for critical matters such as the duty to assist veterans? In order to address these and other concerns about implementation, VA must have the resources and time necessary to address the existing backlog of appeals and ensure a smooth transition to the new system.

Finally, as mentioned above, the most critical factor in the rise of the current backlog of pending appeals was the lack of sufficient resources to meet the workload. Similarly, unless VBA and the Board request and are provided adequate resources to meet staffing, infrastructure, and IT requirements, no new appeals reform will be successful in the long run. As VBA's productivity continues to increase, the volume of processed claims will also continue to rise, which has historically been steady at a rate of 10 to 11 percent of claims decisions. In addition, the new claims and appeals framework will likely increase the number of supplemental claims filed significantly. VA has indicated a need for greater resources for both VBA and the Board to make this new appeals system successful; however, too often in the past funding for new initiatives has waned over time.

The IBSVOs will not compromise any aspect the system's proveteran nature for the sake of simply achieving reform. The due-process protection and duty-to-assist rights currently afforded to veterans cannot be diminished. In order to protect these critical due-process rights, any uncertainties should be resolved through clear statutory language.

The close working relationship between VA, VSOs, and other stakeholders must continue throughout all stages of the planning and implementation process. It would be a fatal error if VA does not fully engage with its VSO stakeholder partners in the design and execution of any new or existing transformation initiatives. VSOs have tremendous experience and expertise in claims processing, and through our service programs the IBVSOs are active partners inside the VAROs.

Private Medical Evidence

VBA must have increased authority and flexibility to use and accept claimant-supplied DBQs and private medical evidence for rating purposes.

Currently, title 38, USCUSC, section 5125, states in part that VA "may" accept medical examinations from private physicians provided by claimants for rating purposes without requiring further confirmation by a Compensation and Pension (C&P) medical examination if that evidence is sufficiently complete and adequate for rating purposes. But as the statute is written today, it simply gives VA the "option" to accept such evidence for rating purposes, rather than requiring it to issue rating decisions based on that information.

Providing VBA with expanded authority to issue rating decisions based on private medical evidence will improve overall decision timeliness and reduce demand on VBA resources when C&P examinations are requested unnecessarily.

Veterans typically submit three types of evidence from their private treating physician or other health care provider:

- treatment records detailing the initial complaints of a health issue, as well as testing, diagnosis, and treatment constitute valuable information that can be used to allow VA to grant service connection or increased evaluations for established service-connected disabilities

- DBQs are forms central to VA's disability evaluation process. DBQs capture very specific medical information that enables adjudicators to make benefit determinations regarding entitlement to service connection and disability ratings. Nearly all DBQs have been available to the public and can be completed by a veteran's private health care provider

- private nexus medical opinions can be used to support a diagnosis, establish etiology of a condition, or connect a present disability to an event in service. Many medical opinions are written by a veteran's treating physician (someone who can provide a long and detailed history of treatment) or by a specialist in the field of medicine encompassing the disability in question. These health care professionals often have specialized knowledge of the veteran's condition and a treatment history that is not available to a VA examiner conducting a onetime C&P examination. Further, many are experts in their field, offering decades of study and experience to support their opinions

Often VAROs and employees are reluctant to issue rating decisions based on private medical evidence supplied by veterans because VA C&P examinations tend to capture very specific information needed for reconciliation and application of VA's schedule for rating disabilities. However, VA should issue interim ratings based on private medical evidence and only request the appropriate C&P examination to close any evidentiary gaps when claimant-supplied medical evidence is not adequate for a complete and comprehensive rating.

Second, VA compensation, pension, and survivor benefit claims are eligible to be filed as FDCs. Use of private medical evidence for rating purposes is a major facet of VBA's FDC program, but enhancements can be made to improve this program. Today, over 50 percent of all claims are submitted as FDCs.

This program provides claimants with a sense of personal ownership as they gather and supply the evidence needed to support their claims. The FDC program continues to play a vital role in helping to keep down the claims inventory and backlog and is integral to providing timely and accurate benefit determinations. FDCs alleviate some aspects of VBA's duty-to-assist requirements that it would otherwise have to perform in conjunction with the adjudication of a claim.

Claim timeliness can be improved and resources can be saved when ratings based on private medical evidence are used, instead of C&P examinations. In order for the FDC program to grow and remain a viable claims-filing option, adjudicators must be encouraged and have broader discretion to make rating decisions based on claimant-supplied evidence. VBA must encourage its adjudicators to use competent and credible private medical evidence for rating purposes and only order VA C&P exams when necessary to close unresolved evidentiary gaps.

Third, over the past several years, the IBVSOs and VBA have collaborated to develop and deploy DBQs. These forms are used by private physicians, VAMCs, and DOD when performing exit exams. DBQs are designed to capture essential and specific information that correlates directly to VA's rating schedule disabilities. Rather than waiting for VBA to complete the C&P examination process, veterans can take these DBQs to their treating physicians for completion, then submit their claim as an FDC to expedite the claims-adjudication process. Veterans currently have access to 71 different DBQs.

The largest area of rework for claims processors tends to be a lack of data provided within a DBQ. Some claims in the FDC program with DBQs still require C&P examinations because some DBQs are deemed

inadequate for rating purposes if they are not filled out correctly or completely. VBA would then be required to order a C&P examination to obtain all the relevant information needed for rating purposes.

Supplemental requests for C&P examinations increase claims-processing times. Although some information may be missing from these DBQs, there may be enough information to issue an interim rating decision while VBA waits on the results from the C&P examination.

Many service-connected veterans rely solely on the Veterans Health Administration (VHA) for their care. When they file claims for disability compensation, it is only natural for them to seek assistance with a DBQ from their VA treating physician. This should be a simple process:: either their VA treating physician can complete the DBQ, or veterans would be referred to VHA's C&P examination division to have the form completed.
Veterans in some states are simply unable to get DBQs completed by VHA personnel. Consequently, they are placed at a disadvantage if they want to file a claim under the FDC program. They cannot fully utilize the FDC program by supplying completed DBQs and are forced to go through the entire VBA C&P examination process. VA must facilitate DBQ completion within VHA when requested by veterans.

