

THE INDEPENDENT BUDGET

Veterans Agenda for the 116th Congress

Policy Recommendations for Congress and the Administration



The MISSION Ahead



The Independent Budget for the 116th Congress

Prologue

After nearly two decades of war, the commitment of a grateful nation to its veterans who have borne the battle and their families remains strong. The 115th Congress resulted in the passage of several major pieces of legislation that have expanded benefits and will result in the creation of new programs and reform existing ones in an effort to improve the lives of veterans. It is through this lens that *The Independent Budget* veterans service organizations (IBVSOs)—Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—have worked to develop and present concrete recommendations to ensure that the Department of Veterans Affairs (VA) remains fully-funded and capable of carrying out its mission to serve veterans and their families both now and in the future.

In light of the calls of some to further privatize VA health care and concerns about rising budget deficits, we remain ever vigilant to ensure that veterans and their families receive the benefits and health care services that they have earned and deserve. The IBVSOs hold dear the longstanding responsibility of highlighting for the Administration, Congress, VA, and the American people, the unique benefits, specialized health care, infrastructure, education, employment, training, and memorial concerns and challenges being faced by our members, their families, and all veterans. Our decades of experience set the IBVSOs apart in the veterans' community. Through *The Independent Budget*, we harness that experience and present real solutions to the concerns facing all of today's veterans.

The Independent Budget Authors

The three co-authoring organizations have worked in collaboration for more than 30 years to produce *The Independent Budget* to honor veterans and their service to our country. Throughout the year, each organization works independently to identify and address legislative and policy issues that affect the organizations' members and the broader veterans' community.

DAV (Disabled American Veterans)

DAV empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: fulfilling our promises to the men and women who served. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; linking veterans and their families to employment resources; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with more than one million members, was founded in 1920 and chartered by the U. S. Congress in 1932. Learn more at www.dav.org.

Paralyzed Veterans of America (PVA)

Paralyzed Veterans of America (PVA), founded in 1946, is the only congressionally chartered veterans service organization dedicated solely for the benefit and representation of veterans with spinal cord injury or disease. For more than 70 years, the organization has ensured that veterans receive the benefits earned through their service to our nation; monitored their care in VA spinal cord injury centers; and funded research and education in the search for a cure and improved care for individuals with paralysis.

As a life-long partner and advocate for veterans and all people with disabilities, PVA also develops training and career services, works to ensure accessibility in public buildings and spaces, and provides health and rehabilitation opportunities through sports and recreation. With more than 70 offices and 33 chapters, PVA serves veterans, their families, and their caregivers in all 50 states, the District of Columbia, and Puerto Rico. Learn more at www.pva.org.

Veterans of Foreign Wars of The United States (VFW)

The Veterans of Foreign Wars of the U.S. (VFW) is the nation's largest and oldest major war veterans' organization. Founded in 1899, the congressionally-chartered VFW is comprised entirely of eligible veterans and military service members from the active, Guard and Reserve forces. With more than 1.6 million VFW and Auxiliary members located in 6,200 Posts worldwide, the nonprofit veterans' service organization is proud to proclaim "NO ONE DOES MORE FOR VETERANS" than the VFW, which is dedicated to veterans' service, legislative advocacy, and military and community service programs. For more information or to join, visit our website at www.vfw.org.

Individually, each of the co-authoring organizations serves the veterans community in a distinct way. However, the three organizations work in partnership to present this annual budget request to Congress with policy recommendations regarding veterans' benefits and health care, as well as funding forecasts for the Department of Veterans Affairs.

Supporters

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Air Force Association
American Coalition for Filipino Veterans, Inc.
American Military Society
American Psychological Association
American Society of Nephrology
American Veterans for Equal Rights
Association of the United States Navy
Blinded Veterans Association
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National Association of State Head Injury Administrators
National Coalition for Homeless Veterans
National Disability Rights Network
National Gulf War Research Center, Inc.
Navy Seabee Veterans of America
Nurses Organization of Veterans Affairs
Vietnam Veterans of America
VetsFirst

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Introduction

Introduction

President Trump signed the VA MISSION Act (Public Law 115-182) on June 6, 2018, in a White House ceremony. One of the most comprehensive and consequential pieces of veterans' legislation ever passed by Congress, this historic law contains a number of policy priorities that *The Independent Budget* veterans service organizations (IBVSOs) had been advocating for years. Most notably, the VA MISSION Act reforms the Department of Veterans Affairs (VA) health care system and expands the VA's Caregiver Support program. Though enactment of the VA MISSION Act was the culmination of more than four years of debate over the future of the VA health care system, it also marks the beginning of a far more complex and critical phase: implementation.

If VA and Congress implement this law fully, faithfully, and effectively, veterans' health care will enter a new era marked by expanded, timely access to high quality care for all enrolled veterans. However, if implementation deviates from the clear and widespread consensus reached by all key stakeholders, the VA health care system could enter a period of decline with devastating consequences for veterans who rely on VA for their care, and perhaps even threaten the viability of the VA health care system itself. Given the stakes involved in getting this right, the IBVSOs have determined that for the 116th Congress the full and faithful implementation of the VA MISSION Act rises above every other policy priority for the next two years. As such, we have chosen to deviate from our longstanding practice of enumerating multiple critical issues for the year ahead, and instead we are designating a single Critical Issue for the 116th Congress: Fully and Faithfully Implementing the VA MISSION Act.

This does not mean that other longstanding policy priorities should not be concurrently pursued: VA and Congress can and must continue to address myriad challenges at the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). VA must continue to fully and faithfully implement a number of new landmark laws approved by the 115th Congress, including the Veterans Appeals Improvement and Modernization Act (Public Law 115-55), The Harry W. Colmery Veterans Educational Assistance Act (Public Law 115-247), commonly known as the "Forever GI Bill", and the Veterans Affairs Accountability and Whistleblower Protection Act (Public Law 115-41).

Critical Issue

One Critical Issue for the 116th Congress – Fully and Faithfully Implement the VA MISSION Act

Introduction

This VA MISSION Act is an historic law that contains a number of policy priorities that *The Independent Budget* veterans service organizations (IBVSOs) had been advocating for years. Most notably, the law reforms the Department of Veterans Affairs' (VA) health care services and provides an expansion of VA's Caregiver Support program.

Though enactment of the VA MISSION Act was the culmination of more than four years of debate over the future of the VA health care system, it also marks the beginning of a far more complex and critical phase: implementation. The VA MISSION Act was the result of a long and deliberative process that led to a broadly-supported, bipartisan consensus for expanding access to and improving the quality of care provided to veterans. Although there were and continue to be some who would prefer more far-reaching changes to VA, such as incremental outsourcing of services leading to wholesale privatization, the law is a carefully balanced compromise that must be faithfully implemented as intended. These reforms will require Congress and veteran stakeholders to aggressively oversee VA's implementation of the law and

continually advocate for sufficient funding.

If VA and Congress implement this law fully, faithfully, and effectively, veterans' health care will enter a new era marked by expanded, timely access to high quality care for all enrolled veterans. However, if implementation deviates from the clear and widespread consensus reached by all key stakeholders, the VA health care system could enter a period of decline with devastating consequences for veterans who rely on VA for their care, and perhaps even threaten the viability of the VA health care system itself.

Given the stakes involved in getting implementation of the law right, the IBVSOs have determined that for the 116th Congress funding and implementation of the VA MISSION Act rises above every other policy priority for the next two years. As such, we have chosen to deviate from our longstanding practice of enumerating multiple critical issues for the year ahead, and instead we are designating One Critical Issue for the 116th Congress: Fully and Faithfully Implementing the VA MISSION Act.

Background

The origins of the VA MISSION Act can be traced back to the 113th Congress (2013-2014), when it became clear that too many veterans were waiting too long to receive care at VA facilities. Some veterans were kept on hidden VA waiting lists. Some veterans may have died due to preventable errors at VA facilities. To address these problems, on August 7, 2014, President Obama signed Public Law 113-146, the Veterans Access, Choice, and

Accountability Act (VACAA) – commonly called the “Choice Act” – which provided veterans with a new way to access community care when VA care could not be scheduled within 30 days or if a veteran would be forced to travel more than 40 miles to a VA facility to receive needed care. However, the short and unrealistic implementation timeframe (90 days) hindered the program from the outset, creating almost as many new problems for its

veteran patients and VA as it resolved.

The Veterans Choice Program was fully phased in during the 114th Congress (2015-2016). Persistent problems with the program led to enactment of Public Law 114–41 on July 31, 2015, which adjusted time and distance access standards, lengthened Choice authorizations for an episode of care to one year, authorized VA to transfer funding from Choice to other VA community care programs, and required VA to develop a plan to consolidate all non-VA care programs, including Choice, into a single new program. In September 2015, the Independent Assessment required by the Choice Act concluded that VA’s access problems were primarily caused by inadequate funding to meet rising demand for health care, echoing what the IBVSOs had been saying for years. On October 30, 2015, VA issued its new plan calling for restructuring and integrating VA and non-VA health care programs into high-performing networks that would seamlessly combine the capabilities of the VA health care system with both public and private health care providers in the community. The IBVSOs welcomed the VA plan, which was very similar to the *IB Framework for VA Health Care Reform*, which was also released in the fall of 2015.

In June 2016, the congressionally-created Commission on Care released its final report and recommendations, calling for establishment of “high-performing, integrated community-based health care networks.” Similar to the VA and *IB* plans, the Commission’s preferred option maintained VA as the coordinator and primary provider of care to address cost and

quality of care concerns, and viewed the use of community providers and the Choice program as a limited means to expand access when VA was unable to meet local demand for care. The Commission overwhelmingly rejected more radical alternatives, such as one known as the “Strawman Proposal,” which advocated privatizing veterans’ health care and completely eliminating all VA health care treatment facilities over the next 20 years. Ultimately, the Commission reached an overwhelming consensus to strengthen and reform the VA health care system.

As the 114th Congress drew to a close in late 2016, the IBVSOs, most other veterans leaders, VA, the Commission on Care, and bipartisan leaders in Congress were all coalescing around a common approach to fixing the access problem and ending long wait times, while maintaining a high-quality, comprehensive, and veteran-focused health care system. All arrived at the same basic 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.

For much of the 115th Congress (2017-2018), the House and Senate Veterans’ Affairs Committees developed and debated separate legislation to replace the Choice program. Ultimately, a broad, bipartisan consensus emerged, and with support from the IBVSOs and other veterans’ leaders, a compromise agreement was reached and the VA MISSION Act was signed into law by President Trump on June 6, 2018.

Overview of the VA MISSION Act – Public Law 115-182

The VA MISSION Act makes significant changes in four areas:

- Consolidation and creation of a new community care program;
- VA health care capacity and program enhancements;
- VA asset and infrastructure review; and
- Caregiver support program expansion.

New Veterans Community Care Program (VCCP)

The law consolidates seven existing community care programs, including the current Veterans Choice Program, into a single Veterans Community Care Program (VCCP), using local integrated networks of community providers, particularly the Department of Defense (DOD) and academic affiliates. By June 6, 2019, VA must complete market area assessments, develop strategic plans to provide care to enrolled veterans in each market, and promulgate all regulations necessary to operate the VCCP. VA will remain the primary provider of care and be responsible for coordinating care, including scheduling.

The law requires VA to develop new access standards by regulation to replace current 30-day, 40-mile

standards, as well as new quality standards, by March 6, 2019. Service lines in VA facilities that fail to meet quality standards will undergo remediation, though VA may not designate more than three lines in a single facility, or 36 total across VA. Enrolled veterans will be eligible to choose non-VA care providers within integrated networks if they are seeking a medical service that VA does not provide; if VA cannot meet its access standards; if the service line at the VA facility is in remediation for failure to meet quality standards; or if the veteran and their clinician agree that it is in the “best medical interest” of the veteran. The law also authorizes veterans to access “walk-in care” a limited number of times each year at clinics that VA has contracted with.

VA Health Care Capacity and Program Enhancements

The law appropriated \$5.2 billion to continue the current Choice program, intended to last until the VCCP is up and running in July 2019. Additionally, the law strengthened, expanded, and created a number of programs to improve VA’s

ability to recruit, hire, and retain high-quality medical personnel. It also expands VA’s ability to provide telehealth programs across state lines and strengthens health programs targeted at rural and underserved areas of the country.

Asset and Infrastructure Review (AIR Act)

The law creates a multi-year process to review VA's health care infrastructure and develop a long-term plan to realign and modernize it. The plan must be reviewed and approved by VA, an independent Commission, the president, and

Congress. The Commission will consist of nine members chosen by the president, including three specifically representing major veterans service organizations (VSOs).

Caregiver Support Program Expansion

The law expands VA's Caregiver Support program to eligible veterans severely injured prior to September 11, 2001. VA must first ensure that it's administrative and IT capacity to manage an expanded caregiver program is ready, followed by

a two-phase expansion: beginning as early as 2019 for WWII to Vietnam War era veterans, followed two years later for post-Vietnam War era to pre-9/11 veterans.

Veterans Community Care Program (VCCP)

Building and Operating Integrated Veterans Health Care Networks

Even before the VA MISSION Act became law, VA began developing a Request for Proposal (RFP) for provider networks that could be used with the existing Choice program and/or with its successor, now identified as VCCP. Additionally, VA had already begun to perform some market area assessments of capacity. In order to create the integrated networks of VA and community providers, VA must complete all market area

assessments; finalize the strategic plans to meet increased veteran demand in each market; establish contracts and agreements with required community providers; and prepare VA, community providers, and veterans to operate and engage with the integrated networks. To comply with the VA MISSION Act's deadlines, all of this work must be completed no later than August 7, 2019.

Recommendations

- VA's process for developing market area assessments and strategic plans must be fully open and transparent, actively engage VSO stakeholders, and maintain robust VA capacity and expertise wherever feasible.

Recommendations continues

The VCCP will be judged on how well the integrated networks meet the needs and preferences of veterans. To win veterans' approval, it is essential that veterans, their representatives, and leaders are fully engaged from the outset, as VA is developing market area assessments and strategic plans. Unless veterans and other stakeholders have confidence in this process, it is unlikely to be successful in the long run. Therefore, VA must develop their assessments and plans in a fully open, transparent process with opportunities for meaningful participation from veterans at key decision points. Finally, as VA makes critical decisions about how best to deliver medical care to veterans in each market, there must be a fundamental understanding that VA is more likely to produce better health care outcomes for veterans than community providers, even those selected for integrated networks. For this reason, preference must be given to maintaining a full continuum of care within VA health care facilities, whenever and wherever feasible.

- **Foundational services should include the widest array of services practicable in each market area, and VA must only grant exceptions in locations or facilities where there will be a clear benefit to veterans' health care outcomes.**

While there may sometimes be unique circumstances or justifiable exceptions, VA must seek to maintain all foundational services in all locations to assure its long-term viability to provide care for veterans. This requires a robust VA health care system. Cost should never be the sole determinant for dropping a foundational service in a market area unless there is a very high degree of certainty that the foundational service can be provided with at least the same level of quality and veteran-centric expertise that VA is capable of providing.

- **Competency standards for non-VA community providers should be equivalent to standards expected of VA providers, and non-VA providers must meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture.**

The success of VA's new Community Care program should be judged on how it improves health outcomes for veterans, not how many veterans use non-VA providers or how many "choices" veterans are provided. Non-VA providers who wish to be part of the integrated networks must demonstrate a high level of expertise in veteran and military medicine, significant cultural competency about the veteran and military experience, and a commitment to improving and maintaining their skills and expertise.

Recommendations continues

Recommendations continued

- **VA should use its authority to create a tiered provider network when building integrated networks, with VA providers in the first tier, and DOD, other federal partners, and academic affiliates occupying the second tier when VA is not feasibly accessible.**

The VA MISSION Act authorizes, but does not mandate, that VA develop a tiered provider network. However, VA should have a strong preference for providers with a demonstrated history of providing high quality care to veterans and military members, which includes DOD, Indian Health Services (IHS), and academic affiliates that regularly treat veterans and with whom VA already has ongoing partnerships. Additional tiers of providers may be necessary for locations and situations where there are an insufficient number of VA, DOD, IHS, or academic affiliate providers available to meet specific veterans' needs. As the integrated networks are built and operated, VA should seek to educate and guide veterans to those providers who work closely with the VA and whose care will most likely result in better health outcomes for veterans. Specifically, these providers would have the most experience, expertise, and cultural competency working with veterans - specifically DOD, IHS, and academic affiliates.