Providing a useful mechanism to give due consideration to claimant-supplied private medical evidence and DBQs for rating purposes would reduce VA's reliance on C&P examinations. Eliminating steps during the claims process would lead to more timely decisions and reduce the time VBA would have to spend performing evidentiary development functions. Greater acceptance of private medical evidence would also increase FDC fillings among claimants.

Finally, to encourage the submission of private medical evidence and DBQs from claimants, Congress should amend title 38, USCUSC, section 5103A(d)(1), to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not require a duplicative and redundant VA medical examination.

Unnecessary Evidentiary Burdens

Claimants are required to supply new and material evidence to reopen claims that have been finally decided. These finally decided claims tend to be those for initial benefit entitlement, such as claims to establish service connection. This evidentiary threshold exists to prevent VBA from reopening and readjudicating claims based on evidence considered in prior decisions but does not preclude claimants from filing claims.

This standard creates an unnecessary evidentiary burden that serves no practical effect other than to delay a claim from ultimately being reopened, because VBA must review all the evidence of record to determine whether the recent evidence is new *and* material. VBA is simply performing this two-part evidentiary test to determine whether to reopen a claim in light of all the evidence of record.

Second, title 38, USCUSC, section 5108, provides no actual benefit since VA must review all the evidence of record in addition to the newly submitted evidence to determine whether it is both "new and material." This evidentiary requirement provides no practical benefit to VA or veterans. It simply generates unnecessary work for VBA and the Board and delays a final determination.

VA should simply be required to determine whether evidence received in conjunction with a claim changes a previous determination. VBA and the Board are still required to expend resources for these claims. They are required to review the evidence of record, issue decisions, conduct hearings upon a claimant's request, and perform other administrative functions if a claimant decides to appeal a finding that new and material evidence has not been submitted to reopen a claim. If the Board does find such evidence, the claim is reopened after a delay that could be up to three years and the expenditure of valuable resources.

The VBA will then have to perform another adjudication based on the evidence of record and the evidence deemed new and material by the Board. Rather than reducing VBA's workload by dissuading additional claims filings, the current statute has resulted in additional work for both VBA and the Board.

Finally, the evidentiary test should simply be to determine whether "new evidence" changes a previous decision. Congress attempted to address this very issue in the 114th Congress within H.R. 5083 and S. 3328 by changing the "new and material evidence" to a "new and relevant evidence" standard. This is essentially the same evidentiary test as adjudicators would then have to determine if evidence was relevant.

VA would expend the same amount of resources when claimants challenge a finding that evidence submitted was not "relevant." The IBVSOs believe that it is better for claimants and VA to simply perform a "new evidence" test and determine if that evidence is sufficient to change a previous decision.

While the current standard may have been intended to prevent the submission of redundant or irrelevant evidence, it does not effectively serve that purpose and should be repealed or amended.

Information Technologies

VBA has undergone significant IT transformation that enabled it to transition away from being an organization that completed most of its work in a paper-based environment to one where today most work is completed almost entirely electronically. VBA's initial focus was the creation and deployment of VBMS, an IT platform that would facilitate electronic processing of claims for disability compensation.

Appeal processing was not developed concurrently with VBMS. As it stands today, VBMS does not provide the full continuum of functionality from claim to appeals resolution. When a decision is appealed, the VBMS platform is not conducive to efficient appeals processing within VBA or the Board.

Much of VBA's focus, resources, and energy have been directed toward disability claims processing to reduce the backlog, and VBMS has helped achieve results. Undoubtedly, VBA's ability to processes over one million claims consecutively over the past few years can be attributed in some part to VBMS, but its workforce also played an integral role in helping to achieve such a claims-processing milestone.

VBA relies heavily on this system to automate much of the adjudication process and improve work flow. Automation has also helped to improve the disability rating quality by mitigating some of the errors and inconsistencies intrinsic to the human element associated with claims processing.

VBMS also provides stakeholders with the ability to perform myriad functions related to claims submission, tracking, and rating reviews. This system does provide a greater level of access and functionality but is also constantly evolving, which requires updates and occasional fixes.

For the IBSVOs and other stakeholders, SEP is the pipeline that plugs directly into VBMS. This conduit enables stakeholders to submit claims and upload evidence directly into VBA's system, yet another feature to improve timeliness by further streamlining the adjudication of claims.

VBA has also migrated to a centralized mail-processing system. Paper documentation submitted by claimants is routed through VBA's claims intake center in Janesville, Wisconsin. These documents are sorted, labeled, and uploaded into a veteran's e-folder within VBMS. However, sometimes this evidence can be uploaded and labeled incorrectly. When this happens, stakeholders and VA adjudicators can overlook key evidence needed to perform proper and complete claims adjudications.

Inefficiencies within this process also require people to spend time sifting through electronically uploaded documents. Evidence labeling within VBMS must become more user friendly and improved to provide a greater level of clarity of all documents contained within the system.

The evidence-upload process must be improved to ensure that when paper documentation is sent in to VA, it is uploaded quickly and the documents being uploaded must be separate and distinguishable from one another.

Congress has provided VA with substantial resources over the past few years to develop, implement, and maintain its IT infrastructure. Since the inception of VBMS back in 2009, this program alone has received close to $1 billion in funding. These resources were needed to create and maintain this electronic claims-processing system that made claims adjudication more efficient through automation, but additional resources will be required to keep pace with current and future workload demands.

Automated Decision Letters

Some aspects of automation must be used cautiously, such as the Automated Decision Letter (ADL) notification process. While ADLs can substantially reduce a VBA adjudicator's production time, ADLs also can significantly reduce an adjudicator's ability to thoroughly discuss elements of a claims decision that are needed for claimants to have a comprehensive understanding of the elements VBA used to arrive at a decision.

The format and content of ADLs can influence the number of appeals filed. As *The Independent Budget* has noted in recent years, current notification letters often insufficient information to enable claimants and/or their representatives to fully understand the rationale for the rating decisions or the evidence that was considered.

The IBSVOs believe that efficiencies gained through ADLs cannot override the requirement to provide claimants with a full and detailed account of the facts and evidence used to decide their claim. Without sufficient confidence in rating decisions, veterans and their advocates are more likely to pursue appeals options. VBA must continue to work with VSOs to improve claims-decision letters.

The Board and Appeals Processing

The Board in particular is trying to use the VBMS e-folder component to perform its work, but it processes appeals in an entirely different manner from VBA. The Board requires a greater level of functionality to properly adjudicate a record within VBMS that will enable it to sort, tab, and annotate evidence. This has led to appeals-processing inefficiencies that, in the end, simply lead to unnecessary delays for appellants seeking resolution of their appeals.

Congress recognized the significance of this issue and provided VA with $19.1 million in FY 2016 funds to develop systems that can provide cross-sectional functionality. Fortunately, IT modernization efforts within VBA and the Board are currently under way.

The Board is planning to replace its current legacy appeals workload management system, the Veterans Appeals Control and Locator System (VACOLS). It is currently evaluating new technologies to determine the best platform that will enable veterans' law judges and attorney to break a VBMS record into different pieces for more efficient evidentiary review and appeals processing. However, any platform the Board finds best suited to its needs must facilitate the needs of VBA personnel and stakeholders involved in the claims and appeals process.

National Work Queue

During FY 2016, VBA deployed its NWQ system, another paperless workload-management initiative designed to improve the VBA claims-processing productive capacity. It builds on the work-flow and management capabilities provided through VBMS, allowing veterans' e-folders to be instantly accessible to any VARO and incorporated into the work queue of any VBA employee.

These e-folders contain personal information, data, and records required to perform claims adjudication. NWQ is intended to provide VBA with the ability to leverage all its resources by redistributing its workload to

all ROs based on various parameters such as the total pending workload and the number, experience, and type of employees working at each RO.

NWQ can also separate and allocate workload based on any parameters or priorities established by VBA. In effect, it acts as the nexus between VBA business processes and IT systems, playing the role of "traffic cop" for claims processing.

During the first phase of the NWQ deployment, the primary filter for determining where a veteran's claim will be processed will be the veteran's place of residence, as is the case under the current organizational model. However, if the veteran's local VARO is under resourced or overburdened with work, NWQ will assign that claim to another RO, brokering it in a much more efficient, timely, and accountable manner. .

NWQ can provide VBA with significant technological capabilities to reorder and redistribute workload. It will also have the functionality to assign development of a claim to one RO but the rating work to a different RO if that referral results in a timelier decision. It could potentially divide claims by issue, assigning some of the development and rating work to multiple ROs, but the IBVSOs would have concerns about this practice. However, VBA has indicated it does not have plans to divide or separate claims in this manner.

VA's IT infrastructure must be planned, developed, resourced, implemented, and integrated properly to keep pace with current processing demands and those occurring when work processes and priorities change. IT systems such as VBMS, NWQ, and SEP must have efficient interoperability with other government systems to facilitate seamless electronic transmission of information.

These systems must have the capability to capture information that can be used to enhance quality, consistency, and accountability. Stakeholders must be included in the design, development, and implementation of these systems to ensure there is adequate access and functionality to facilitate adequate client representation.

Summary

Sweeping claims and appeals-reform efforts would fail to achieve their intent iss not planned, implemented, monitored, and resourced correctly.

For instance, relaxing evidentiary standards would simplify the process for veterans and VA adjudicators, but without adequate IT systems in place to properly manage the workload, the benefits gained from simplification would be minimized by continued deficiencies within the IT infrastructure. These critical issues are essential components to truly reform VA's claims and appeals processes. They are all very much interrelated and have an impact on one another in some way.

But with a partnership between Congress, VA, and stakeholders all working together, from start to finish, we can ensure the reengineering of a system that adequately meets the needs of our ill and injured veterans, their dependents, and their survivors seeking timely, accurate, and fair decisions for benefits based on their service to our country.

Realign and Modernize Capital Infrastructure

Recommendations:

VA must begin requesting funding that will close all safety, condition, access, and utilization gaps and at the same time present a five- and 10-year plan that will systematically describe when and how VA plans to close each gap.

VA must submit a plant replacement value (PRV) for all VA-owned property and calculate its baseline and each facility's nonrecurring maintenance (NRM) funding request from that value.

Congress must fund a 10-year comprehensive facility master plan.

Congress must pass legislation to allow VA to enter into public-private partnerships when proposing major construction projects and alternative means to closing access and utilization gaps.

NRM funding calculations should be removed from the VERA model.

VA must submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects.

Background and Justification:

The VA health care systems goes back more than 150 years to when it opened its first national home on November 1, 1866. When World War I veterans returned from Europe with complications from shell shock and mustard gas exposure, the United States was ill prepared to care for these unique conditions. In 1918, the need to care for veterans had grown so quickly that Congress authorized rapid expansion of veterans' hospitals. But due to a lack of planning, the Bureau of War Risk Insurance and Public Health Service had to rent space in existing hospitals and hotels to ensure care was provided to our returning veterans. By 1930, 54 veterans' hospitals had been built to provide direct care for the unique needs of veterans.

Today, VA operates the largest integrated health care system in the United States, including 152 hospitals, more than 900 community-based outpatient clinics, and 161 extended-care and domiciliary facilities. Unfortunately, many of these facilities are aging and struggling to meet the needs of today's veterans. In 2004, VA's facilities were utilized at about 80 percent of their planned capacity. Today they are utilized at 109 percent of capacity, even though based on the actual conditions of the facilities they should be operating at just under 80 percent. Over the past few years, the VA budget request and the Congress's VA construction appropriation has fallen far short of the actual need. VA facilities are where enrolled veterans receive health care, and the facilities are just as important as the physicians and staff who deliver that care. A VA budget that does not adequately fund facility maintenance and construction will continue to negatively impact the quality and timeliness of veterans' health care.

In its FY 2015 budget submission, VA introduced the Strategic Capital Investment Planning (SCIP) process. SCIP provides an in-depth analysis of VA infrastructure, identifying gaps in access, utilization, and safety and details the cost to close these gaps.