- **The VCCP training program for VA employees and contractors must ensure that VA maintains responsibility for tightly managing the networks and coordinating the care of veterans.**

The law requires VA to develop a training program for VA employees and contractors on operation of the new VCCP. The curriculum developed to accomplish this training must include clear instruction that VA retains the primary responsibility for managing the network to ensure the highest levels of quality, access, and cost-effectiveness. The training must also make clear that VA remains responsible for the seamless coordination of care, as well as scheduling and payments by veterans and to providers.

- **VA must have sufficient resources, personnel, and IT capacity to handle scheduling and develop effective self-scheduling options for veterans.**

Recommendations continues

Recommendations continued

In order to create an efficient and veteran-centric process for scheduling appointments within the integrated networks, VA must be provided sufficient resources to develop new scheduling systems, including self-scheduling options that veterans can easily access and utilize. To be successful, VA must be provided sufficient funding, personnel, and IT support to develop these new systems on time. As VA begins implementation of its new COTS software for electronic patient records, which should ultimately lead to better communications between VA and its provider networks on all aspects of patient care and management, every effort must be made to keep this vital project appropriately resourced and on schedule.

Providing Access to Timely, Quality Care for All Enrolled Veterans

Among the most crucial provisions of the VA MISSION Act are those involving new standards and practices which will act as triggers for veterans to make decisions about accessing community providers within the integrated community networks. Under the Choice program, access was primarily defined by arbitrary time and distance standards, generally 30 days or 40 miles. Under the new Veterans Community Care Program (VCCP), there will be new access and quality standards designated that will have greater detail and specificity to account for the variety of conditions and circumstances of the enrolled veterans population. The law requires VA to finalize these standards by March 7, 2019, so most of the decisions will have already been made by the time

this document is published. The law also requires that access and quality standards be regularly reviewed and adjusted to ensure veterans are not forced to wait too long or travel too far, or because a shift from VA-provided care to community care is financially unsustainable or threatens the viability of the VA system of one or some of its VA facilities.

The law also provides access to community care when a clinician and veteran patient determine it is in the “best medical interest” of the veteran, even if VA care is readily available. Veterans may also elect to access community providers in the network when a service line of a VA facility is under remediation. In addition, the law provides veterans limited access to “walk-in care.”

Recommendations

- **Access standards for timeliness, distance, and other factors that impact veterans' ability to receive care at VA facilities must balance the need to be objective and specific for different types of care with the need for standards that are simple, understandable, and usable by veterans, VA employees, and VCCP providers.**

It is important for VA to establish access standards that define objective criteria for when veterans have the option to use non-VA network providers. Unless these standards are realistically achievable and clinically appropriate, either veterans or the VA system will suffer negative consequences. VA must establish standards that are realistic in relation to VA's capacity, and comparable to measures of local private sector access. Given the critical role these standards will play in the new VCCP, both VA and Congress must be willing to revisit them regularly and as necessary.

- **VA quality standards must be applied equally to VA and non-VA providers to ensure the highest level of care practicable, carefully balancing the need to align VA quality standards with private sector standards, against the need to maintain veteran-specific standards that make VA the leader in veteran medicine.**

As with access standards, quality standards must balance the need to be simple and objective with the need to maintain the unique features of the VA health care system that effectively serve veterans, but are different than those in the private sector.

- **VA must develop clear and understandable criteria for determining when veterans and their referring clinicians agree that it is in the veterans "best medical interest" to use non-VA providers, and there must be a rapid and transparent appeal process for veterans when there is disagreement.**

As with access and quality standards, the criteria guiding "best medical interest" determinations must be a balance: in this case - between the need to be clear and objective with the need to address each veteran's individual health care circumstances. The guidelines for using "best medical interest" to access community providers when VA has sufficient capacity must be clinically based, but must also take into account how their implementation will affect VA's ability to manage and sustain a robust health care system to meet the needs of all enrolled veterans.

Recommendations continues

Recommendations continued

- **VA must develop a clear and consistent methodology for selecting service lines in VA facilities that are not meeting quality standards and will undergo remediation.**

While subpar quality is the principle determining factor, VA must also determine whether there is sufficient high-quality care locally in the private sector before offering veterans the option to utilize non-VA care.

- **VA must receive and properly allocate sufficient funding, personnel, and other resources to improve the quality of care in service lines of VA facilities under remediation.**

In order to improve quality and expand capacity to deliver care, VA must devote adequate resources and focus to resolve problems causing any decline in quality in service lines under remediation.

- **VA should implement the new “walk-in care” benefit without requiring copayments by service-connected veterans, and VA and Congress should develop a new plan to expand from “walk-in care” to a full “urgent care” benefit for enrolled veterans.**

While the IBVSOs support the “walk-in care” benefit, we view it as a first step towards developing and implementing a more comprehensive “urgent care” benefit for enrolled veterans, a benefit that is standard in most health care plans and has proven to be cost effective when coupled with a toll-free nurse triage line.

- **In close consultation with VSO stakeholders, VA must develop and implement an education program for veterans about the new VCCP, with tiered providers such as DOD, IHS, and academic affiliates, and with a focus on the demonstrated advantages of VA’s comprehensive, holistic health care program.**

In addition to making veterans aware of how the new VCCP operates and their options for care within the integrated networks, it is essential that veterans are provided evidence-based information about the relative advantages of VA’s holistic model of care and benefits in order to make informed decisions.

Sustaining and Improving the VA Health Care System

During and after the establishment of VA's new Veterans Community Care Program (VCCP), it will be essential that VA, Congress, and veteran stakeholders continue advocating for funding and policies that will sustain and improve veterans' health care services. The most critical factor will be ensuring VA has sufficient funding and resources to meet the full demand for care by enrolled veterans. As history has repeatedly proven, when demand rises faster than available resources, veterans end up waiting for necessary care, resulting in worse health

outcomes, lower quality of care, and a weaker VA health care system.

The law also authorizes the creation of a Center for Innovation for Care and Payment within VA, which is intended to test new care and payment models in order to reduce costs while maintaining or enhancing quality of care. Congress must specifically authorize any legal or regulatory waivers VA requires to move forward with pilot programs proposed through the Center.

Recommendations

- **VA must request, and Congress must provide, sufficient and timely funding to meet the full demand for care by enrolled veterans within VA facilities and through non-VA providers in the integrated networks, including full demand funding of advance appropriations for VA's medical care accounts.**

As both the Independent Assessment and the Commission on Care concluded, the primary reason for the access crisis that led to the Choice program was insufficient funding provided to VA to meet the rising demand for care by enrolled veterans. The Choice program has further proven that when access to care is improved, more veterans enroll in VA and overall utilization rises, both requiring additional resources. It is imperative that Congress fund the full demand for care that will be generated by increased access through integrated networks. Additionally, VA must request, and Congress must provide, sufficient advance appropriations for medical care to meet all projected demand, rather than appropriating a "base" level of funding for the second year, and then providing the balance the following year, an approach often referred to as a "second bite of the apple" approach.

Recommendations continues

- **Congress should make adjustments to existing and future budget caps, and consider changes to budget and appropriations statutes, to accommodate increased funding needs of VA due to the increased demand for, and higher utilization of, health care resulting from the new VCCP.**

As Congress and the Administration continue to negotiate and adhere to overall budget caps for domestic discretionary spending, demand for VA health care services is expected to rise significantly and often unpredictably - particularly in the first few years as the new VCCP and integrated networks are being optimized. In order to help ensure that VA is provided sufficient medical care funding, without cutting any other essential veterans benefits or services, Congress should temporarily or permanently exempt VA from budget caps, sequestration, and other budget cutting strategies.

- **VA must not use the new Innovation Center to propose pilot programs based on proposals that were previously rejected by the Commission on Care, VA, or Congress, or that contradict the underlying consensus upon which the VA MISSION Act was approved.**

Innovation has been critical to VA's success as a health care system, and the Innovation Center has the potential to help VA as they undergo a generational transition to a new model of integrated and seamless networks of care. However, the Innovation Center must not become a backdoor for ideas and proposals that have already been rejected during the development and approval of the VA MISSION Act, such as proposals to change the governance of VA health care or make VA primarily an insurer rather than a provider of care.

Veterans Community Care Program (VCCP) - Key Implementation Dates	
Date	Deadline or Milestone Explanation
March 6, 2019	VA Must Finalize Access and Quality Standards for Health Care
June 6, 2019	Promulgate All Regulations Necessary to Implement VA MISSION Act
June 6, 2019	Finalize Competency Standards for Non-VA Providers in Networks
June 6, 2019	Disqualify Non-VA Providers Who Fail to Meet VA Standards
June 6, 2019	Complete Strategic Plan to Meet Demand for Care within Market Areas
July 6, 2019	Effective Date for New Veterans Community Care Plan
March 6, 2020	Begin Designating Substandard Service Lines for Remediation
June 6, 2020	GAO to Issue Report on Disqualified Non-VA Providers
December 6, 2020	Report on Implementation and Compliance of Access Standards Due
March 6, 2021	Solicit Public Comment and Consider Changes to Quality Standards
March 6, 2022	Review and Update Access Standards for VA Health Care
June 1, 2023	New Strategic Plan to Meet Demand for Care Due
June 6, 2023	Updated Market Areas Assessments Due

Expanding VA's Capacity to Provide Care

With VA reporting over 45,000 vacancies in its August 31, 2018, report to Congress, it is imperative that VA be provided adequate resources and additional tools to make VA the preferred employer for medical professionals. The VA MISSION Act contains numerous provisions to strengthen, expand, and create new programs, including the VA Health Professional Scholarship Program, Education Debt Reduction Program, VA Specialty Education Loan Program, Veterans

Healing Veterans Medical Access and Scholarship Program, Recruitment, Relocation, and Retention Bonuses, and Pilot Program on Graduate Medical Education and Residency. Additionally, the law expands VA's authority to operate telehealth programs across state lines and requires VA to develop new health care programs specifically targeted to rural and underserved areas, both of which must remain priorities for VA.

Recommendation

- **VA must fully and faithfully implement the provisions of the VA MISSION Act that would enhance VA's ability to hire quality medical personnel, as well as provisions to expand VA care to rural and underserved areas.**

It remains imperative that VA continue to improve its hiring process and pay standards, and Congress continue to invest in expanding VA's internal capacity to provide care to enrolled veterans since it was lack of capacity that caused the access crisis in the first place.

Modernizing and Aligning VA's Infrastructure (AIR Act)

Subtitle A of Title II of the VA MISSION Act contains the provisions of the Asset and Infrastructure Act (AIR Act), H.R. 4243 in the House, which creates a new, one-time process to design, approve, and implement a comprehensive long-term plan to modernize and realign VA's health care infrastructure. The AIR process is timed to begin after VA develops and optimizes the integrated networks called for in Title I of the VA MISSION Act, so that VA and stakeholders can identify program service gaps and capital asset needs in the new local integrated networks.

Under the AIR process, VA will develop criteria to determine which VA facilities will be modernized, expanded, realigned, reduced, and/or potentially closed. The final guidelines must be published by May 2021. VA will then develop a list of recommendations for the future state of all VA facilities based on market assessments about the capacity of VA and non-VA providers to meet the demand by enrolled veterans for health care. VA's

recommendations then go to an independent nine-member Commission, three of whom will represent major VSOs. After undergoing a public review process in 2022, the Commission may approve, revise, or reject the facility recommendations. If approved by the Commission, the recommendations then go to the president in 2023 for review and potential approval. If approved by the president, the recommendations next go to Congress, which is required to hold a vote within 45 days on approving the full slate of recommendations. If a simple majority disapproves the resolution, the AIR process ends. If the recommendations are approved by Congress, VA must request sufficient funding to make the recommended changes and begin to implement the recommendations no later than March 2026. Importantly, the law requires that during the AIR process, VA must continue ongoing construction and leasing activities, as well as long-term infrastructure planning and budget requests to fulfill those plans.

Asset and Infrastructure Act (AIR Act) – Key Implementation Dates	
Date	Deadline or Milestone Explanation
February 1, 2021	VA Submits Draft Criteria for Infrastructure Recommendations
May 31, 2021	VA Publishes Final Criteria for Infrastructure Recommendations
May 31, 2021	President Nominates Nine Commissioners - Need Senate Confirmation
January 31, 2022	After Consultations, VA Reports Infrastructure Recommendations
Jan - Dec, 2022	Commission Reviews VA's Recommendations, Public Hearings
January 1, 2023	Commission Approves, Modifies, or Rejects Recommendations
February 15, 2023	President Approves or Disapproves the Commission's Report
March 1, 2023	If President Disapproves, Must Report Reasons to Commission and Congress
March 15, 2023	If President Disapproves, Commission Responds With or Without Changes
March 30, 2023	Final Deadline for President to Approve or Disapprove Commission Report
May 15, 2023	If President Approves, Congress Has 45 Days to Pass Disapproval Resolution
2024 to 2025	VA Develops Implementation Plans, Congress Must Approve Sufficient Funding
March 1, 2026	Latest Date VA Can Begin to Implement Approved Recommendations

Recommendations

- **Congress should amend Section 203(b)(3) of the VA MISSION Act to fully align the “Capacity and commercial market assessments” required for the VA Asset and Infrastructure Review (Title II, Subtitle A) with the “Market Area Assessments” required under Title I, Subtitle A –Developing an Integrated, High-Performing Network.**

During the 115th Congress, the AIR Act (H.R. 4243) was separate from VA community care reform legislation (H.R. 4242) in the House and only became part of the VA MISSION Act as a result of a late compromise between the House and Senate. As a result, there are two separate references to “market assessments” in the final VA MISSION Act. After consultation with VA and other key stakeholders, Congress should draft and enact legislation to align and harmonize the “market assessments” in the VA MISSION Act, and thereby eliminate any confusion. As part of this legislation, Congress should further emphasize the importance of performing market assessments in an open and transparent manner in collaboration with VSOs and other veteran stakeholders.

Recommendations continues

Recommendations continued

- **In consultation with VSO stakeholders and Congress, VA should develop and implement a communications plan over the next two years to increase awareness and understanding among veterans, the public, and the media about the purposes and processes involved in the asset review.**

Prior attempts by VA to realign its infrastructure have been significantly hampered and curtailed due to public and congressional opposition based on local and parochial concerns. The AIR process will be most effective if the process is open, transparent, and well understood by veterans who will be affected by changes. VA should partner with VSOs in the design and dissemination of communications materials to prepare veterans, the public, and the media for the AIR process that will begin in 2021.

- **Congress must continue to appropriate, and VA must continue to request and properly allocate, sufficient funding to maintain VA's existing health care infrastructure and expand capacity to deliver care in locations where demand for care justifies additional VA infrastructure.**

Although the AIR process does not formally begin until 2021, history has shown that once a review of VA assets is planned, Congress tends to scale back infrastructure funding until the process is complete. In the past, particularly during the Capital Asset Realignments for Enhanced Services (CARES) process in the early 2000s, reduction of infrastructure funding not only limited VA's capacity to meet rising demand, it also endangered both veterans and VA employees in aging facilities, some of which required immediate improvements for life safety problems. To avoid this problem with the AIR process, Congress specifically required that VA continue to request construction funding, and the IB recommends that VA and Congress apply this provision effective immediately, not just once the formal AIR process gets underway in 2021.

- **VA must continue to increase its internal capacity and expertise to maintain existing infrastructure, and build or lease new facilities, by hiring additional personnel and implementing the covered training curriculum and the covered certification program required by the VA MISSION Act.**

Recommendations continues

Recommendations continued

Regardless of the scale and scope of infrastructure changes that ultimately come out of the AIR process, VA must improve the management and oversight of its capital asset portfolio. The VA MISSION Act included provisions requiring that a new training and certification program be established no later than September 30, 2019, for its construction management employees, and it must meet that deadline. Additionally, VA must begin to increase the number of construction professionals to prepare for greater construction activity during and after the AIR process.

- **Congress and the Administration must resolve problems caused by Congressional Budget Office (CBO) and Office of Management and Budget (OMB) budgetary scoring rules for leasing federal facilities that have made it so difficult for VA to extend current or initiate new leases for health care facilities.**

As a result of decisions by OMB and interpretations by CBO, under current congressional Pay-As-You-Go (PAYGO) rules, Congress is required to offset the full 10-year lease cost of new or extended leases during the first year, thereby scoring it as if it were the same as a capital purchase. Due to the enormous overall score of such leases, Congress has been unable to overcome the PAYGO requirements for offsets and VA has had much greater difficulty leasing new and necessary facilities. This problem must be resolved prior to initiation of the AIR Act provisions in order to ensure that the infrastructure modernization and realignment can be successful.