The vastness of the VA capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a PRV of approximately $45 billion. Although VA has reduced the number of critical infrastructure gaps, more than 4,000 gaps remain that will cost between $52 billion and $63 billion to close, including $11 billion in activation costs.[1]

While SCIP clearly identifies the access, utilization, and safety gaps, and projects the cost to close these gaps, it fails to strategically plan how VA will close these gaps. Currently, SCIP rates the gaps and places them on an integrated priority list from the most to least critical. Then, each year, VA submits a budget request that does not consistently follow the priority list. For example, seismic corrections for Building 12 on the West Los Angeles VA campus were first funded in FY 2009 and were placed as number 3 on the integrated priority list as part of a larger consolidated construction project for the campus. No further funding was provided for this project until FY 2015. Projects in Long Beach, California, and Canandaigua, New York, both lower on the priority list, have received substantially more funding.

[1]VA, *FY 2017 Budget Submission Construction and 10 Year Capital Plan*, vol. 4 of 4, February 2016, 1–4, 9.3–8.

The IBVSOs understand that some projects move through the planning and contracting stages quicker than others, but to allow safety gaps to sit for years, like the one in West Los Angeles, with no clear strategy to correct them, not only impedes access for veterans but also potentially puts them in harm's way.

Without a comprehensive understanding of the health care resources that exist within and outside of VA, the department would have difficulty making sound decisions on capital investments and right-size its inventory of facilities for the near, mid, and long term. Funding to close infrastructure gaps continues to be insufficient. VA must begin requesting funding that will close all safety, condition, access, and utilization gaps and at the same time present five- and 10-year plans that will systematically describe when and how VA plans to close each gap. In developing these plans, VA must work from a budget proposal that is designed to maintain VA facilities for the buildings' expected life-cycle, as well as to eliminate existing gaps in safety, access, and utilization.

VA must submit a PRV for all VA-owned property and calculate its baseline and each facility's NRM funding request from that value. Adding the PRV to SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively decide when a facility becomes more costly to maintain than to replace. Using PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for the reduction in the NRM backlog and fully funding future needs in a way that would be the most cost-effective. The industry goal for NRM is around 2 percent of the PRV. At that rate, facilities can operate for 50 years or more without outspending the cost to replace the facility. Knowing what percentage of the PRV is being spent will allow Congress and VA to take a long-term view of capital planning and better assess when a facility will need to be replaced.

Even though NRM is funded through the VA Medical Facilities account and not through a construction account, the account is critical to the VA capital infrastructure and provides for more than 40 percent of the current infrastructure backlog. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are onetime repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Completing NRM is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

VA increasingly lags in closing current NRM safety, condition, utilization, and access gaps and continues to fall behind on preventing future gaps from occurring. Just to maintain what VA has in its infrastructure portfolio, the VA NRM account must be funded at $1.3 billion per year, based on IBVSOs' estimate of PRV. NRM is currently being funded at $462 million per year. Along with PRV-calculated funding baseline, additional funding needs to be invested to prevent the $22 billion NRM backlog from growing even larger.[2]

Because NRM accounts are organized under the Medical Facilities appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health care dollars to those areas with the greatest demand for health care. In our opinion, VERA is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating them to newer facilities where patient demand is greater, even if the maintenance needs are not as great. IBVSOs are encouraged by actions the House and Senate Committees on Veterans' Affairs have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.

To close all major and minor construction safety, condition, access, and utilization gaps, VA will need to invest approximately $23 billion. Nearly $5 billion is needed to rectify seismic deficiencies. Studies have identified 12 major construction seismic-correction projects, nine of which are partially funded. These projects cannot wait any longer. As VA develops its five- and 10-year plans, it must make closing these gaps a priority, with the goal to have seismic deficiencies rectified within five years.

[2]VA, *FY 2017 Budget Submission Construction and 10 Year Capital Plan*, vol. 4 of 4, February 2016, 9.3–8.

The remaining gaps are building specialty-care, spinal-cord-injury, mental health, and women's health clinics; additions to existing structures; cemetery expansions; and new, freestanding medical facilities. Based on the access and financial analysis, VA looks at four alternatives to determine the most effective way to close each gap. New construction would be the most cost-effective, and in many cases the only, method to close the remaining $18 billion gap in major and minor construction need. VA must begin requesting adequate funding and develop a long-term plan to close all major and minor construction gaps.

While VA works to close all identified gaps, VA must also develop a more comprehensive system of identifying and addressing future needs. Included in this plan must be a system-wide program for architectural master planning.

Over the life cycle of a medical facility, utilization and services often change because of shifting patient demographics and new technologies that change the way health care is delivered. VA must invest in medical-center architectural master planning so these changes can be better anticipated and funding can be made available as the need arises, not years later. Congress must fully fund a 10-year comprehensive facility master plans.

VA must do a better job of engaging local community partners to increase access and better utilize resources. Each facility master plan should have an analysis of services provided and services needed, and, when it makes sense, VA must leverage those partnerships to improve care and better allocate resources through expanded use of public-private partnerships.

The IBVSOs fully support the Government Accountability Office (GAO) recommendation in the January 2011 report to enhance transparency by requiring VA to submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects. The IBVSOs also support the inclusion of new gap-analysis criteria that consider resources that are available to the VHA through existing contracts and sharing agreements. We urge a more rigorous gap analysis that informs the priority list of projects in SCIP. The IBVSOs, in turn, will be monitoring the level of funding for each of the infrastructure accounts to ensure that all current gaps are closed within 10 years and that emerging and future gaps receive sufficient funding.

Quality, accessible health care continues to be the focus for the IBVSOs. To achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital asset plan is important, which VA has done, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization, and safety gaps will not fulfill VA requirements, nor will it serve veterans' best interests.

Improvements Needed in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) of Severely Injured Veterans

Recommendations:

Congress must pass legislation to correct the inequity in access to VA's PCAFC.

Congress must provide and VA must request sufficient funding of the caregiver program.

Congress must conduct oversight of VA's in-home and community-based services for supporting caregivers.

Congress must pass legislation to allow primary caregivers to earn income credits for caring for disabled veterans, to safeguard their own income security.

VA must fill key leadership vacancies within the VA Caregiver Support Program Office to improve the program's delivery and quality of support to caregivers.

VA must establish a complementary Caregiver Support Program operations office to monitor and ensure integrity, quality, and value of caregiver supports.

VA must issue a publicly available document to establish the department's authority, policy, requirements, and lines of responsibility for implementation and delivery of caregiver supports and services.

VA must provide a more integrated, robust, and flexible IT system to properly manage, evaluate, and improve all aspects of the Caregiver Support Program.

VA must better integrate supports and services to caregivers of veterans not eligible for the program.

To improve the program, VA must conduct periodic surveys to assess the caregiver population being served, its challenges, and its needs and whether existing programs are meeting those needs. The study must be designed to yield statistically representative data, the results of which should be provided to Congress.

Background and Justification:

Family caregivers supporting severely disabled veterans require real strength to tend to the needs of family and home, assist their veteran with everyday activities, take their veteran to appointments, or just be there in their time of need. Caregiving takes endurance, commitment, and patience.

There are many benefits to veterans residing at home in their community with proper support as opposed to institutionalization. Support from family caregivers plays a crucial role in helping to reduce health care costs and improves the veteran's psychosocial well-being. There is however, a cost that caregivers bear.

Studies also show sustaining caregivers work requires a multifaceted approach—including training, health care coverage, and support services—to reduce the burdens of caregiving and to bolster their ability to serve long term.

Title I of P.L. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010 (Caregivers Act), requires VA to create caregiver-support programs to serve three types of family caregivers:

- primary caregivers who are the main source of support for veterans severely injured on or after September 11, 2001
- secondary caregivers who generally serve as a backup to the primary caregiver
- general caregivers who are the main source of support for all other severely ill and injured veterans enrolled in the VA health care system

The law has a multifaceted approach of support from VA:

- general caregiver supports are those such as caregiver education and training, use of telehealth technologies, restricted counseling and mental health services, and respite care.
- secondary family caregivers supports includes all general caregiver supports, monitoring their veteran's quality of life, instruction and training specific to their veteran's needs, paid travel expenses while accompanying veterans to appointments, information and assistance to address the routine, emergency, and specialized caregiving needs, individual and group therapy, counseling, and peer support groups

Primary family caregivers support includes all general caregivers and secondary family caregiver supports, a monthly caregiver stipend, at least 30 days a year of respite care, and Civilian Health and Medical Program of the VA (CHAMPVA) health care coverage if they have none.

Most recent data indicates 22,850 primary caregivers were receiving needed supports and services through this program at the end of 2016. Also available is an evidence-based six-week online workshop designed to reduce caregiver stress and increase family caregiver well-being. VA's family caregiver web site (caregiver.va.gov) averages 1,400 hits a day. The Caregiver Support Line (1-855-260-3274) averages 200 calls a day.

The Law's Inequity for Caregivers and Veterans

Family caregivers of veterans suffering from a severe service-connected illness, such as amyotrophic lateral sclerosis (ALS), or multiple sclerosis, provide enormous amounts of care and support. However, they are excluded from primary caregiver supports no matter what era they served in.

While title I of P.L. 111-163 created a program to address the adverse impact of caregiving, the law turned a blind eye to those caring for ill veterans and veterans ill or injured before September 11, 2001. The IBVSOs recognize this law authorizes similar yet limited services and supports to general caregivers but failed to recognize the need to integrate these with existing supports and services such as those discussed below. VA must integrate existing caregiver supports for general caregivers to ensure broad access and seamless delivery.

Program Leadership and Operations

Despite some service enhancements to the Caregiver Support Program, reports in 2014 by GAO and VA Office of the Inspector General (OIG) describe specific weaknesses. Because VHA's Caregiver Support Program Office does not have the tools, resources, or support to properly manage, evaluate, and improve the program, caregivers of ill and injured veterans are being adversely affected.

Currently only one person acts as both the director and deputy director of the Caregiver Support Program. The program and the caregivers of severely injured veterans this individual serves are therefore not being effectively represented in higher organizational policy discussions. Moreover, the IBVSOs appreciate VHA leadership support toward hiring of a program analyst; however, unlike other clinical programs under VHA's current organizational structure, its Caregiver Support Program Office has no corresponding clinical operations office to work collaboratively with its policy office and support field operations.

In addition, the VHA directive needed to establish the authority, policy, requirements, and lines of responsibility for implementation and delivery of caregiver supports and services has yet to be issued. Program integrity and success may continue to be compromised without a public policy outlining uniform and consistent national procedures for providing caregiver supports and services. Such a directive should correspond with existing policy, such as VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics.

Having a program director, deputy director, and Caregiver Support Clinical Operations office would better facilitate developing and deploying a more robust and integrated IT system for the caregiver program a high priority to capture comprehensive workload data to support effective oversight and management. In September 2014, GAO recommended VA expedite short- and long-term solutions for an IT system that fully supports the program and enables program officials to comprehensively monitor the program.

Without reasonable support and reliable data, the IBVSOs are concerned about VA's ability to properly analyze and project the amount of resources needed to address the backlog of pending applications, while supporting the growing caregiver. The administration's FY 2015 budget request appeared reasonable. A, flat-lined FY 2016 advance appropriations request for the Caregiver Support Program is not.

Enhancements Needed in Caregiver Services and Supports

The IBVSOs have heard consistent criticism from primary caregivers on certain aspects of this program. Many primary caregivers comment on differences between this program and DOD's Special Compensation for Assistance with Activities of Daily Living (SCAADL) in terms of eligibility and caregiver training. For example, while both SCAADL and PCAFC provide monetary benefits, SCAADL provides monetary compensation to eligible service members, whereas VA provides a stipend to primary family caregivers. Moreover, SCAADL does not distinguish between illness and injury when determining eligibility, compared to PCAFC, which limits eligibility to veterans and service members who incurred or aggravated a "serious injury."

The IBVSOs hear most from primary caregivers about the training and education component of the program as being more an orientation. While the education and training component is required by law, the content is wholly within VA's discretion, and VA should amend such education and training to account for the primary caregiver's experience and meet specific caregiving needs.