Expanding VA's Caregiver Program to All Eras

VA will begin to extend eligibility for the Program of Comprehensive Assistance for Family Caregivers to severely injured veterans of all eras, through a phased approach. First, VA must submit to Congress certification that the IT system relied upon by the program is prepared to accommodate a higher workload. Once the system is prepared, VA will begin processing applicants injured on or before May 7, 1975, in addition to those injured after September 11, 2001. Two years after this expansion, the program will accept all veterans severely injured in all eras.

When the program was launched in 2011, VA

estimated some 4,000 veterans would apply. Over 45,000 did, demonstrating unmet need for services and supports for families. Currently, some 19,000 veterans access these services. In the years to come, an estimated 76,000 veterans are likely to enter. The task before VA is monumental. The Caregiver program must correct current flaws while preparing to meet and serve a larger, older population of veterans.

The majority of veterans in the program are in their 30s. Having been injured young, they are still finding the new normal for their lives. Often, these veterans access services for three to four

years before graduating out of the program when their conditions improve to a degree where a daily caregiver is no longer needed. As the program expands to include additional eras of service, this

trend line will likely stop, as the majority of geriatric veterans are unlikely to see their independence improve to the point of no longer needing daily caregiving.

Expansion of VA Caregiver Assistance Program – Key Implementation Dates	
Date	Deadline or Milestone Explanation
September 1, 2018	VA-Certified New IT Systems for Expanded Caregiver Program Are Ready
September 1, 2019	One Year After VA Certification, Caregiver Program Expands to Vietnam War and Prior Era Veterans
September 1, 2021	Three Years After Certification, Caregiver Program Expands to Post Vietnam through Pre-9/11 Era Veterans

Recommendations

- **VA must accommodate a more variable set of family members serving as caregivers.**

While older veterans' participation is unlikely to fluctuate, caregivers of older veterans likely will. Younger veterans tend to rely consistently on a spouse or a parent for care. Older veterans, on the other hand, are less likely to have a spouse still capable of the physical demands of providing daily care. We anticipate adult children, nieces, nephews, or other family or community members of veterans to provide care in greater numbers. It is not uncommon for families to rotate out primary care responsibilities after a period of time. This trend is likely to continue as the parents of post-9/11 veterans age out of their caregiving role in the decades to come. Adult children may alternate primary care providers over the course of a year with siblings and cousins. Effective communication with caregivers by caregiver support coordinators (CSCs), adequate provision of mental health services and respite, and tailored training that addresses issues of aging and disability are critical. Caregivers for pre-9/11 veterans are more likely to endure physical strain; maintaining a veteran with severe physical disabilities means they are bending and lifting for a duration that is likely to jeopardize their own health. VA must be able to accommodate rotating caregivers, and provide the adequate and relevant training they need in order to sustain their veteran and maintain their own health.

Recommendations continues

- **VA must implement and sustain the IT system required, prior to extending eligibility.**

Congress judiciously required an IT system be in place to properly manage and support the Program, avoid the delays in access, and immediately identify resource needs. The law required such implementation to be no later than October 1, 2018. According to VA, it has implemented a permanent IT solution for current Program participants. This system, however, is insufficient to support extending Program eligibility.

- **Eligibility determinations must clearly prioritize clinical need of veteran.**

In the years to come, the majority of program participants will be older veterans with greater challenges to their independence. Administrative and clinical eligibility determinations and personal care needs assessments will likely be more difficult to determine for elderly veterans – as will determining what needs are a result of service-connected injuries borne of non-service related reasons. Assessing the personal care needs of veterans based solely on service-connected conditions can be extremely difficult – especially when there are comorbid conditions contributing to the veteran’s functional limitations. Spending clinical time picking apart the degrees of personal care needs necessitating a caregiver does not serve the well-being of the veteran and is an imprudent use of clinical time.

- **VA must sufficiently staff and resource the Program of Comprehensive Assistance for Family Caregivers.**

Issues of insufficient resourcing and hiring of CSCs has burdened the program throughout portions of the country. VA must request sufficient resources for the management and staffing of this program. Without sufficient staff to respond to the needs of veterans, any efforts at successful expansion will be severely compromised. As noted by an August 2018 OIG report, VHA has not established a staffing model to ensure medical facilities are well-equipped to manage the current program’s workload, including processing applications and routine monitoring of veterans and caregivers. The eligibility expansion will see the program triple in size. As of 2018, there are 20,000 post-9/11 participants. A total of 76,000 pre-9/11 veterans are expected to enter the program by full expansion in 2022. It is of highest importance that VHA right size and revise its program governance and workload as quickly as possible.

Health Care

Timely and Comprehensive Mental Health Services

The Department of Veterans Affairs (VA) must provide timely access to mental health services and sustain a comprehensive mental health program for all veterans.

Recommendations

- *The Independent Budget* veterans service organizations (IBVSOs) urge Congress to ensure resources are provided for VA mental health programs and promotion of evidence-based treatments in an effort to eradicate the causes and symptoms that lead to veteran suicide.
- VA and the Department of Defense (DOD) must properly implement the Joint Action Plan to enroll newly discharged veterans into Veterans Health Administration (VHA) and to ensure access to mental health services that are comparable to other health services and screenings.
- VA should improve timely access to mental health services for veterans in mental health crisis while concentrating on targeted outreach to those most at risk, including those with other- than-honorable (OTH) discharges.
- VA must ensure all veterans with war or sexual trauma-related mental health issues have access to VA specialized mental health services from providers who have the cultural competency and expertise to understand and treat their unique needs.
- VA must expand telehealth services for patients seeking mental health care who have access barriers to care, including veterans in rural areas, and minority populations.
- VA must increase options for veterans and family-centered mental health care programs.
- VA must continue outreach to veterans of recent deployments and identify veterans of past service eras who may benefit from screening and treatment of traumatic brain injury (TBI).
- VA must continue to investigate the most effective treatment programs for veterans with comorbidities of post-traumatic stress disorder (PTSD), military sexual trauma (MST), and TBI with substance use disorder (SUD) and chronic pain; as well as develop treatment options for veterans who are newly diagnosed. VA providers must take steps to prevent at-risk veterans from becoming dependent on drugs or alcohol used to “self-medicate.”

Recommendations continues

Recommendations continued

- VA must continue researching biomarkers for PTSD and TBI, as well as non-traditional mental health care treatments and medical cannabis.
- Congress should hold MST-related oversight hearings to improve VA-DOD collaboration, and policies and practices for MST-related care and disability compensation.
- Veterans Benefits Administration (VBA) should employ the clinical and counseling expertise of sexual trauma experts within VHA during the disability compensation examination phase; as well as train staff and review MST-related claims to ensure established directives for claim adjudication are being followed.

Background and Justification

Suicide among the nation's veterans continues to be a top priority for both VA and DOD. This is why VA, in cooperation with other government agencies, now releases annual data regarding veteran suicide. In September 2018, VA released its most recent analysis of veteran suicide with data from 2016. The data found suicide has remained fairly consistent within the veteran community over recent years. An average of 20 veterans and service members die by suicide every day. While this number must be eradicated, it is worth noting that as the number of veteran suicides has remained consistent in recent years, non-veteran suicides have continued to increase.

One death by suicide is one too many. Congress must ensure sufficient resources are available for effective VA suicide prevention efforts, including to identify those at higher risk of suicide, to deploy new interventions, and to effectively treat those with previous suicide attempts. Programs such as the Veterans Crisis Line (VCL); the placement of suicide prevention coordinators at all Veterans Affairs Medical Centers (VAMCs) and large outpatient facilities; integration of behavioral health

into primary care settings, and joint campaigns between DOD and VA should be continued to aid in anti-stigma efforts and to promote suicide prevention efforts.

Timely access to mental health care is a critical aspect of health care quality. Over the past decade, the VA Office of Mental Health Services has developed a comprehensive set of services while seeing a significant increase in the number of veterans receiving care. VA provided specialty mental health services to 1.6 million veterans in fiscal year (FY) 2015. In 2016, the MyVA Access initiative was announced to address urgent health needs of veterans, with a plan to make same-day primary care and mental health services available at all VAMCs. From the beginning of FY 2016 through June 2017, VA had completed over one million same-day appointments for more than 500,000 unique patients through the primary care-mental health integration or regular mental health clinics. In 2017, VA began providing access to care for veterans with OTH discharges who were in a mental health crisis.

The Government Accountability Office (GAO) has identified several key barriers that deter veterans from seeking mental health care. These include stigma, lack of understanding or awareness of the potential for improvement, lack of child care or transportation, and work or family commitments. Early intervention and timely access to mental health care can greatly improve quality of life, promote recovery, prevent suicide, obviate long-term health consequences, and minimize the disabling effects of mental illness.

Since 2012, VA has increased staffing of new mental health providers, made efforts to improve wait times for mental health services, and addressed numerous barriers to care. Despite the increased need and improved outcomes of these services, according to an annual Office of Inspector General (OIG) report determining VHA staffing shortages, FY 2018 saw the most frequent staffing shortage in psychiatry and the fourth most frequent in psychology. Out of 141 facilities surveyed, 98 had a shortage for psychiatrists and 58 had a shortage for psychologists. By not adequately staffing VHA, the capacity to serve veterans and provide the necessary access to mental health care needed by so many veterans will continue to be limited.

Veterans who served in Iraq and Afghanistan make up only a small percentage of VA's patient population, yet they require a significant proportion of VA specialized mental health services. There are nearly 3.5 million veterans who served after September 11, 2001. Without an end date for the Global War on Terror, this cohort will continue to grow, as will the need for specialized mental health services.

Alarming, VA's annual report on suicide data has continuously shown that veterans ages 18-34 have the highest rates of suicide. These numbers have continuously risen over the past three years, which is particularly worrisome as 54 percent of post-9/11 veterans fall into this age range. Studies show post-9/11 veterans who leave the military are also at increased risk of suicide during their first three years after service.

With this in mind, Executive Order 13822 established a requirement for VA, DOD, and Department of Homeland Security to coordinate an interagency plan. The Joint Access Plan (JAP) that was developed must provide seamless access to mental health treatment and suicide prevention resources for service members transitioning out of the military during their first year of separation.

Additional framework was also built into the JAP to provide more support for veterans identified as being at increased risk for suicide. This includes using current algorithms already implemented to identify veterans within VHA who are among the highest risk of suicide. The overall goals of the JAP, which are still being implemented, include better assurance that all new veterans know how to access VA services.

There are also provisions in the plan that call for increasing partnerships between VA and private sector providers. The IBVSOs understand that sometimes there is a need for care to be supplemented from within the community, but also firmly believe these non-VA providers must be held to an equally high standard of care. It is imperative that veterans recently leaving their military service are able to access knowledgeable, evidence-based care through VA. Current reports show the care provided by non-VA providers is of lower quality, and these providers prescribe veterans opioids at higher rates.

Another population at increased risk of suicide are veterans who received OTH discharges. Veterans with this particular discharge have rapidly increased in recent years, and mostly received these discharges for administrative purposes without any due process, rendering them without access to VHA. With the goal of eliminating veteran suicide in mind, VA expanded access to emergency mental health care for veterans who received an OTH discharge in July 2017. At the end of FY 2018, just over 100 veterans had utilized this care.

Surveys conducted by IBVSOs show veterans prefer using VA for reasons such as continuum-of-care and

cultural competency. VA must continue expanding ways veterans may access mental health care. VA must continue expanding telehealth options for veterans seeking mental health who are in rural areas and may struggle to access any form of health care. It is also crucial VA provide telemental health for women, lesbian, gay, bisexual, and transgender (LGBT) and racial/ethnic minorities who face unique barriers such as travel difficulties, lack of access to childcare, or increased concerns of stigmas. VA must also expand mental health programs beyond trauma. Veterans need access to these appointments for struggles related to families and lifestyles, as well as gender-specific needs such as post-partum struggles or during menopause.

Along with TBI, PTSD is closely associated with post-9/11 veterans. PTSD is the psychological impact of experiencing or witnessing something traumatic. Like TBI, the effects of PTSD can be of an acute nature where veterans spontaneously recover, or they can be chronic, resulting in symptoms that veterans may experience for the rest of their lives without effective treatment. Unfortunately, multiple deployments with intense exposure to warfare have put many veterans of recent deployments at high risk for developing chronic PTSD.

Lessons learned from the Vietnam War better informed VA's deployment of resources to address PTSD in the wake of the Global War on Terror. Early on, VA was able to screen for veterans' exposure to events associated with the development of chronic PTSD and use existing protocols to assess symptoms associated with the disorder. VA and DOD developed post-deployment screenings that identify appropriate candidates for more comprehensive assessments. VA also integrated behavioral health into the primary care setting, which allows individuals who screen positive for PTSD or mental health issues to be assessed almost immediately.

VA has trained thousands of clinicians in the evidence-based protocols shown to be most effective

in addressing PTSD — cognitive processing and prolonged exposure therapies. Yet, treatment becomes more difficult as more veterans come to VA struggling with co-morbidities. Common co-morbidities include PTSD, MST, or TBI with SUD and chronic pain. Symptoms of PTSD, MST, and TBI can all resemble one another, and often times patients who survived sexual trauma do have PTSD. Many affected individuals experience high levels of anxiety or depression and exhibit difficulty with self-regulation, judgment, and concentration due to preoccupation with the memories of traumatic events. Diagnosis is further complicated by the fact that veterans often may have coexisting conditions of TBI and PTSD. Symptoms of PTSD may significantly impair veterans' ability to re-engage with their community and put them at higher risk for developing SUD or death by suicide.

Unfortunately, many veterans have more than one mental health disorder. Patients with more than one diagnosis are often among the most difficult to treat. While estimates of the prevalence of coexisting PTSD and SUD vary, most findings suggest significant portions of the population with PTSD also have SUD. Researchers from the VA National Center on PTSD cite a large epidemiologic study, finding almost half of those in the general population with lifetime PTSD also suffer from SUD. This is why it is incredibly important for VA providers to take the proper steps in preventing at-risk veterans from self-medicating, while also being responsible for handling patients with chronic pain and their necessary treatments.

VA has also taken steps to ensure it appropriately uses pharmaceutical treatments. Under the Opioid Safety Initiative (OSI), VA has reduced the number of veterans for whom it prescribes opioids by over 22 percent. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of PTSD and SUD to ensure better health outcomes. IBVSOs have been disheartened

to hear from so many veterans who were abruptly taken off their opioids used for pain management, without receiving warning or a fair treatment plan. Often times, this leaves veterans desperate to self-medicate.

Research on mental health issues associated with combat or sexual trauma, such as PTSD and TBI, has allowed providers and researchers to better understand and diagnose mental health disorders in ways that have never before been possible. This can be advanced by continuing genomic research on biomarkers for varying risk factors. To aid in this ongoing and important research, VA must complete recruitment of the Post-Deployment Afghanistan/Iraq Trauma Related Inventory of Traits study, which will provide a pool of 20,000 veterans of Iraq and Afghanistan to identify possible genetic variations that may influence risk of PTSD and TBI.

VA developed the polytrauma system to address TBI and other frequently co-occurring injuries (including wounds requiring amputation, sight, or hearing impairment, spinal cord injury, pain, and mental illnesses such as depression and PTSD), using a highly integrated and coordinated approach to address the complex needs for medical, rehabilitation, and supportive services. The system integrates VA and DOD care delivery and works closely with the grantees from the National Institute on Disability, Independent Living, and Rehabilitation Research TBI Model Systems to share data and best practices. Much more research, including research into assistive technologies that may assist veterans with reintegration into the community, is necessary.

To meet the emerging needs of veterans with TBI, VA uses polytrauma rehabilitation centers (PRCs). PRCs serve as the hubs of the nationwide system VA has in place at 148 medical facilities today, which include five PRCs in addition to network sites, polytrauma clinics, and polytrauma care teams (embedded in some primary ambulatory care teams).

Veterans with the most chronic and severe brain injuries and their families often require a lifetime

of care and support. VA has a case-management system in place designed to follow these patients into at least the first two years of recovery in the community. An individualized rehabilitation and community reintegration plan is developed with an interdisciplinary care team, including the veteran or their family caregiver, prior to the veteran's discharge from a PRC facility. The successful implementation of the plan is highly dependent upon the family's ability to adequately support the veteran at home, the patient's distance from needed care, and the PRC case manager's ability to provide the necessary resources to execute the discharge plan. For example, the PRC may prescribe speech therapy for a discharged veteran, yet the VAMC that is nearest to the veteran's home responsible for delivering the care may not deem the veteran an appropriate candidate for treatment. VAMCs also significantly vary the amount of care (such as physical, speech, and occupational therapy) they are willing to reimburse or provide, often halting such services once it deems a maximum level of benefit has been reached. Unfortunately, without these services, veterans may regress and even develop secondary conditions that require more intensive medical treatment.