In addition, family caregivers applying for comprehensive supports under this program voiced frustration over the lack of transparency of the applications process and details about the program. Creating and implementing policy to better serve caregivers of severely injured veterans should depend on representative data that can be used to determine validity, reliability, and statistical significance. We note that in an earlier version of the Caregivers Act, Congress would have authorized VA and DOD to contract for a national survey of family caregivers of seriously disabled veterans and service members, with a report to Congress. The final bill failed to include this language. VA estimates the survey would cost approximately $2 million over a four-year period.

We applaud VA's initiative and efforts to evaluate the short-term impacts of the PCAFC on health and well-being of veterans and their primary family caregivers, as well as how caregivers use and value components of both the PCAFC and the Caregiver Support Services Program. The results from this comprehensive evaluation should help inform the VA about the value and benefits of caregiver supports and services and identify best practices for improving and better targeting its programs.

To date, the evaluation indicates increased use of health care services by veterans participating in PCAFC, but the cause of the increase has not yet been determined, nor is it known if this increase in health care use is improving health status, health outcomes, and quality of life for veterans. Equally important, the evaluation is suggesting caregivers in PCAFC are more confident and better prepared in their role and that the stipend is reducing the financial strain of caregiving; however, the caregiver sample size is small and limits the applicability of these preliminary findings. The IBVSOs urge VA continue this evaluation while addressing exiting limitations to better guide the current program and policy and to inform policymakers oversight of the program.

Future Income Security for Primary Caregivers

Caregivers of severely injured and ill veterans often withdraw from school and/or give up time from work and forgo pay in order to spend many hours per week supporting, attending, and advocating for their injured veteran.

Under PCAFC, predominantly spouses—but also some parents, relatives, and friends—receive a tax-free stipend based on the amount of hourly assistance the veteran requires. Over 6,000 of these caregivers are assigned to Tier 3 (the highest level, for providing a maximum of 40 hours of care per week) for their stipend payments.

This "living stipend," a term used by Congress, has been interpreted by VA to be "exempt from taxation under 38 U.S.C. 5301(a)(1)" based on the language contained in the law that states, "[N]othing in this section shall be construed to create . . . an employment relationship between the Secretary and an individual in receipt of assistance or support under this section."

Because of the relative youth of these seriously injured veterans, many primary caregivers are facing a long horizon of supporting their veteran. Due to stipend payments' tax-free nature, primary caregivers cannot claim them as income, and stipends are not considered wages or earnings creditable for the purposes of Social Security, which places the caregivers' future income security at risk.

Home and Community-Based Services for Supporting Caregivers

The Caregiver Support Program does not consider primary caregivers as working more than 40 hours a week, and it assumes that VA will provide 40 days of in-home respite care and other in-home and community-based services. The reality is many primary caregivers are in their formal caregiving role more than 40 hours, and access to in-home and community-based support services is limited at the discretion of local VA facilities.

VA OIG and GAO reports from early 2000 to as recently as late 2013 document the same issue time and again: that some VA medical facilities employed local restrictions to limit access to these services. In September 2013, OIG reported some VA medical facilities depressed waiting time data and used various methods and strategies to restrict access to homemaker/home aides, respite, and skilled care services—in-home services often employed to support family caregivers.

Veteran-Directed Home and Community-Based Services

Many veterans are finding themselves requiring more assistance to continue living at home in their community. To help them, VA, in partnership with the Administration on Aging (now the US Administration on Community Living [ACL]), established the Veteran Directed-Home and Community Based Services (VD-HCBS) program in 2008.

Veterans participating in this program are authorized a monthly flexible-spending budget to buy goods and services based on a needs assessment, to allow a severely disabled veteran to live safely at home. That is, veterans participating in this program are able to hire family and friends to provide for their personal care needs—or to provide support to their family caregivers.

Through local partnerships between VA facilities and Aging and Disability Network officials, the VD-HCBS program has served over 3,600 veterans across 34 states, the District of Columbia, and Puerto Rico. At the same time, 61 VAMCs have partnered with Aging and Disability Network agencies, including State Units on Aging, Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living, to offer the program.

VD-HCBS provides another option to veterans who would otherwise need to be placed in a nursing home due to, among other things, the burden placed on their caregiver.

Ensure that VA Provides High-Quality, Effective Programs and Services to Meet the Unique Needs of Women Veterans

Recommendations:

VA and DOD should aggressively pursue cultural and organizational changes to ensure that women are respected.

The federal government must collect, analyze, and publish data by gender and minority status for every program that serves veterans, to improve understanding, monitoring, and oversight of programs that serve women veterans.

DOD and VA should work together to establish peer support networks for women veterans. VA should establish child-care services as a permanent program to support better access to health care, vocational rehabilitation, education, and employment services.
VA should continue its local community partnerships and outreach established for other programs, such as those for homeless veterans, to establish support networks for women veterans in accessing health care, em¬ployment, financial counseling, and housing.

VA needs to ensure timely access to gender-specific health care for women veterans by requiring every VAMC to hire or contract with a part-time or full-time gynecologist.

VA and DOD must remove existing barriers and improve access to mental health programs for women and explore innovative programs for providing gender-specific mental health programs. An interagen¬cy work group should be tasked to review options, develop a plan, fund pilots, and track outcomes. VA and DOD should consider collaboration on joint group therapy, peer-support networks, and inpatient programs for women who served after 9/11.

DOD must allocate the resources needed to fully implement its Sexual Assault Prevention and Response Office's strategic plan. It should conduct program evaluations and prospective scientific studies to monitor the success of its plan to prevent military sexual trauma (MST), change the military culture, and assess program progress and outcomes.

TAP partners should conduct an assessment to determine needs of women veterans and incorporate specific breakout sessions during the employment workshops or add a specific track for women in the three-day sessions to address those needs.

DOD should transfer contact information and data on all TAP participants to VA and the Department of Labor (DOL), which should be responsible for providing gender-specific follow-up with all service members six to 12 months after separation to offer additional support and services.

Data on participation, satisfaction, effectiveness, and outcomes for TAP must be collected and analyzed by gender, ethnicity, and race and returned in real time to commanders for assessments and corrective actions. To judge the success of TAP, employment outcomes and educational attainment should be tracked and reported on a rolling basis, analyzed by gender, ethnicity, and race, for all separated service members.