MST continues to be a problem within DOD for all active, reserve, and guard components. The definition of MST under federal law (Title 38, USC, section 1720D), is defined as psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while the veteran was serving on active duty, active duty for training, or inactive duty training.

MST affects service members and veterans of all backgrounds without regard to age or race. Most survivors of sexual trauma during their time in the military are males, but women are disproportionately affected.

While DOD continues to increase its efforts to reduce or eliminate sexual trauma within the military service, the number of service members affected by MST is slow to decline. Congress must ensure DOD and VA improve their collaborative effort

in awareness, reporting, prevention, and response among both service members and veterans. The identification of service members transitioning from military service having been affected by MST is a vital step in ensuring the veteran receives all of the appropriate care he or she needs.

VA's national screening program screens all patients enrolled in VHA for MST. National data from this program reveals about one in four women and one in 100 men respond affirmatively to having experienced MST. All veterans who screen positive are offered a referral for free MST-related treatment, which notably does not trigger the VBA disability claims process. Previous years of VA data show growing numbers exceeding 100,000 veterans receive care for MST related treatment.

In FY 2017, 3,681 men and 8,080 women submitted claims to VBA for health problems related to MST. Of those claims, 55 percent of men's and 42 percent of women's claims were denied. This is why IBVSOs encourage Congress to hold oversight hearings on VA care related to MST and VBA's process of handling MST claims.

It can take many years for survivors to even acknowledge a trauma occurred, and sharing details with advocates and care providers can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to recount their experiences to disability compensation examiners. Therefore, we encourage VBA to employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.



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

Recommendations

- Congress must pass legislation making veterans with service-connected illnesses eligible to access VA's PCAFC.
- VA must request and Congress must provide sufficient funding for PCAFC within medical services' appropriations.
- Congress must conduct oversight of VA's 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 primary caregivers' own income security.

Recommendations continues

- VA must provide a more integrated, robust, and flexible IT system to properly manage, evaluate, and improve all aspects of PCAFC.
- To improve PCAFC, VA must conduct periodic surveys to assess how the caregiver population is being served, its challenges, and its needs, as well as 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

VA provides essential health care services to severely disabled veterans. It is their caregivers, however, that provide the day-to-day services and support needed to sustain a veteran's well-being. Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries. Their welfare directly impacts the quality of care veterans receive. The VA's PCAFC is unique in the United States. It is the only integrated program that is required to provide health care, a stipend, travel expenses, mental health care, respite care, and injury-specific training. Without these support services, the quality of care provided by the caregiver is likely to be compromised and the veteran is more likely to experience frequent medical complications and require long-term institutional care. Veterans who access PCAFC are medically stable enough to live within their community but lack the functionality to care for themselves on an ongoing basis.

Title I of Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, required VA to create a caregiver-support program for those veterans catastrophically injured as a result of their service. When the program started in 2011, it was estimated 4,000 veterans would apply. Instead, more than 45,000 applied, demonstrating a critical and unmet need. There are currently 19,926 participants – a precipitous drop from a high of just

under 27,000 in FY 2016. Given the unique nature of the program and the larger than anticipated demand, VA has encountered several complications including staff shortages, unclear procedures, and an antiquated IT system. After a comprehensive review in 2017 and the issuance of VHA Directive 1152(1), *Caregiver Support Program*, the IBVSOs believe VHA has made consistent improvements. Overwhelmingly, veterans in the program have reported positively on their experience. Their caregivers are better equipped to serve and they experience fewer financial and emotional stresses because of the availability of respite, mental health care, and a monthly stipend.

As of January 2019, to be eligible, a veteran must have been catastrophically injured in service on or after September 11, 2001. Expanded access to veterans of earlier eras is expected to begin in 2020, further raising demand for PCAFC's services. The veteran's injuries must require the assistance of a caregiver in order to complete one or more Activities of Daily Living (ADLs) or require supervision due to a neurological injury. Veterans may be discharged from the program for noncompliance or if their condition improves. The program is run by caregiver support coordinators (CSCs) across 140 medical centers. Every 90 days, VHA evaluates participants' wellbeing and every year they conduct in-home assessments to confirm or adjust the fami-

lies' level of care and support.

Most recent data indicates 19,926 primary caregivers were receiving needed supports and services

through this program at the end of 2018. VA's family caregiver website (caregiver.va.gov) averages 2,241 hits a day. The Caregiver Support Line (1-855-260-3274) averages 230 calls a day.

The Law's Inequity for Caregivers and Veterans

While Title I of Public Law 111-163 created a program to address the adverse impact of caregiving, the law turned a blind eye to those caring for veterans that became ill because of their service. Family caregivers of veterans suffering from a severe service-connected illness, such as amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS), provide enormous amounts of care and support. They are, however, currently excluded from primary caregiver supports for no other reason than congressional concerns regarding cost.

The IBVSOs challenge the cost concerns, contending there are savings to be had by delaying a veteran's entry into an institutional setting. According to the Congressional Budget Office (CBO), to participate in PCAFC is about \$19,000 per year compared to the annual federal cost of nursing home care of over \$60,000 in state veterans homes (matched by equal or greater state funding), \$100,000 in community nursing homes, and about \$400,000 in VA nursing homes.

If caregivers can no longer afford to meet family members' needs, or become ill themselves,

veterans likely have no other option but to be institutionalized. VA is obligated to pay the full cost of nursing home services for veterans needing care due to a service-connected disability, including illness. Yet, VA is not allowed to delay such an admission by supporting their caregiver.

It is unconscionable that the needs of one group of veterans and the work of their caregivers be recognized and supported, while another group continues to labor in the shadows, unacknowledged and with no reprieve. The largest cohort of veterans that will be applying to participate in PCAFC is from the Vietnam era. As they age, it is preferred – from both a financial and quality of life perspective – that every effort be made to let these veterans age in place opposed to in an institution. As Vietnam era veterans age, the demand for long-term care resources will grow significantly. Seriously ill veterans will require the most intensive and expensive institutional care. By providing their caregivers the means to keep them at home with family, they will live healthier lives, and delay higher costs.

Program Leadership and Operations

VHA operated the caregiver support program for more than five years under interim guidance. A final VHA Directive 1152, *Caregiver Support Program*, was not issued until June 14, 2017. This overdue directive was distributed in the midst of a temporary suspension initiated in April 2017 of discharging or revoking caregivers' eligibility for the Caregiver Support Program and to conduct

an internal review to evaluate the consistency of the program nationwide. Upon completion of its review, VA reinstated full operation of the program in July 2018, making significant changes to the program to affect policy and execution moving forward. This change includes mandatory VA staff training on the new directive, standardizing program information, a Frequently Asked Questions

webpage for the program, and a document outlining the roles, responsibilities, and requirements for caregiver support coordinators, family caregivers, and veterans participating in the Caregiver Support Program.

Despite these enhancements, reports from 2014 and 2018 by GAO and VA Office of the Inspector General (OIG) describe specific and prevalent 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 and 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.

The IBVSOs appreciate VHA leadership support toward the hiring of a program analyst. Unlike other clinical programs under VHA's current organizational structure, however, its Caregiver Support Program office has no corresponding clinical operations office to work collaboratively with its policy office and support field operations.

Variable application of eligibility and unclear roles across facilities continue to plague the program participants and applicants. VA must give consistent and transparent information to veterans regarding eligibility and tier reduction. Without reasonable support and reliable data, the IBVSOs are concerned about VA's ability to properly analyze and project the number of resources needed to address the backlog of pending applications, while supporting and preparing for the impending number of caregivers expected to come into the program over the next five years.

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 veterans. 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 4,800 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 the veteran when they become injured, many primary caregivers face a lifetime of supporting their veterans. 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. There have been bills introduced in this and past Congresses, and likely will be introduced in the 116th Congress as well, to give up to five years of caregiving credit under Social Security. Some bills have been written in a way that would disadvantage veteran caregivers by the way they define “compensation.” While not a VA issue, Congress should be cautioned not to inadvertently harm veteran caregivers in this manner.

Enhancements Needed in Caregiver Services and Support

The IBVSOs often hear from primary caregivers that the training and education component of the program is basically an orientation. While the education and training component is required by law, the content is wholly within VA's discretion. VA should amend such education and training to account for the primary caregiver's experience and meet specific caregiving needs. This will be particularly pertinent as longtime caregivers from earlier eras join the program.

Caregivers report the unreliable availability of respite. Currently, the program includes many caregivers who are young spouses, many with young children in the home, creating barriers to respite services if childcare is not equally available. The caregiver is unable to truly experience respite if his or her caregiving responsibilities shift from the veteran to the children. Caregivers may also not be using this critical benefit due to unavailability of the service in their community and because they are concerned about entrusting the health and well-being of their veteran to a stranger. It is imperative

VA identify local barriers to receiving respite care in the most convenient setting for the caregiver and veteran. IBVSOs support VA's current efforts to use every means available, such as innovating an existing program, the Veteran-Directed Home and Community Based Services (VD-HCBS) to address this unmet need.

To date, VA evaluations of both the PCAFC and the Caregiver Support Program indicates increased use of health care services by veterans participating in PCAFC, though it is unclear if this increase in health care use is improving health status, health outcomes, and quality of life for veterans. Equally important, the evaluations suggest caregivers in PCAFC are more confident and better prepared in their role and that the stipend is reducing the financial strain of caregiving. The IBVSOs urge VA to continue program evaluations while addressing the existing limitations to better guide the current program and policy, and to inform policymakers overseeing the program.



Long-Term Care

Recommendations

- VA must make a multi-year commitment to the successful balancing of its long-term services and supports (LTSS) system while maintaining a safe margin of community living center capacity.
- VA should publicly report VA LTSS workload and waiting times.
- Congress must address differing authorities for VA LTSS and provide adequate funding.

Recommendations continues

- Congress should conduct oversight of VA's initiative to provide home and community-based services (HCBS).
- Congress should request GAO conduct a follow-up report on veterans' access to, and availability of, VA home and community-based services.

Background and Justification

LTSS encompasses a broad range of assistance to veterans who have physical or mental impairments and have lost the ability to function independently. LTSS includes help with performing self-care activities and household tasks, habilitation and rehabilitation, adult day services, case management, social services, assistive technology,

home modification, medical care, and services to help disabled veterans remain an active member of their community. LTSS are provided to veterans who require help with activities and instrumental activities of daily living in a variety of settings, including in the home, assisted living and other supportive housing settings, and nursing homes.

Veterans Who Will Need Long-Term Services and Supports

According to the VHA, the projected total number of veterans most likely to require geriatric services in the coming decade — predominantly those ages 85 and older, and those of any age with significant disabilities due to chronic diseases or severe injuries — will remain well over one million strong. Nearly 40 percent of veterans who served on or after September 11, 2001 have a severe disability, which is higher than any other veteran cohort of earlier war eras. Population data show the number of veterans enrolled in the VA healthcare system who exhibit limitations in one or more activities of daily living will remain more than 1.2 million. VA can expect that as these veterans with functional limitations age, they will need LTSS and the VA's LTSS workload concurrently.

Women veterans age 65 and older in the national veteran population will increase by 73 percent between 2019 and 2029 to over 617,000, despite the fact that the total veteran population older than 65 will decline by 16 percent to 7.6 million. The

higher rate of young female veteran enrollment and health-care utilization, combined with longer life expectancy for women, suggests there will be a rising demand in VA geriatric and extended-care settings for gynecological care and management of chronic disorders more prevalent among older women, such as osteoporosis and breast cancer.

The IBVSOs additionally believe that there are differences in culture, needs, and expectations in the newest generation of the severely ill and injured veteran patient population that require LTSS compared to the needs of elderly veterans. In most instances, the expectation is that these younger, severely disabled veterans will not want to reside in a nursing home, but rather receive appropriate support for safe and independent living in their community of choice. Gaps in VA's LTSS package and in the geographic availability of LTSS is beginning to describe the limitations of VA's current LTSS model of care.

Rebalancing of Long-Term Services and Supports

With the exception of nursing home care, the majority of LTSS is part of VA's uniform health benefits package and these services are available to all enrolled veterans as outlined in Public Law 104-262, Veterans' Health Care Eligibility Reform Act of 1996, and Public Law 106-117, Veterans Millennium Health Care and Benefits Act of 1999 (Millennium Act). In response to VA's largely nursing home-based system of LTSS, the Millennium Act directed VA to expand non-institutional HCBS while maintaining the "level and staffing of extended-care services" that existed in 1998.

Since these laws were enacted, VA has been attempting to balance its LTSS system substituting nursing home services with more cost-effective and veteran preferred HCBS, which can reduce costs and improve the veteran's quality of life. Over the last decade, VA has helped veterans move out of, and has diverted them from nursing homes. VA adopted a performance measure to increase access to HCBS using 2006 as the baseline fiscal year. In 2008, the VHA added two new HCBS programs with its Medical Foster Home (MFH) and Veteran-Directed Home and Community-Based Services, in partnership with the Department of Health and Human Services. From FYs 2008 to 2017, the proportion of VA's LTSS budget being spent on HCBS has risen from 15 to 36 percent.

VA should be commended for such a tremendous shift in spending to balance its LTSS system. However, according to the Medicaid and Children's Health Insurance Program Payment and Access Commission, for the fourth consecutive year in 2016, more than half of Medicaid spending for LTSS was HCBS rather than institutional care. This shift is the result of a variety of factors, including efforts by federal and state policymakers to balance Medicaid LTSS spending towards HCBS in order to curb spending growth and meet beneficiary preferences to live in the community. Clearly, VA has much more to do.

Last Congress, the IBVSOs made recommendations directed at the leadership of the VA, VHA, and VAMCs to sustain the commitment of balancing the Department's LTSS. There must be an open commitment by VA leadership, a performance metric to measure and guide regional balancing at the Veterans Integrated Service Networks (VISN) level, and an evidence-based assessment instrument to be adopted and utilized by all local VA facilities, to help determine the level of HCBS services needed for veterans and their caregivers that would enable them to remain active participants in their community.

These recommendations were made in light of institutional inertia supported by conflicting authorities. Current law requires VA to provide nursing home care services based on medical need to a subpopulation of veterans enrolled in VA health care. In contrast, VA policy makes HCBS available to all veterans in need who are enrolled. Not until recently has there been serious attempts made to address these conflicting authorities; not in law, but within the parameters of national handbooks and directives.

As a result, in 2017, VA formalized these efforts and announced its Choose Home initiative designed to allow veterans to remain in their homes instead of institutional settings. It is to employ evidence-based policy and action to improve the experience of veterans and their families. VA has indicated it will continue to capture LTSS expenditures and workload to align services provided with veterans' needs. Finally, guidance has been issued to VA facilities to adopt an evidence-based assessment instrument.

If VA is to successfully execute its Choose Home initiative, VA must identify gaps, weaknesses, strengths, and unmet needs of the aging and younger complex patient population. Unlike previous budget requests, VA's request for FY 2019 and 2020 did not include LTSS workload data in a non-institutional setting. This data was included in

response to inadequate oversight and monitoring to ensure veterans were receiving needed home care services. To address this gap, VA should resume public reporting of LTSS workload data in its budget requests. Furthermore, the required assessment instrument utilized for the Choose Home initiative should allow the collection and reporting of validated data and other information to support local and national policy decisions, as well as justify future budget requests.

While VA is continuing to balance its LTSS system, all VAMCs should be able to meet the requirement to provide the full array of HCBS to veterans in its assigned service area. We continue to hear of waiting lists for in-home support, which is not publicly reported, and of reductions of in-home services, without clinical justification or time allotted for veterans and their families to adjust to the reduction of services.

Another area in need of attention are the innovations and advances in VA's LTSS, which have been slow to proliferate. For example, VA's Veteran-Directed Home and Community-Based Services (VD-HCBS) program, initiated in 2008, is serving over 2,100 younger and aging veterans with catastrophic disabilities whose individual needs have not been satisfied with VA's traditional LTSS. Yet, VD-HCBS is only offered at 79 out of 170 VAMCs.

To enhance its LTSS benefit package while addressing its mounting nursing home spending, VA piloted the Medical Foster Home (MFH) program in 2000. It allows veterans in need of nursing

home care to receive such care at a private home in which a trained caregiver provides round-the-clock care — including room and board, assistance with activities of daily living, medication management, and recreational and social support — to a small group of veterans. Veterans residing in MFHs also receive care through VA's Home Based Primary Care program. MFHs have successfully served over 4,000 veterans with more than 1,000 residing in MFHs today. The program costs approximately \$1,500 to \$3,000 per month, while traditional nursing home care costs approximately \$7,000 per month.

Currently, VA has no authority to pay for care in a MFH, and veterans — even those who VA is required by law to pay for needed nursing home care — must pay out-of-pocket to reside in a MFH. As a result, “VA pays more than twice as much for the long-term nursing home care for many veterans than it would if VA was granted...authority to pay for care in a MFH.”

Slow progress to provide more cost-effective and veteran-centric LTSS must be addressed by the Administration in its budget requests, and by Congress in providing the authorities and resources necessary for VA to meet the current and projected demand for LTSS. In doing so, however, the IBVSOs will oppose any proposal to eliminate the minimum bed capacity for VA Community Living Centers (CLCs). We strongly recommend that Congress enforce its average daily bed census mandate for VA to provide institutional care, and provide adequate funding to allow VA to expand HCBS to meet current and future demand.



Women Veterans

Recommendations

- Ensure designated women’s health providers are well trained and proficient in addressing women veterans’ gender-specific and specialty care needs through mini-residencies and other training opportunities
- Ensure VA’s women veterans program managers and other coordinators are provided adequate time to fulfill their duties, including ensuring that community care meets access and quality standards.
- Assist women veterans in overcoming known barriers to care by offering access to childcare, transportation, or beneficiary travel services.
- VBA and VHA should collect and publish data by gender and race on benefits and disability compensation applications and decisions, as well as health outcomes, to ensure equity.
- Ensure that environment of care standards in clinics treating women are met, and that reported deficiencies are quickly corrected.

Background and Justification

Women’s representation within the Armed Forces (16 percent), Military Reserves, and National Guard (20 percent each) is growing, composing an increasingly large share of the military and veterans’ populations. Women veterans now comprise about 10 percent of the total veteran population, and more than 7 percent of the veterans using VA health care services. In the next decade, women are projected to make up more than 10 percent of VA’s users. The diverse population of women veterans using VA care require knowledgeable providers in women’s health to deliver comprehensive primary care services, including mental health, gender-specific care, and referrals for reproductive health care needs.

VA has had difficulty in keeping pace with the rapidly growing numbers of women seeking care and benefits from VA — a population that is diverse, including both younger and older women

with different health care needs. Women veterans using VA often have complex health care needs that require specialty care for service-connected conditions such as post-deployment readjustment challenges, PTSD due to war-related trauma and sexual trauma, mental health care, and substance use disorders — services which, on average, they use at higher rates and more often than male veterans.

Women veterans, on average, use significantly more contract care as men in VHA, in part because VA cannot always accommodate their gender-specific care needs due to lack of providers with expertise in women’s health, and VA’s inability to provide safe maternity care and obstetric services due to low volume. Despite these limitations, IBVSOs believe that VA is the best system to provide comprehensive primary care, mental health, and specialty services for women veterans and strongly support the Department’s decision to include women’s health

care as a foundational service in VA. VA's programs feature preventative services, behavioral health integration, care coordination, and wraparound specialty and social services that best meet the needs of this complex patient population. Assisting women veterans in overcoming known barriers to care by offering access to childcare, transportation, or beneficiary travel services is often necessary to ensure that they have access to critical services.

Women veterans using VA health care require care coordination to ensure they receive the same quality of care in the community that they would receive at VA, and access to VA specialty care services. Care coordination duties within VA can be time-consuming and often these are collateral duty assignments. As such, VA must allow enough time

for women's health program managers and other coordinators to perform these essential duties.

VA should ensure all of its health care and benefits programs are collecting data on gender and race to ensure equity in benefits, access, and health outcomes for all veterans. Likewise, VAMC directors should be responsible for ensuring that environment of care standards are met in all clinical spaces seeing women, and that identified deficiencies are quickly resolved.

Finally, institutional cultural change from the top down is necessary to ensure women's contributions to military service are recognized and appreciated so that women veterans feel welcome at VA and receive quality care at all VA facilities.



Prosthetics

Recommendations

- Assurance from VA and Congress that Prosthetic and Sensory Aids Service (PSAS) will have centralized protected funding.
- Continuous training of prosthetic staff in the field.
- Timely delivery of prosthetic orders.
- Consistent administration of the program applied in a uniform standard process at each VAMC.
- Ensure quality and accuracy of prosthetic prescriptions in a uniform manner at every VAMC.
- Implement policies that ensure VA meets the prosthetic needs of women veterans.

Recommendations continues

Recommendations continued

- Inclusion of stakeholders in the development and updating of rules, policies, and directives.
- Maintain quality, service, and oversight of prosthetics provided in the Community Care Model.
- Continued improvement of the PSAS website.
- Continued increased funding of prosthetic research and development dollars.

The VA has a reputation in the United States and around the world of providing the best possible prosthetic care to its disabled veterans. This was not true after WWII, but steady progress by Congress, veterans service organizations (VSOs), and VA employees has made it so. America's disabled veterans, present and future, depend on VA maintaining its global leadership in prosthetics care and service.

The recommendations for this section of the *IB*

have evolved from lessons learned and experiences of all those involved in the development of the VA prosthetics program. Constant oversight and attention are necessary in order to manage the program and monitor the performance to maintain the highest quality and service to provide the best prosthetic care in the world. The recommendations are warning flags of what must be done for the VA to continue the provision of high-quality prosthetics to America's disabled veterans.

Continuation of Centralized Prosthetic Funding

Congress must ensure that appropriations are sufficient to meet the prosthetic needs of all enrolled veterans—including the latest advances in technology—so that funding shortfalls do not compromise other programs. VA must continue to protect all funding for prosthetics and sensory aids. VHA leadership should continue to hold field managers accountable for ensuring that data is properly entered into the National Prosthetic Patient Database (NPPD). The national director of the PSAS should closely monitor prosthetic budgets at the facilities.

Protection of PSAS funding has had a positive

impact on meeting the specialized needs of disabled veterans. Prior to the implementation of centralized funding, many VAMCs reduced budgets by withholding dollars for prosthetics. Such actions delayed provision of wheelchairs, artificial limbs, and other prosthetic devices. Once centralized funding was implemented, the Veterans Affairs Central Office (VACO) could better account for the national prosthetic budget and medical spending related to specialized services, including veterans with spinal cord injury and disorders (SCI/D), TBI, or amputations.

The IBVSOs strongly encourage VA to maintain a

dedicated, centralized funding prosthetic budget to ensure the continuation of timely delivery of quality prosthetic services to the millions of veterans who

rely on prosthetic and sensory aids' devices and services to recover and maintain a reasonable quality of life.

FY 18 Cost and FY 19 Projected Expenditure		
Category	FY 18	FY 19 (Budgeted)
Surgical Implants	\$700,451,662.23	\$810,662,182.25
Medical Equipment	\$525,010,598.73	\$607,616,857.26
Sensori-Neuro Aids	\$482,630,056.62	\$558,568,072.59
Oxygen And Respiratory	\$282,808,628.40	\$327,306,325.64
Wheelchairs/Accessories	\$280,532,741.24	\$324,672,345.67
Shoes/Orthotics	\$112,327,118.31	\$130,000,900.50
Orthosis/Orthotics	\$101,632,045.72	\$117,623,042.98
Biological Implants	\$92,161,912.01	\$106,662,858.75
All Other Supplies & Equipment	\$83,664,449.74	\$96,828,388.11
Artificial Legs	\$80,495,085.47	\$93,160,349.47
Home Improvements and Structural Alterations (HISA)	\$39,814,268.20	\$46,078,727.89
Misc	\$16,656,728.04	\$19,277,532.25
Restorations	\$9,224,975.60	\$10,676,452.43
Artificial Arms/Terminal Dev	\$6,893,355.17	\$7,977,969.99
Home Dialysis Program	\$4,406,132.24	\$5,099,402.24
Repair	\$501,066,714.03	\$579,905,591.98
Total	\$3,319,776,471.74	\$3,842,117,000.00

Continuous Training of Prosthetic Staff in the Field

The process of prescribing prosthetics and the procedures to be followed in selecting, purchasing, delivering, and training in the use of prosthetics is an involved, complex, bureaucratic ordeal. The skills and training required to manage and implement the prosthetic policies and procedures in a standard, consistent manner uniformly at the facility level is the key to successfully providing prosthetics to disabled veterans, and also the root cause of problems

if employees are not properly trained. Training should be conducted on a continual basis through conference calls, webinars, face-to-face meetings, and other tools. An annual training plan for all levels of employees should be developed and implemented. This would help the prosthetic employees who are most likely to be the disabled veterans' first point of contact. VA should provide a plan and funding to ensure training is conducted.

Timely Delivery of Prosthetic Devices

Prosthetics are as personal to an individual as the original body part or function. The purpose of prosthetics is to replace or support a body function in order for the individual to regain mobility and independence, which contributes to the individual's dignity as a human being. Delays in providing prosthetics are unacceptable. A person without a wheelchair or legs is immobile. A person without arms is not independent. A person without glasses cannot read. A person with a disability cannot function without the tools to do so. The reduction of delays to a minimum is a priority that can be solved through training and expediting the purchase

process. Currently, the procurement process is also a major source of delays that are caused by an overloaded system and a lack of training. The increase of the micro-purchase threshold to allow prosthetic staff to make purchases up to \$10,000 was a major positive step to reduce delays and speed up the provision of prosthetics to the disabled veteran. As a result, the procurement workload in prosthetics has increased which requires VA to address the shortage of staffing in prosthetics' services, training, and updated administrative tools to do their job.

Consistent Oversight and Management of the Prosthetic Program

The PSAS spends over three billion dollars annually to purchase and repair prosthetics and services. This is accomplished through a myriad of directives written by the policy program leader and staff in VACO. The effectiveness of how well those policies are carried out can only be accomplished by oversight at the VA facility, Veterans Integrated Services Networks (VISN), and VACO levels. The burden of carrying out these processes lies directly with the service chief and staff level. They are the ones who receive the consult, process the consult, and deliver the product to the veteran. How well they do their job can be measured in the data generated and recorded. To be useful, the data must be monitored daily at the facility level and up the chain of command in the operational side and by the program managers in the VACO.

Ensuring quality and accuracy of prosthetic prescriptions is imperative to patient care.

The clinician must prescribe the highest quality prosthetic that will accomplish the objective of improved mobility and independence for the patient, regardless of cost. If cost is the only determining factor, then excellent health care will become mediocre. Training for the prescriber, the clinical staff, and the administrative staff will help them all decide the benefits of a product based not on cost but on outcomes. This is yet another reason why prosthetic centralized funding is so important to maintaining high quality prosthetic care—the clinician does not have to worry about the subtle pressure to hold down costs.

Importance of Prosthetics to Women Veterans

Women veterans constitute a higher percentage of the veteran population than ever before. Despite the increase in the number of women who serve, the realization of what differentiates women

veterans from male veterans has been lagging far behind the actions required to improve women's prosthetic services. The VA must assure prosthetists and administrators at every level understand

women's prosthetic needs. VA must include women in the development of processes necessary to match women's prosthetic needs, to ensure their outcomes and satisfaction is equal to men in using prosthetic aids. All VA facility leaders must be accountable for meeting women veterans' standard of care for quality, privacy, safety, and dignity. Research

and Development service should ensure that VA researchers lead and fund cooperative studies. VA must include academic affiliates, other federal agencies, and for-profit industry in order to advance understanding and application of prostheses for women.

Inclusion of Stakeholders in the Development of Rules, Policies, and Directives

VA's proposed prosthetic rule would modify regulations governing prosthetic and rehabilitative items and services. IBVSOs are concerned that the regulations as written will lead to the denial of critical prosthetics and services to our members and other disabled veterans. We strongly urge VA to make changes before finalizing these regulations.

These items and services are critical to our members' overall health and well-being, their quality of life, their independence and reintegration into regular activities, and their participation in the community through sports and other activities. A veteran whose mental, emotional, and overall health deteriorates because he or she cannot access needed prosthetic or rehabilitation devices is of significant concern. We therefore request: 1) VA's specific reassurance that this proposed rule will not result in any reduction of devices, items, equipment, or services currently available to qualifying veterans, and 2) VA amend the prosthetic regulation before finalizing it.

With respect to amending the proposed regulations, the IBVSOs request language changes in two specific ways. While we understand that VA is moving to update and reorganize its regulations by creating a new subchapter to cover prosthetics and rehabilitation, we believe the "promote, preserve, or restore" language in the current § 17.38(b) should be maintained in the new § 17.3230. Removing this language could result in significantly reducing services to veterans. Congress has not enacted any law requiring such a change, and if the agency intends to continue current practices under the new regulations, there is no reason to delete this language.

Given how long the current regulations have been in effect, the proposed changes will be difficult to implement. We urge VA to include VSO stakeholders in drafting any handbooks, directives, or other guidance that will be used to implement any new regulations that are promulgated. We welcome the opportunity to work with the agency in drafting or reviewing any material.

Prosthetics Provided in the Community Care Model to Maintain Quality, Service, and Oversight

Changes in America's health care delivery and payment systems will affect all aspects of VA care, including purchasing prosthetics and sensory aids. VA must have a plan to safeguard the viability

and quality of its current prosthetics program. Medicare and Medicaid payment systems are now dictating the standards for durable medical equipment and other aids that lead to a proliferation

of “lowest common denominator” devices and discourage innovation and early adoption of new technology that may improve veterans’ satisfaction and health care outcomes. The private sector is totally unaware of how encompassing VA prosthetic care is for disabled veterans. They are, however, very aware of the stringent limits of Medicare and Medicaid payment schedules, and that is the current model they use in prescribing prosthetics to disabled

veterans. Consequently, VA must have a robust plan to implement prosthetic care in the community, aggressive training of VA and private care staff, and must increase their oversight of the community care model in the provision of prosthetics. A data system must be able to capture and track prosthetics such as is done with the National Prosthetic Patient Database. It is also imperative that the VSOs be included in this process.

Keep Directives Updated

The complexity of the prosthetic program requires clear guidelines and instructions of the process to effectively and efficiently permit staff at the facility level to do their job. As directives age, administrations change, technology improves, and overall change occurs, the paper processes must evolve to address those changes so that the disabled veteran is served in a quality, timely

manner. Currently, the majority of directives and guidelines are years out of date and are a constant source of misunderstanding and confusion for VA staff, veterans, and VSOs. Stakeholders need to be included in the development of directives and guidelines to improvement management of the program. Working together will also help VA and the VSOs develop renewed trust.

Continued Improvement of the Prosthetic and Sensory Aids Website

Veterans coming out of their service have received the best in technical training and are experts in using technology in all aspects of their career, at every level in every Military Occupational Specialty (MOS). When they exit the service, they expect the VA to be on a par with their experience and training. Applying for benefits, health care, education, housing, clothing allowance, Home Improvements and Structural Alterations (HISA), automobiles, and grants should be a seamless effort.

Questions veterans have about prosthetics and sensory aids should be easily accessible through the internet with links to specific areas. In turn, those sites should include links to the directives describing the processes that VA staff use to provide prosthetics to the disabled veteran. VA must devote IT resources to develop these much needed internet resources, and maintain and update the sites on a continual basis.



Electronic Health Record Modernization (EHRM)

Recommendations

- VA must ensure the new EHRM supports VA's model of health care delivery.
- VA must ensure its EHRM effort is led by a team who have experience in successful adoption of a replacement Electronic Health Record (EHR) of similar size and scale.
- To enable successful adoption and sustainment of EHRM, a VHA Chief Information Officer (CIO) with a direct line to the VA CIO should be appointed to identify and advocate for health information technology (IT) needs.
- Congress must ensure the VA/DOD Interagency Program Office (IPO) is effectively positioned to function as the single point of accountability with resources and staffing control, authority to develop interagency processes, and decision-making authority.
- VA must request, and Congress must provide, resources to continue development of the Veterans Information Systems and Technology Architecture (VistA) until the replacement EHRM is not just implemented, but fully adopted and sustained.

Background and Justification

VA's health IT and EHR system — the VistA — is an innovative, enterprise-wide clinical and business information system that enhances care for veterans. VistA's veteran-centric focus represents the clinical workflow processes that both supports and measures VA's holistic models of care delivering the best quality medical care to veterans. It also supports a myriad of clinical, administrative, and financial functions that are not normally found in private sector health care EHR systems.