To assist women veterans with job placement and retention, DOL and VA should develop structured pilot programs that target unemployed women veterans, modeled on the promising practices from DOL Career One Stop service centers.

Congress should reauthorize and fully fund the Supportive Services for Veteran Families (SSVF) program to promote positive transitions for women veterans during the anticipated downsizing of the armed forces.
VA and the Department of Housing and Urban Development (HUD) should invest in additional safe transitional and supportive beds designated for women veterans, especially those with children.

VA should work with community partners to provide housing programs to accommodate women veterans with dependent family members.

VBA should continue to track, analyze, and report all its rating decisions separated by gender to ensure accurate, timely, and equitable decisions on claims filed by women.

VA and DOD should develop a pilot program for structured women's transition-support groups to address issues with marriage, deployment, changing roles, child care, and life as a dual military family. VA should evaluate the effectiveness of transition-support groups and determine whether these efforts help achieve more successful outcomes for women.

Congress should make permanent the authority for the VA Readjustment Counseling Service's women veterans retreat program. VA researchers should study the program to determine its key success factors and whether it can be replicated in other settings.

VA should address the needs of women veterans in education by piloting programs such as education and career counseling, virtual peer support for women students, and child-care services. VA should establish comprehensive guidelines that schools can use to assess and improve their services and programs for student veterans.

Background and Justification:

Women continue to be a rapidly increasing and important component of the US military service branches. Today women constitute approximately 20 percent of new recruits, 15 percent of the 1.3 million active-duty component, and 20 percent of the 1.1 million reservists. DOD's 2014 Demographics Report indicates a continuous increase not only in the number of women serving, but also the number of women officers. Of the 300,000 women veterans who served in Afghanistan and Iraq, 166 have made the ultimate sacrifice, and over a thousand have been wounded in action.

In January 2016, the secretary of defense removed the ban on women serving in combat, making all roles in each branch of the US military open to women. As women begin to serve in the newly acquired combat positions, a new set of challenges will arise as a result of battlefield injuries. In addition, as these servicewomen transition from the military, VA will also be faced with a unique set of challenges, to include the need for increased specialized care and care for a larger population of women in their childbearing years. According to VA, the number of women veteran patients under 35 years old has increased by 120 percent between FY 2003 and FY 2013. The impact of wartime deployments for women will also continue to contribute to a number of new transitional and reintegration challenges for women in the years to come, requiring VA and other federal agencies to ensure they evaluate and adjust programs and services to meet the unique needs of women veterans, instead of solely focusing on the traditional programs and services that were tailored to the needs of male veterans.

Deployment to theaters of combat pose a unique challenge for servicewomen and their health care providers. It is important for clinicians treating women to understand the reproductive risks associated with military service, especially when deployed to a theater of combat or other deployments where proper handwashing is inaccessible. The inability to properly perform daily hygiene increases the difficulty of managing menstruation, therefore increasing the likelihood of urinary tract infections or other gender-specific conditions. Deployment to combat theaters can also disrupt basic preventive care and ongoing treatment for conditions such as endometriosis. According to a committee opinion issued by the American College of Obstetricians and Gynecologists, women who are deployed to theaters of combat may have higher rates of abnormal Pap smears. All military service branches have the responsibility to ensure these unique challenges for women are addressed and that they are responding to the care needs of women service members during deployment.

As servicemen and -women transition from military service, they attend the Transition Assistance Program (TAP), which is designed to inform them of the many benefits and services available to them as veterans once they are discharged from the military. TAP is conducted during the final days of active-duty service and is designed to assist service members as they prepare to separate from the military, with the goal of helping them transition successfully back into the community as civilians. TAP courses are designed to assist former service members to reenter the job market able to compete for positions for which they are qualified. Unfortunately,

individuals seek out and absorb information when they perceive they need it, not necessarily when it is made available. Some service members may be more receptive to this information six to 12 months after discharge, while they are more actively engaged in seeking help and assistance.

Additionally, there have been no comprehensive studies completed to evaluate the effectiveness of TAP for women. TAP partners should assess the unique needs of women veterans when developing course curriculum to ensure their issues are addressed. Like their male counterparts, women transitioning from the military seek to establish satisfying, gainful employment. Many women are able to transition successfully; however, according to DOL, higher rates of unemployment are present among post-9/11 veterans. For women veterans, this trend was even more pronounced. According to a March 2014 GAO report (No. 14-144), with the drawdown from the wars in Iraq and Afghanistan and planned force structure reductions, many service members are projected to leave the military through 2017. It is important that federal employment programs be prepared to equally and efficiently provide guidance and assistance to transitioning women veterans.

Employment and housing are also essential components to the overall well-being of women veterans. According to VA, women veterans' homelessness rates have increased. Compounding this issue, within this population you also find increased rates of MST, and more servicewomen are likely to be single parents. According to the National Center on Homelessness among Veterans, 8.5 percent of all female veterans using homeless programs served in Operations Enduring and Iraqi Freedom (OEF/OIF), of which 82 percent were age 39 or younger. Given these factors, it is imperative that resources are provided to adequately take care of this relatively small population and that it is not overlooked.

Following military service, as women reintegrate into society, they are faced with overcoming many different challenges, including difficulty accessing services that are specific to their unique needs and feeling invisible. This gap helps to feed a feeling of not belonging or lack of identifying. There is a perception within VA that when a woman veteran comes to VA, she is not there to receive services but on behalf of a male family member. Likewise, women also feel as though society does not view their service as valuable or as important as that of men and often end up fighting just to be recognized as veterans. According to the May 2015 report from the Advisory Committee on Women Veterans, many women themselves still do not identify as veterans. For these reasons, VA has launched several campaigns such as "I'm One," yet this problem is slow to be resolved and requires continuous effort from all who work within VA. It is necessary for VA to continue to educate employees at all levels on the importance or recognizing the contributions from women veterans and their honorable service as equal to the service of their male counterparts. VA should also continue its culture change campaigns to ensure women are treated with the same dignity and respect as that of men.