At a time when patient records were not readily available electronically, VistA allowed VA to significantly reduce duplicative tests, medical errors, and costs. Harvard Business School awarded VA the coveted Innovations in American Government Award in 2006 for VistA as a model EHR. However, in response to congressional mandate

stemming from administrative disorganization, failed IT initiatives, and security breaches, all of VA's administration and management of IT were centralized into a single organization that same year. Since then, VA has struggled to comprehensively maintain, adapt, and innovate its once dynamic VistA system, which has led to security, maintenance, and development challenges. Additionally, VA continues to experience interoperability issues between itself, DOD, and community health care providers.

With the rise of commercial health IT solutions, the stagnant modernization of VistA, and the publicly announced 2017 decision for VA to no longer develop its own health IT platform, then VA Secretary David Shulkin awarded Cerner Corporation the task of replacing VistA with a

new VA EHRM solution over the next 10 years in June 2017. The contract itself was signed nearly a year later in May 2018. Certainly, bi-directional exchange of information resulting in meaningful use of such information with a closed/proprietary system presents distinct challenges that VA must overcome in its contract, but collaborating with

DOD offers potential cost savings and opportunities for VA such as capitalizing on challenges DOD encounters deploying its own Cerner solution, applying lessons learned to anticipate and mitigate issues, and identifying potential efficiencies for faster and successful deployment.

Customization to Support VA

According to the announcement of VA pilot site’s assessment in the Pacific Northwest, the new EHRM system from Cerner will be *identical* to the one currently in the pilot phase at DOD. The roots of commercial EHRs were targeted to support commercial healthcare systems and their revenue concerns. Whether commercial or DOD, neither health system delivers the same breadth and depth of services or benefits that VA provides veterans. Moreover, the manner by which these services and benefits are delivered is markedly different. While the decision for VA to no longer develop software appears to be settled, the IBVSOs are concerned that VA is not acknowledging the reality that successful adoption and long-term sustainability of an EHRM will likely require considerable modification and customization.

Of immediate concern to the IBVSOs is the notion, according to the Office of Electronic Health Record Modernization, that the incoming “EHRM program is not simply a technical solution or software replacement. VA is redesigning the way it delivers health care, with a future state that is patient-focused and efficient with an effective delivery system—one that offers veterans and their families the best health care available.” [1] The VA health care system has moved beyond patient-focused care to providing veteran-centric holistic care that touches every domain of a veteran’s life where health care is but only one important aspect. Congress and the Administration must ensure that the incoming EHRM, at a minimum, does not diminish from VA’s world-renowned health

care system. Additionally, the product must have the capability to support and nurture future VA innovations.

Over its lifetime, VistA and the graphic user interface Computerized Patient Record System, has been highly customized to support VA and its comprehensive approach to wellness throughout the continuum of care during a veteran’s life. The multitude of applications in VistA, the uniqueness of benefits and services delivered, and the robustness of VA’s health care delivery makes satisfaction of all users — veterans, their family caregivers, and clinicians, administration, and financial managers alike — paramount. Medscape EHR reports for 2014 and 2016 rank the VA’s computerized record system as the Overall Top Rated EHR with physicians, placing it in the top three for ease of use, overall satisfaction, connectivity, and usefulness as a clinical tool. For VA clinicians, workflows that are unique to VA and to the needs of veterans that improves patient care and outcomes, promotes safety and best practices, enhances communication between veterans and multiple providers, and reduces the risk of error, must remain. In other words, the EHRM must support VA’s healthcare delivery model, not the reverse.

EHR is the core but not the entirety of VistA. VA does not just treat physical injuries and mental health, but includes the delivery of other VA benefits and services not generally offered in other health care systems such as a full complement of long-term services and supports, home adaptation,

and travel assistance. VistA also supports veterans through various means including web portals such as My Health^eVet, mobile applications, kiosks, and call centers.

For veterans, the patient portal must be secure, user friendly, and facilitate engagement in their own care. Medical information important to veterans and their caregivers such as their treatment plans, prescriptions, and lab results must be easily viewed. Communicating asynchronously with their clinical team, requesting refills, and updating their medical history and status must be simple. My Health^eVet provides a suite of online tools to help veterans engage in and manage their health. They are able to enter and track personal health information, receive wellness reminders, conduct transactions with the VA health care system, communicate asynchronously with their VA health care team members, and access content from the VistA EHR. There are about 4.2 million registered users and 2.5 million identity-validated users of My Health^eVet who have requested more than 114 million refills, exchanged over 57 million secure messages, and downloaded over 27 million Blue Button files.

My Health^eVet also has the potential for telemental health, computerized therapies, online peer support groups, and other successful therapies. Despite its success, VA has yet to engage the veteran community on whether or when My Health^eVet

will be replaced in this modernization effort and if additional patient facing transactional features will be added.

VA's Office of Electronic Health Record Modernization (OEHRM) will play a central role in both selecting and implementing the new EHMR system as well as communicating its benefits to the veterans VA serves. This office is to manage the preparation, deployment, and maintenance of VA's new electronic healthcare record system and the health information technology tools dependent upon it. In the preparatory phase, OEHRM is charged with configuring and designing a system focused on quality, safety, and patient outcomes, which will encourage IT innovations to be used across the entire VA healthcare system. Primarily, it is critical VA ensures OEHRM has the resources, knowledgeable and experienced staff, and the authority to effectively discharge its responsibilities.

As it convenes clinical councils, OEHRM must not forget that the most important part of VA's clinical team in delivering patient-centered care — the veteran and their family caregivers. The integration of patient and family caregivers into the VA health care system holds tremendous promise for improving the well-being of veterans, while having the potential to reduce costs associated with hospital readmissions and nursing home care.

Governance

GAO's September 2018 report found the VA-DOD IPO has been involved in various approaches, since 2008, to increase health information interoperability. Its mission is to lead and coordinate the adoption of, and contribution to, national health data standards to ensure interoperability across the DOD, VA, and private sector healthcare providers. However, the IPO must be more than a convening body.

Congress must ensure the IPO is effectively positioned to function as the single point of accountability with resources and staffing control, authority to develop interagency processes, as well as decision making authority for both departments' EHR system interoperability efforts. Congress must reinforce its original intent in creating the IPO and enable the office to fulfill its management responsibilities while guaranteeing issues will be resolved at the lowest level.

VA's EHR modernization efforts require collaboration with the VA Office of Information Technology (OIT) which, unfortunately, has degraded over the last decade resulting in uncoordinated execution of VHA's IT strategy and restricted development of new and improved

capabilities for VistA and the Computerized Patient Record System (CPRS). The IBVSOs recommend adding a VHA Chief Information Officer with a direct line to the VA CIO to identify and advocate for health IT needs and priorities.

Continued Development and Sustainability of VistA

Cost of full integration of the Cerner EHR is projected at \$16 billion over the next 10 years, with \$5.8 billion of those funds set aside to manage and support the current VistA infrastructure. VA has indicated VistA will remain throughout the implementation phase, but has not fully described timelines, projected implementation of the new system, draw-down dates for the old system, and what the maintenance schedule will be for all or part of the system.

A 10-year EHRM deployment presents challenges to VA facilities and may impact the care veterans receive, especially those on the East Coast where EHRM will be deployed last, while the rest of the VA health care system has EHRM, and in snowbird destinations where veterans will be traveling from a northeastern VA facility using VistA to another in the southwest using EHRM. In January 2018, VA had reviewed and mapped all VistA modules and indicated that it planned to stop adding new capabilities to VistA modules that VA will eventually

retire. The IBVSOs believe this approach raises potential patient safety issues since state-of-the-art medicine and telehealth changes almost daily. We recommend VA's strategy be clear on targeted investments to maintain the state-of-the-art nature of VistA.

The incoming VA CIO pledged to maintain VistA during the 10-year process to implement the new Cerner EHR, yet concerns continue to be raised based on past performance and about the reduction in spending for development and maintenance of VistA. For example, during the past decade, VistA and CPRS development has been reactionary and confined to addressing concerns with minor enhancements and point solutions. Additionally, VA's research program is one of the Department's four main missions. Despite it being a priority, the FY 2019 budget for this program requested no funding for new technology solutions or for existing solutions undergoing development, modernization, or enhancement.



Non-VA Emergency Care

Recommendations

- Congress must enact legislation to simplify non-VA emergency care authorities.
- Congress must conduct oversight to ensure veterans are not impoverished using the non-VA emergency care program.

Background and Justification

In order for VA to pay for emergency services provided to veterans by non-VA providers, VA must apply three disparate statutory authorities with varying eligibility requirements. This difference in criteria has led to some non-VA emergency care claims being inaccurately and improperly processed, resulting in waste for the agency and extraneous out-of-pocket expenses for veterans.

According to VA, approximately 30 percent of the 2.9 million non-VA emergency claims for payment or reimbursement filed with the VA in FY 2014 were denied. Between the start of FY 2014 and August 2015, approximately 89,000 claims were denied because they did not meet the timely filing requirement; 140,000 claims were denied because a VA facility was determined to have been available; 320,000 claims were denied because the veteran was determined to have other health insurance that should have paid for the care; and 98,000 claims were denied because the condition was determined not to be an emergency. In all of these instances, a veteran was in need of care and shouldn't have had to shoulder a disproportionate financial burden because of administrative errors.

Erroneous denials of non-VA emergency care claims make veterans financially liable for care that VA should have covered. Because the financial liability is often large and credit ratings are negatively affected, veterans choose to delay or avoid going to non-VA

emergency rooms or go to a VA facility instead.

Additionally, the Court of Appeals for Veterans Claims ruled unanimously on April 8, 2016, that VA wrongly denied claims for reimbursement when the Department ignored a 2010 statute meant to protect certain veterans from out-of-pocket costs when forced to use non-VA emergency care. From this ruling that held VA's regulation as inconsistent with the statute and invalid, it is estimated more than two million claims submitted since 2010 could be eligible for reimbursement, and that over the next decade nearly 69 million claims could be submitted, which could cost as much as \$10 billion.

The IBVSOs recommend VA issue an interim final rule to remedy the inconsistency between current non-VA emergency care reimbursement regulations and statute. In January 2018, VA issued such a rule yet veterans who filed claims before April 8, 2016, would see no reimbursement from VA. Without legislative relief, these veterans will have to pay emergency care bills that Congress had intended the VA pay.

Moreover, current law prescribing non-VA emergency care benefits are convoluted and burdensome for veterans to interpret, and for VA staff to administer. The risk of being liable for such high costs can keep veterans from going to the emergency room. A 2010 study in the *Journal*

of the American Medical Association found that almost half of uninsured patients or patients with financial concerns waited six hours or more to seek care, while those without financial concerns were more likely to seek emergency care within two hours. Veterans should not be forced into weighing

choices between impoverishment or risking chronic disability or death in using their non-VA emergency care benefit. VA must review and synchronize its policy guidance to ensure both VA administrators and veteran patients are aware of when it is appropriate to seek and fund emergency care.



Strategies for Ending Veteran Homelessness

Recommendations

- Increase program resources for emergency and transitional housing in cities or regions seeing large increases in unsheltered homeless veterans.
- Expand the use of VA peer specialists who themselves have experienced homelessness.
- Develop preventive case management programs for veterans at the greatest risk of homelessness, particularly subpopulations including women, minorities, those with serious, chronic mental illness or traumatic brain injuries, and aging veterans.
- Increase funding for VA's Supportive Services for Veterans Families (SSVF) program and for the Homeless Veterans' Reintegration Program (HVRP).
- Maintain the growth of the Enhanced-Use Lease (EUL) program, and work in partnership with the Department of Housing and Urban Development (HUD) on project-based HUD—Veterans Affairs Supportive Housing (VASH) vouchers.

Background And Justification

The Annual Homeless Assessment Report (AHAR) point-in-time census for 2018 once again shows promise in eliminating homelessness among veterans. Homeless veterans are now estimated to number fewer than 40,000. The count dropped by 5.4 percent over the past year and reversed a slight uptick in the AHAR count from 2017. In the last decade, VA has made remarkable

progress in decreasing homelessness in the veteran population by nearly half – reducing it from 74,087 individuals in 2010. For the first time since 2010, in 2017, the number of homeless veterans increased since VA began its targeted initiative. Trends were most pronounced in major cities including Los Angeles and New York City, among women veterans, (seven percent increase for women

compared to a one percent increase for men), and among unsheltered veterans, which increased by 18 percent. The number of veterans with families who experienced homelessness continued to decrease.[1] The 2018 count shows corrections in homelessness among women veterans dropping by 10 percent over the past year. There was also a smaller decrease among the unsheltered veterans population, which decreased by almost 5 percent between 2017 and 2018.

Research indicates there are a number of risk factors that can contribute to a veteran becoming homeless including a history of sexual abuse, unemployment, single parenthood, mental

health or substance use issues, family dissolution, and lack of social support.[2] VA identified that veterans who experience homelessness are more than five times as likely as other veterans to attempt suicide, and about 50 percent of those veterans identified as high risk for suicide had contact with VA's homeless programs.[3] Veterans with mental health issues and traumatic brain injuries diagnosed at separation are also more likely to experience homelessness. Women veterans are twice as likely as women in the general population to become homeless, and in 2017, were becoming homeless at a rate that is seven times the rate of male veterans (see increases in 2017 AHAR counts for women and men veterans discussed above). Among homeless women veterans, 30 percent have children living with them, and 45 percent of women veterans who were unstably housed had custody of children.[4]

VA recognizes homelessness among the veteran population is a multi-dimensional problem that requires a multifaceted approach. In collaboration with other federal, state, and local agencies, VA has deployed a range of programs and complementary services that help coordinate outreach to identify veterans who are homeless or at risk of becoming homeless, connect veterans with resources for housing, and provide access to health services, vocational training, and employment services. Key programs include: the Homeless Providers Grant

and Per Diem Program (GPD)[5]; HUD-VASH[6]; SSVF Program[7], and Health Care For Homeless Veterans (HCHV) Program[8]. According to VA, in FY 2017, over 600,000 veterans and their family members were prevented from falling into homelessness, were rapidly re-housed, or permanently housed.

VA's homeless programs are comprehensive including medical, dental, and mental health services, as well as specialized programs for post-traumatic stress disorder, sexual trauma, substance use disorder (SUD), and vocational rehabilitation. VA adopted a model of housing veterans first — rather than requiring them to be in recovery or treatment for mental health or SUDs prior to receiving housing assistance. Homeless prevention coordinators and peer mentors are essential to the success of the program and helps veterans navigate the system and get the services they need. VA should consider increasing the use of peer specialists, particularly those who are in recovery from SUDs and/or have experienced homelessness. Peers who have had similar experiences are often able to connect on a more personal level and can help homeless veterans overcome challenges, actively engage in treatment, and maintain healthy, sober lifestyles.

While VA's comprehensive services, efforts, and approach to ending homelessness among veterans is effective overall, the National Coalition for Homeless Veterans recommends increased funding for the SSVF program — the only program targeted at those at risk of losing housing. This would allow VA to maintain these prevention efforts, expand the program to new communities, and focus on innovative approaches to preventing more veterans from becoming homeless. The IBVSOs recommend VA address unique risks associated with subpopulations of homeless veterans, particularly women, minorities, those with serious, chronic mental illness or traumatic brain injuries, and aging veterans. VA should also continue to develop relationships with community providers that supplement current services and ensure its programs

remain effective, and flexible to provide the services these veterans need to successfully transition into stable housing. The IBVSOs commend VA and HUD for establishing a new pilot program to provide grants to make housing more accessible for low-income veterans with physical disabilities.

The IBVSOs further recommend that VA continue the growth of its EUL program, and work in partnership with HUD on project-based HUD-VASH vouchers, in order to spur the construction of critically needed affordable housing for homeless veterans with the highest needs.



Spinal Cord Injury and Disorder (SCI/D) Care

Recommendations

- VHA must ensure that the SCI/D continuum of care model is available to all SCI/D veterans nationwide.
- VA must continue mandatory national training for the SCI/D “spokes” facilities.
- VHA must centralize policies and funding for system-wide recruitment.
- Congress must establish a specialty pay provision for nurses working in SCI/D centers.
- VA and Congress must work together to ensure that the SCI/D System of Care has adequate resources to staff existing long-term care centers, as well as increase the number of long-term care centers throughout VA.
- VA must design a SCI/D long-term care strategic plan that addresses the need for increased access and make certain that VA SCI/D long-term care services “help SCI/D Veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability.”[1]

Background and Justification

SCI/D System of Care

VA’s SCI/D System of Care is provided using a “Hub and Spokes” model. This model has been shown to work very well as long as all patients are seen by qualified SCI/D trained staff. Because of

staff turnover and a general lack of education and training in outlying “spokes” facilities, not all SCI/D patients have the advantage of referrals, consults, and comprehensive annual evaluations in a SCI/D

center.

This is further complicated by confusion as to where to treat spinal cord diseases, such as multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS). Some SCI/D centers treat these patients while others deny admission. In December 2009, VA developed and published the *VHA Handbook 1011.06: Multiple Sclerosis System of Care Procedures*, which identifies a model of care and health care protocols for meeting the individual treatment needs of SCI/D veterans. Additionally, the *VHA*

ALS Handbook 1101.07 (2014) speaks to the importance of coordinating care with SCI/D services (e.g. bowel and bladder care), encouraging ALS clinics to be located within SCI/D centers, and incorporating SCI/D staff into the ALS interdisciplinary care team. More of a national effort must be taken to integrate the ALS and MS Systems of Care with SCI/D, instead of deferring to the local level. In the meantime, MS clinics should be encouraged to engage in efforts to have SCI/D centers provide certain services on a consultative basis necessary for MS veterans.

Nursing Staff

Historical data has shown that SCI/D units are the most difficult places to recruit and retain nursing staff. Caring for a SCI/D veteran is physically, mentally, and emotionally demanding. SCI/D nursing staff provides hands-on care that involves frequent bending and heavy lifting. Repetitive movements and heavy lifting associated with caring for SCI/D patients often lead to work-related injuries and high turnover. Occupational injuries correlate with a shortage of nursing staff. Veterans with SCI/D often have psychosocial conditions such as PTSD, depression, and paranoia as a result of their injury/disorder. Special skills, knowledge, and dedication are required in order for nursing staff to care for SCI/D veterans.

Facilities are faced with local budget challenges when considering a recruitment or incentive specialty pay in the area of SCI/D. The funding necessary to support this effort is taken from local facility budgets, thus detracting from other needed medical programs. A consistent national policy of salary enhancement for specialty services should be implemented across the country to ensure qualified staff is recruited and retained.

Funding to support this initiative should be made available to the medical facilities from the Veterans Integrated Service Networks (VISN) or Veterans Affairs Central Office (VACO) to supplement their operating budgets.

Unfortunately, the significant nurse shortage has resulted in VA facilities restricting admissions to SCI/D centers. Reports of bed closures have been received and are attributed to nursing shortages. When veterans are denied admission to SCI/D centers, leadership is not able to capture or report accurate data for the average daily census. The average daily census is not only important for adequate staffing to meet the medical needs of veterans, but is also a vital component of ensuring that SCI/D centers receive adequate funding. Since SCI/D centers are funded based on utilization, refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA's ability to address the needs of new incoming and returning veterans. Such situations severely compromise patient safety and serve as evidence for the need to enhance nurse recruitment and retention programs.

SCI/D Long-Term Care

As the veteran population ages, VA must assess and prepare for veterans' long-term care (LTC)/extended care needs. Of particular concern is the availability of VA LTC services for the vastly growing aging SCI/D veteran population. VA is not devoting sufficient resources to meet the demands associated with onset of secondary illnesses and complications associated with aging.

Nationwide, VA operates only six designated extended care facilities for SCI/D veterans, with a total of 160 staffed beds. Often, the existing centers cannot accommodate new veterans needing long-term care services due to lack of beds. Furthermore, only three of these extended care SCI/D centers accept ventilator-dependent patients. These facilities manage long waiting lists for admission, and veterans remain underserved, bearing long-term costs that remain invisible to decision makers who

focus on short-term gains at the expense of long-term care for veterans in need.

Although the majority of SCI/D veterans in LTC reside in community living centers (CLCs), these facilities do not have the same rigorous staffing requirements as extended care SCI/D units. Additionally, their staff is likely not trained in caring for SCI/D LTC patients.

While VA has identified a need to provide additional SCI/D extended care centers and has included these additional centers in ongoing renovation plans, many of these plans have been languishing for years. Therefore, the IBVSOs strongly recommend that VA and Congress work together to ensure that the SCI/D System of Care has adequate resources to staff existing LTC centers, as well as to increase the number of centers throughout the VA system.



Access to Specialty Care

Recommendation

- VA and Congress must work together to improve the travel reimbursement benefit to ensure that all catastrophically disabled veterans have access to the care they need.

Background and Justification

Veterans who have incurred a spinal cord injury or disorder are entitled to health care through VA's Spinal Cord Injury/Disorder (SCI/D) System of Care. When veterans with a SCI/D are in need of care for recurrent problems and/or have complex issues at times requiring surgery that needs

specialized knowledge, it is essential that they have access to the comprehensive health care services that can only be provided by a VA SCI/D center.

VA policy identifies transportation as a major component in ensuring veterans with SCI/D

receive a comprehensive annual health exam at the SCI/D hub facilities. Two years ago, the VA implemented the extension of travel reimbursement for catastrophically disabled non-service connected

veterans seeking SCI/D annual examinations. However, there are many cases where veterans do not receive travel reimbursements for appointments related to their SCI/D annual examination.



Amyotrophic Lateral Sclerosis (ALS)

Recommendation

- The VA ALS System of Care should be further integrated within the VA's Spinal Cord Injury/Disorder (SCI/D) System of Care.

Background and Justification

ALS is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. Research shows that the risk of ALS is increased among veterans. It leads to the gradual loss of brain and spinal cord cells that facilitate motor skills such as walking or running, eventually eliminating one's ability to move voluntarily.[1] ALS is fatal and usually progresses at a fast rate after diagnosis. Therefore, it is of great importance for veterans to receive timely care and for the VA to be able to provide the clinical expertise that is needed to meet veterans' medical needs.

VA issued *VHA Handbook 1101.07: ALS System of Care Procedures* in July 2014. It describes the essential components and procedures to ensure that all enrolled veterans have access to ALS care and that the veteran and the veteran's family and caregivers are given necessary clinical care and support provided by a comprehensive, professional ALS interdisciplinary care team. The major focus of clinical care is to provide the highest quality of life through the management of symptoms and

emotional and physical suffering.

Though there is no cure for ALS, certain actions can be taken to optimize remaining function, maintain functional mobility, and maximize the veteran's quality of life. Exercise programs may be physiologically and psychologically beneficial for veterans with ALS, particularly before there is a great deal of muscle wasting.

Care integration is also an essential aspect in the ALS System of Care. It is vital that VA utilize the established programs within other systems of care to help inform veterans of treatment modalities and support services that are available. The ALS handbook encourages having ALS clinics within SCI/D centers, and states that on SCI/D units the social worker, the advanced practice registered nurse, or the registered nurse case manager would be the best points of contact for veterans and their caregivers. However, more must be done to integrate the two services.

Improving VA's National System of Care for Multiple Sclerosis (MS)

Recommendations

- VA must provide mandated direction to make certain that all Veterans Integrated Services Networks (VISNs) are in compliance with the *MS System of Care Procedures: VHA Handbook 1011.06*.
- VA must take further national efforts to integrate the MS System of Care with the Spinal Cord Injury/Disorder System of Care.
- VA must comply with the MS care delivery model that requires an appointed MS care coordinator to partner with veterans, their caregivers, and family members to help coordinate and manage all medical care provided by VA and non-VA providers.
- VA must provide adequate funding to properly staff and support MS regional programs and MS support programs that provide the full continuum of MS specialty care.
- Congress and VA must ensure that medical facilities are adequately funded to provide funding for cognitive rehabilitation, respite care, long-term care, and home care services for veterans with MS.

Background and Justification

The VA has averaged 18,000 unique MS patients per year. MS is an extremely complex and chronic neurological disease that results in cognitive deficits such as short-term memory loss and physical impairment; afflicted veterans often lose employment and their independence. VA must increase access to quality care for veterans with multiple sclerosis by ensuring adequate staffing, coordinating care across disciplines, and enforcing *VHA Handbook 1011.06*.

Despite the establishment of the Multiple Sclerosis Centers of Excellence (MSCoEs) and the *VHA Handbook 1011.06* in 2009, veterans still do not have consistent access to timely care for MS within VA. Issues such as the shortage of appropriate

medical staff or the lack of care coordination are still precluding veterans from receiving care.

VHA Handbook 1011.06 states that VA must have “at least two MSCoEs, and at least one MS Regional Program in each Veterans Integrated Service Network (VISN)... Any VA Medical Center caring for Veterans with MS and not designated as an MS Regional Program must have a MS Support Program, spoke sites for MS care.” The *VHA Handbook 1011.06* is not being enforced. Consequently, veterans do not have adequate access to MS care due to the lack of resources in local and regional facilities.

Local facilities are not adequately funded and

therefore are not able to recruit and retain medical professionals with this specific experience to meet necessary staffing requirements. VA must provide local facilities with the necessary resources and funding to provide the appropriate health care services and cognitive rehabilitation that veterans

with MS need. Equally important is the need for adequate funding for respite care, long-term care, and home care services for this population. Quality care can only be provided if all of the medical needs of veterans are being addressed and all individuals involved are informed.



Reproductive and Sexual Health

Recommendations

- Congress must make in-vitro fertilization (IVF) a part of the Medical Care Package.
- Congress must address the needs of women veterans whose injuries prevent a full-term pregnancy.
- Congress must address the needs of veterans whose injuries destroyed their ability to provide genetic material for IVF.
- Congress must remove pharmaceutical co-payments for preventive medicines, to include oral contraceptives.

Background and Justification

As a result of the recent conflicts in Afghanistan and Iraq, many service members have incurred injuries that have made them unable to conceive a child naturally. Since 2010, DOD has provided IVF to active duty and retired service members. In late 2016, Congress enabled VA to offer the same services to veterans with a service-connected reproductive injury.[1] As of this publication, over 500 veterans have been referred to IVF services. The overwhelming feedback IBVSOs receive is frustration with the VA contracting process with fertility clinics – a process that can last nearly a year. As the process is inherently time sensitive, Congress must enable VA to provide IVF services quickly to

both the veteran and spouse. An estimated 3,000 veterans with spinal cord injuries and urogenital injuries are likely to avail themselves of this service in the years to come.

For over 20 years, veterans have not had access to fertility advancements because of a 1992 act of Congress prohibiting VA from providing IVF.[2] Despite the initial and recent reauthorization lifting the ban for a two-year period, the uncertainty of the service weighs heavily on veterans and their families. The permanent availability of procreative services through VA will ensure veterans and their spouses are able to have a full quality of life, one that would

otherwise be denied to them as a result of their service.

Some women veterans with a catastrophic injury may be able to conceive but be unable to carry a pregnancy to term due to their injury. In such instances, implantation of a surrogate may be their only option. VA is not authorized to provide IVF services with a veteran's surrogate. As such, the needs of women veterans with a catastrophic reproductive injury go unmet.

For veterans who have sustained a blast injury or a toxic exposure that has destroyed their genetic material, a third-party donation may be the only option. VA is not authorized to use any genetic material in IVF service that does not belong to the veteran and his or her spouse. Again, the needs of these veterans; those who have an injury due to their service, are unmet as they are not able to receive the corresponding medical treatment to address it.

There is a growing body of evidence linking post-deployment problems such as depression or post-traumatic stress disorder to sexual health problems.

One study found almost 18 percent of veterans screened positive for sexual dysfunction.[4] Healthy sexual functioning and satisfaction with one's sex life are predictors of general well-being and overall health. VA providers must work to navigate sometimes awkward questioning to ensure veterans are able to voice concerns or problems about their sexual health that undoubtedly will impact their overall health and quality of life.

The Affordable Care Act (ACA) prevents individuals with insurance from being charged pharmaceutical co-payments for all 11 categories of preventive medicine as determined by the U.S. Preventive Task Force and Centers for Disease Control and Prevention. Yet, with VA being exempt from the ACA, Section 1722A(a)(3) requires VA to charge for these categories with exemptions provided by the Secretary for immunizations and smoking cessation. Veterans are experiencing a disparity in co-payment requirements for the remaining nine categories including contraceptives women veterans receive from the pharmacy. This is an undue and unjust barrier to accessing birth control that only women veterans and the uninsured must face.



Homeland Security and Funding for the Fourth Mission

Recommendations

- Congress must provide the funds necessary to fund the VA's fourth mission — to serve civilians, both domestic and foreign, in times of national emergency. When necessary, VA must request appropriate funding for its fourth mission, separately from the medical services appropriation.

Recommendations continues

Recommendations continued

- Congress must ensure that the VA is properly integrated into the broader emergency preparedness, response, and recovery system.

Background and Justification

VA has four critical health care missions, the first of which is to provide health care to veterans. Its second mission is to educate and train health care professionals who work with veteran populations. The VA's third mission is to conduct medical research. Its fourth mission is to serve civilians — both domestic and foreign — in times of national emergency.

Whether the emergency is precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for such events — known as the National Response Framework (NRF) — involves multiple agencies. As the largest integrated health care system in the country, with medical facilities in cities and communities all across the nation, VA is uniquely situated to provide emergency medical assistance and plays an indispensable role in our national emergency preparedness strategy.

Multiple laws authorize VA's fourth mission. Public Law 100-707 created the NRF under the Stafford Act for federal agency involvement in natural and man-made disasters. The NRF is comprised of 15 emergency support functions for which one federal agency serves as lead. The Federal Emergency Management Agency (FEMA) is assigned about half of the emergency support functions.

The VA is tasked with a variety of public health and medical responsibilities under Emergency Support Function 8 (ESF 8) of the NRF, yet the Department of Health and Human Services (HHS) is the lead agency for that function. The typical process that is followed in a disaster involves the state/territory

going to FEMA for assistance. FEMA determines if the support involves medical and public health needs and requires the engagement of HHS, which then determines the best approach to address those needs.

According to officials with the VA Office of Emergency Management (formerly the Emergency Management Strategic Health Care Group) under the Stafford Act, if the VA is activated to help with ESF 8, the agency can seek reimbursement for expenses incurred due to participation in the National Disaster Medical System (NDMS). Situations may arise in which the care provided by the VA under a Stafford Act declaration is not reimbursed by another federal department or agency.

VA's role in homeland security and response to domestic emergencies was amplified further by Public Law 107-188, the Public Health Security and Bioterrorism Preparedness Response Act of 2002. That law reorganized the NDMS to combine federal and non-federal resources into a unified response and as an interagency partnership between HHS, the Department of Homeland Security, DOD, and VA. Through NDMS, VA serves as the principal medical care backup for DOD during and immediately following a period of war or a period of national emergency. Public Law 107-188 also requires VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, medical devices, and other biological products and emergency supplies. To accomplish this part of its fourth mission, VA has established emergency pharmaceutical and medical supplies' caches at 141 VAMCs. These

stockpiles are intended to supply medications for several thousand casualties for up to two days. Unfortunately, a 2018 audit by the VA OIG found expired, missing, or excess drugs, or a combination thereof, at all 141 emergency caches. The OIG found that as a result “of ineffective management, the mission ready status of the caches was impaired.”

Also in 2002, Congress enacted Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act. This law directed VA to establish four emergency preparedness centers. These centers were intended to be responsible for research toward developing methods of detection, diagnosis, prevention, and treatment regarding the use of chemical, biological, or radiological threats to public health and safety. Although authorized by law at a funding level of \$100 million, these centers did not receive funding and were never established.

Additionally, 2017’s hurricane season revealed a number of problems within the VA’s own emergency response protocols, as well as gaps in coordination between the VA and the rest of the Department of Homeland Security’s emergency preparedness and response system. VA resources and supplies were re-directed to the wider community response needs which stretched the VA’s capacity to serve both veterans and civilians. Failure by the VA to alert local pharmacies to its emergency prescription program led to confusion and inconsistent information given to veterans seeking to obtain needed medications. Incomplete address records

held by the VA made locating veterans a challenge. Emergency shelters and intake processes failed to identify veterans so that those individuals could receive appropriate services from the VA. Many veterans with physical disabilities were unable to use emergency shelters because the structures did not comport with requirements for barrier free design.

The IBVSOs believe that the Administration must request, and Congress must appropriate, sufficient funds to ensure VA can meet its responsibilities as called for in Public Law 100-707, Public Law 107-188, and Public Law 107-287. Additionally, the IBVSOs continue to believe that these funds must be provided outside the medical services appropriation. VA has invested considerable resources to ensure it can support other government agencies when disasters occur. However, it is unclear whether the VA has received all necessary funding to fulfill its fourth mission. VA makes every effort to perform the duties assigned to it as part of the national emergency response system, but if dedicated funding is not provided, VA will be required to divert from the already strained resources it needs for direct health care programs.

Lastly, the IBVSOs also believe that Congress should undertake appropriate oversight to ensure that veterans and their families are taken into consideration within the context of the nation’s emergency management processes.