As women transition from the military and attempt to access services and benefits as veterans, they often encounter several barriers. The 2015 VA report Barriers for Women Veterans to VA Health Care discussed nine barriers: comprehension of eligibility requirement and scope of services, effect of outreach specifically addressing women's health services, effect of driving distance on access to care, location and hours, child care, acceptability of integrated care, gender sensitivity (VA users only), mental health stigma, and safety and comfort (VA users only). Women veterans continuously indicate child care as barrier to obtaining services from VA. Forty-two percent of women surveyed indicate it is difficult to find child care so they can seek VA health care services and would find on-site child care to be useful. The IBVSOs urge Congress to make this program permanent to enhance access for women veterans who wish to receive their care through VA.

Where Do Gaps Exist

Health Care Services

According to VA researchers, unlike their male counterparts, who are able to achieve a basic level of care in one visit, women veterans are more likely to receive the same basic level of care from an assortment of VA and non-VA providers in multiple visits. The VA has taken steps to transform the care for all veterans with the implementation of Patient Aligned Care Teams (PACTs). A PACT is a partnership between the veteran and his or her health care team that has the goal of treating the whole person, with emphasis on prevention and

promotion through coordinated care whereby each member of the team has a clearly defined role, with the veteran at the center. The team members include family members and caregivers, primary care provider, nurse, clinical associate, and administrative clerk. When additional services are required, another team may be added for support, such as mental health care providers, other specialists, and other non-VA health care professionals. All the members work with the veteran and together to ensure the whole person is taken care of. However, researchers note that it is not fully understood how the PACT model will meet the needs of women veterans and other special populations or how to include specific accommodations for gender-specific care and improve gender sensitivity. The IBVSOs recommend that VA find ways to ensure the PACTs are adapted to meet the needs of women veterans.

According to VA, women's mental health has seen a 154 percent increase in the number of women veterans accessing VHA mental health services since 2005, and in FY 2015, 182,107 women veterans received care. VA offers many mental health programs specifically tailored for women veterans; however, many women are unaware of these programs and services. Ensuring women are aware of the services provided by VHA has continued to be a challenge. To better represent women and ensure women have a place to turn to for assistance, VA has employed Women Veterans Program Managers (WVPMs) at every VAMC. WVPMs are able to assist women veterans in navigating the VA health care system, informing them about specialized services, state and federal benefits, and resources where they reside.

The impact of wartime service affects male and female service members differently, but both servicemen and -women may develop posttraumatic stress disorder (PTSD). Research has found that men are more likely to display anger and divert to substance abuse, whereas women are more likely to develop depression. Due to these differences in responses, it is necessary for the unique needs of women to be acknowledged to ensure proper treatment and services are provided. VA is the largest integrated mental health system in the United States that provides specialized treatment for PTSD, while also offering a comprehensive array of mental health and specialized post-deployment mental health services. These services include the Mental Health Residential Rehabilitation Treatment Program. The MH RRTP addresses the goals of rehabilitation, recovery, health maintenance, quality of life, and community integration. VA also offers inpatient mental health programs, programs for substance-use disorder (SUD), and suicide prevention.

Although VA has excellent evidence-based mental health treatment programs, there is still a need for increased access to gender-specific group counseling, residential treatment, and specialty inpatient programs to serve women. According to VA researchers, mental health providers need to be aware of physiological and hormonal changes that occur during a woman's life span and the possible impact of those changes on mental health. This is especially important since 40 percent of women veterans seen in VHA are in their childbearing years (ages 18–44) and over 25 percent are aged consistent with pre-menopause (ages 45–55). The IBVSOs recommend that VA continue its research on women veterans and mini-residency training programs to ensure VA providers have expertise in women's health. DOD and VA should also work cohesively on new approaches for transition from DOD to VA care for veterans with mental health issues

Education

The Post-9/11 Veterans Educational Assistance Act of 2008 (known as the Post-9/11 GI Bill) represents the largest expansion of educational support to military and veterans in our post–World War II experience, and this congressional authority provides excellent educational benefits. However, there is a paucity of information available on the education subsidies and support received by women veterans and on the outcomes of the use of the Post-9/11 GI Bill benefits and services by women. We do know that women veterans are more likely than nonveterans of either gender to have a college degree. According to statistics from DOL, 42 percent of females who served our country are college graduates, just as they are more likely to be enrolled in school.

A survey conducted by Student Veterans of America shows that 46 percent of veterans using their education benefits have children and 14 percent are single parents. Many times, the mother in single-parent situations has sole custody of the child/children. Where institutions of higher education close or lose their accreditation,

veterans may lose the housing allowance they receive while attending school. This may cause special hardship for single parents responsible for supporting their families while pursuing academic or vocational degrees or certificates. VA must take steps to ensure this does not happen to any veteran, let alone single parents.

VA must gather data on the needs of women veterans currently using the Post-9/11 GI Bill to ensure their successful completion of academic goals. As research shows, individuals with degrees as well as those currently enrolled in higher education have lower rates of unemployment.

Employment

The need for assistance will become even more pressing if DOD executes its downsizing plans. Those who expected a full military career may be suddenly thrust, with little warning, into ill-prepared civilian communities and job markets as new veterans. DOL has provided women veterans with many customized programs, communications, and supports. Despite these efforts, the unemployment and underemployment rates for women veterans are not only higher than those of their male veteran counterparts, but they are also higher than for nonveteran women. Yet women veterans have higher rates of degrees from institutions of higher education.

Women veterans who successfully transition not only help the economy, but are also personally successful in doing so. Data from VA reflects that the gender wage gap is significantly closer to nonexistent between female and male veterans. Women veterans use less public assistance programs such as the Supplemental Nutrition Assistance Program, are significantly less likely to live in poverty, and are almost three times more likely to have health insurance.

Women veterans can serve as a successful example for women in the civilian professional job market. Downsizing the military is likely to exacerbate this problem. Additional efforts from Congress are needed to reverse these trends and assist women veterans in successfully joining the civilian workforce.

The IBVSOs recognize all of the work being done by VA to enhance the care provided to women veterans; however, more should be done to ensure the needs of women veterans are met at the same level of their male counterparts. The growing portion of women in the veterans' population compels VA and other federal partners to prepare for increased demand for treatment, benefits, and services.