American Indian and Alaska Native Veterans

Recommendations

- Congress must enable the Office of Tribal Government Relations (OTGR) to undertake targeted outreach to tribal governments to increase awareness of VA services.
- VA must improve efforts to ensure culturally competent care is provided to American Indian/Alaska Native (AI/AN) veterans.
- VA and the Indian Health Service (IHS) must address care coordination and streamline access to specialty care for veterans living in Indian country in order to ensure timely access to quality care.
- VA and IHS must efficiently and quickly implement reimbursement agreements to ensure veterans' access to care.
- Congress must ensure research is conducted to adequately assess the barriers to health care for veterans in Indian country.

Background and Justification

American Indians and Alaska Natives serve in the U.S. military at higher rates than any other race. While only making up 1 percent of the overall population, AI/AN make up 2 percent of the active duty personnel and 1.5 percent of the total veteran population. AI/AN veterans are more likely to have a service-connected disability and the highest unmet healthcare needs.[1] AI/AN veterans are the least likely to access their earned benefits and services through VA.

Despite the trust responsibility of the federal government to provide recognized tribal members' health care, AI/AN experience the greatest health disparities in the United States.[2] For AI/AN veterans living in Indian country — reservations or tribal communities — they often face barriers to care that are unlike those faced by non-native veterans. AI/AN veterans are more likely to have an average household income of less than \$10,000 —

twice the rate of veterans in the general population living at this income level. Nearly 60 percent are unemployed.[3] Of the 27,500 miles of reservation road owned by the Department of Interior, only 7,100 is paved. These are some of the most unsafe road networks in the nation.[4] Only 25 percent of households on reservations have a vehicle. In many communities, there is limited, if any, access to the internet.[5] Without reliable means to travel to health care appointments or even access telehealth, AI/AN veterans continue to go without care.

For AI/AN veterans who are dually eligible for IHS and VA, confusion at the facility level regarding payment is a significant barrier. According to congressional testimony and media reports, AI/AN veterans have trouble accessing either IHS and VA and are often turned away by both. [6] For those who have accessed care but do not return, a negative experience — a culturally insensitive provider or

lack of appropriate services — [7] is often the cause. In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve Native American veterans' access to VA. Since 2010, VA has worked to build trusting relationships with tribes, expand telehealth services, and provide cultural competence training at VA. The VA Office of Tribal Government Relations (OTGR), established in 2011, is charged with overseeing tribal consultations and ensuring that VA understands the government-to-government relationships with tribes. The implementation of the MOU has been led by the VA Office of Rural Health, OTGR, and the IHS chief medical officer. As of 2018, AI/AN veterans have seen an increase in outreach from VA, improved quality, and coordination between the two federal health systems and tribal governments.

In 2012, VHA and IHS signed a reimbursement agreement allowing VA to reimburse for direct care services provided to eligible native veterans at all IHS sites across the country. Tribal health Programs (THP) enter into local reimbursement agreements with nearby VA medical centers. As of 2018, there are 104 signed local reimbursement agreements with IHS/THPs serving 9,253 veterans. VA has reimbursed IHS/THPs a total of \$64 million for direct services provided to eligible AI/AN veterans. [8]

A difficult history between tribes and the federal government impacts VA's legitimacy in tribal communities. VA must continue to work to build trust in these communities that have long been ignored.



LGBT Veterans

Recommendations

- Congress must provide the funds necessary in the VHA FY 2020 appropriation for research into health disparities and barriers to access experienced by LGBT veterans.
- VA must ensure providers are able to meet the health care needs of all LGBT veterans.
- VA must ensure all VA facilities have fully trained LGBT veteran care coordinators.
- VA needs to conduct an outreach campaign for pre-exposure prophylaxis (PrEP).

Background and Justification

According to VHA's Offices of Patient Care Services and Health Equity, an estimated one million LGBT veterans face unique challenges to accessing the quality health care they have earned through their service. As a result, LGBT veterans experience overall lower health statuses. LGBT individuals also experience mental health problems and death by suicide at a higher rate than their heterosexual counterparts. Other high-risk conditions for LGBT veterans include certain cancers, heart disease for gay and bisexual men, as well as intimate partner violence, obesity, and early death from cancer for lesbian and bisexual women. Older LGBT veterans are less likely to receive care from adult children and may experience discrimination in nursing homes or community living centers, or live in fear of such scenarios if their sexual orientation or gender identity is not publicly known. These health disparities also change and worsen for LGBT veterans who are also racial or ethnic minorities. Transgender veterans who are black have increased rates of alcohol abuse, congestive heart failure, HIV, serious mental illness, end-stage renal disease, and other illnesses when compared to white transgender veterans. Just as post-9/11 veterans face different health care challenges than those who served in the Korean War, and just as women veterans face different health care challenges than their male counterparts, LGBT veterans have specific, medically necessary needs that must be met.

Since VHA's first directive for transgender veterans in 2011, the number of veterans enrolling in VHA who identify as transgender has been steadily increasing. To assure providers are able to deliver the highest quality of care to transgender veterans, VHA's current Health Equity Action Plan (HEAP) was established in 2016 to undertake, advance, and achieve equitable health for all veterans who use VHA. The action plan has five key implementation focus areas which consist of (1) awareness, (2) leadership, (3) health system and life experience, (4) cultural and linguistic competency, and (5)

data, research, and evaluation. Implementation focus areas (4) and (5) are the most important for IBVSOs in the 116th Congress.

To improve cultural competency, VHA must improve the diversity of its health-related workforce. While this recommendation was made in 2016 as part of HEAP, there is no current data available regarding VHA's LGBT staffing numbers to note any areas of improvement in diversifying staff. The remaining recommendations are supportive of interactive learning, the inclusion of educational curriculum in training, and partnerships that yield the inclusion of cultural competency into training and activities. Yet, these recommendations have not been addressed in internal directives, such as VHA's Directive 1341, *Providing Health Care for Transgender and Intersex Veterans*, which was established in 2018 and requires no formal training for VHA medical staff.

Some efforts to train staff have been made, and have resulted in minor improvements. For example, the employee education system, VHA TRAIN (Training Finder Real-time Affiliate-Integrated Network), has courses on the introduction to transgender veteran health care and mental health services available for them. Yet, there is little evidence that staff have availed themselves of these courses since 2016. In the meantime, the IBVSOs still hear from veterans using VHA about confusion surrounding questions of protocols for transgender veterans. While these courses are accredited and provide both certificates and credits for medical staff who complete them, more requirements, encouragement, and incentives must be provided.

As directed in VHA Directive 1341, VHA must assure the National LGBT Health Program positions are staffed. This includes the national program director position at the VA Central Office, every LGBT Veterans Integrated Service Networks (VISN) lead, and all LGBT veteran care coordinators.

VHA's HEAP also calls for improving data availability and coordination, utilization, and diffusion of research and evaluation outcomes. Yet, the only National Veteran Health Equity report published in 2016 details VHA care for veterans receiving care in FY 2013. This is the most recent data available based on race/ethnicity, gender, age, geography, and mental health status. Having such minimal and outdated data makes identifying health inequities and systematic failures difficult for LGBT veterans who deserve and are entitled to the same quality of care that all veterans have earned through their service.

One area with timely data is VA pharmacies. Since 2012, when the U.S. Food and Drug Administration approved the first drug to reduce the risk of HIV infection in uninfected individuals who are at high risk of HIV infection, VA has annually increased the number of PrEP prescription rates. In FY 2018, VA pharmacies filled 84,425 30-day equivalent prescriptions at a cost of \$76.1 million. While these prescription rates seem high, they are not nearly high enough for the current population estimates of LGBT veterans. This is why VA must work to conduct a strategic outreach campaign to educate LGBT veterans that PrEP is available at VA pharmacies.



Rural Veterans' Health Care

Recommendations

- VA must expand innovative approaches to ensure better transportation for rural veterans.
- VA's Office of Rural Health (ORH) must receive funding commensurate with its mission of expanding access to a large portion (one-third) of VA's enrolled users.

Background and Justification

Rural populations have difficulty accessing high-quality health care, but for veterans requiring specialized treatment for service-incurred disabilities or conditions, receiving needed care may be even more challenging. Rural populations are generally poorer, older, less likely to have health insurance, and more likely to describe their health status as worse than urban peers. More rural veterans (56 percent) are enrolled in the VA health care system compared to urban veterans (36 percent). Only a

quarter of all veterans live in rural America, yet rural veterans constitute a third of all VA enrollees.

Health care providers cannot sustain operations in many rural areas of the country where the individual's need may be great but the combined population does not have enough need for services to fully engage a health care clinic or provider. Rural populations often rely upon safety net providers — federally qualified health centers (FQHCs), rural

health clinics, critical access hospitals, or other community resources — to address the needs of all community members. Indian Health Service and military treatment facilities also help fill rural health needs but follow stricter eligibility guidelines.

VA has 21 hospitals or medical centers located in rural areas. Community Based Outpatient Centers add another 350 points of access in rural settings. Still, access to health care for rural veterans is a problem, particularly as veterans age, become more disabled, or lose family caregivers. Transportation is one of the most pressing issues for rural veterans. Beneficiary travel funds reimburse eligible veterans for part of their travel expenses, but the reimbursement depends upon the veteran finding an able and available driver and vehicle. Some veterans are able to tap into VSO community resources for the aged and disabled to meet transportation needs but may require assistance in coordinating these services. The White River Junction VA Medical Center in Vermont may offer a model for meeting transportation needs. It has a transportation program that allows veterans to schedule van rides for medical appointments at VA facilities or care

paid for by VA in the community. It uses vans with wheelchair lifts and employs drivers living in different parts of its catchment area to improve coverage. The program takes calls from about 200 veterans daily, demonstrating the tremendous need for such a program.

VA has used telehealth initiatives to reach rural populations, particularly for providing mental health care. Unfortunately, more than a third (36 percent) of rural veterans lack access to the internet at home, which further constrains VA's ability to meet their needs. The web-based technologies that VA routinely uses to monitor and educate so many veterans cannot be used for them in their homes.

VHA's Office of Rural Health (ORH) is charged with developing innovative approaches to addressing veterans' needs and produces a national rural needs assessment. It also develops and funds rural promising practices to offer new models of rural care and provides training to rural health providers. ORH additionally collaborates with other VA programs and federal agencies to develop options for expanding veterans' access to high-quality health care in rural communities.



Black, Hispanic, or Latino, Asian, and Multiracial Veterans

Recommendations

- Congress must provide the funds necessary in the VHA FY 2020 appropriation for research into health disparities experienced by black, Hispanic, or Latino, Asian, and multiracial veterans.
- VA must continue to ensure providers are able to meet the health care needs of all black, Hispanic, or Latino, Asian, and multiracial veterans.

Background and Justification

According to VA's Office of Research and Development, health care is distributed unevenly in the United States. Minority populations often receive less care or care of lesser quality compared to their Caucasian peers.

The minority veteran population makes up 22 percent of all veterans and accounts for over 34 percent of the women veteran population. As the veteran population declines to an estimated 12.9 million by 2040, the minority veteran population is expected to increase from 23 to 24 percent during this time. Some of the health disparities faced by racial and ethnic minorities consist of chronic illnesses such as diabetes and high blood pressure, the highest rates of cancer, and increased diagnosis of mental illness.

There are no simple answers to these disparities. These disparities are prevalent across the entire American healthcare ecosystem and are still demonstrated within VHA, where many financial barriers to receiving care are minimized. With this in mind, VA and Congress are committed to providing veterans with high-quality care in an

equitable manner. To do this, research must be conducted and analyzed on how to eliminate racial and ethnic disparities. Recent research found health disparities amongst racial and ethnic minority veterans for arthritis and pain management, cancer treatment, cardiovascular disease, diabetes, HIV and Hepatitis C, mental health and substance abuse, rehabilitative and palliative care, dental procedures, use of new medical technology, preventive and ambulatory care, and more. VA must also be able to conduct outreach to those who are not actively trying to obtain health care so they can be brought into the system for care. The need is evident as studies published by the *American Journal of Public Health* have found mortality rates are higher for black veterans.

Solving these health disparities will not come with a straightforward or simple solution. While access to health care is certainly a major piece of this puzzle, other factors – including income, life experiences, education, support, and social context are all components of why these disparities exist. VA will not be able to address racial and ethnic health disparities without a holistic approach.



Veterans Justice Outreach Program

Recommendations

- VA and its stakeholders, including Department of Justice (DOJ), should develop clear program objectives, metrics, and outcome measures for the Veterans Justice Outreach (VJO) program.
- VA should commission a gap analysis assessment to determine how well the VJO program is meeting the needs of justice-involved veterans and VA's capacity to assist these veterans.

Recommendations continues

Recommendations continued

- Following a gap analysis assessment, VA should determine the appropriate number of VJO specialists needed to meet the demand for services and build program capacity accordingly.
- VA should work to strengthen partnerships with community providers and recruit peer volunteers to mentor justice-involved veterans during and after treatment.
- VA should determine and disseminate best practices and the most cost-effective means of using program resources.
- VA and DOJ should collect data on gender and race to ensure equity in access and outcomes for all veterans eligible for the Veteran Treatment Courts (VTCs) program and VJO facilitated services.

Background and Justification

VTCs were established in 2009 to offer eligible justice-involved veterans an alternative path diverted from incarceration, and into treatment. The program is modeled on adult drug courts. These have been found to be successful in diverting offenders from the judicial system into treatment, was designed to reduce recidivism, homelessness, and unemployment while helping veterans successfully integrate back into their communities. While these courts operate independently of VA, they are supported by the VA's VJO program. VJO specialists, primarily social workers, work directly with the courts and veteran enrollees to help to coordinate treatment for issues associated with their military service that may have contributed to their involvement with the justice system such as traumatic brain injury, mental health disorders, and/or substance abuse. VJO specialists also help veterans link to supportive services such as transportation, peer mentoring, specialized programs for combat and sexual trauma, and other federal benefits and services for which they may be eligible.

GAO issued a report (*GAO 16-393*) on VA's VJO

program. The report identified 261 full-time employee VJO specialists working within the Department in 2015 — with each medical center having at least one program specialist. The report noted the significant growth in the program over a three-year period, with VJO specialists providing services to about 46,500 veterans in FY 2015 — a 72 percent increase from FY 2012. Congress recently addressed the need for increased staffing for the programs by funding 50 new VJO specialists under Public Law 115-240, the Veterans Treatment Court Improvement Act of 2018. The law also requires a GAO study of VA's court program effectiveness.

While VTCs may be effective, each case requires VJO specialists to monitor and report to the courts about the veteran's progress with treatment over a 12-24 month period. Preliminary evidence suggests that getting justice-involved veterans into treatment can lead to positive outcomes for veteran participants.[1] To determine the overall success of the program, VA should work with the Department of Justice, Homeless Veterans Re-entry Programs, and veterans to establish specific

objectives and performance measures that support the VJO programs' broad strategic goals, and measure long-term outcomes for veterans. It would also be beneficial to identify best practices to ensure consistency and effectiveness of the VJO program at all VA sites.

The IBVSOs also recommend VA track the VJO program participants by gender and race to ensure that they are meeting the needs of all veterans. While women are a minority of justice-involved veterans compared to male veterans in the program, they are generally younger, more likely to have a service-connected disability, mental health needs, and are at higher risk of becoming homeless.[2] Women veterans frequently report histories of abusive relationships and military sexual trauma which may place them at a higher risk of post-traumatic stress disorder. Without data on gender, it is difficult to assess unique challenges or any potential differences in program access or outcomes for women veterans. The IBVSOs urge VA to

collect program data and assess veteran outcomes by gender to ensure women veterans have equal access to this exceptional program and to determine if any adjustments in the program are necessary to effectively serve women veterans.

VJO specialists serve as the facilitator for veterans' entry into VA's Justice Outreach Treatment programs. They have little control over appropriate staffing levels and availability of treatment programs for VTC-eligible veterans, especially for placement in residential substance use disorder treatment facilities and securing housing for sexual offenders. Existing wait times for mental health care, particularly more intensive evidence-based treatment services at some VA facilities, indicate high demand for these specialized services. Growing demand for services and existing program challenges warrant increased resources to establish appropriate staffing levels that reflect demand for services and comfort with the ability of VJO specialists to carry out all their program duties.



Eye Injuries Among OIF/OEF/OND Veterans

Recommendations

- Congress must conduct oversight hearings on the implementation of two DOD/VA Centers of Excellence for Hearing and Vision since these centers were moved to the Defense Health Agency in 2017 and 2018, respectively.
- Congress must conduct oversight of the Defense Veterans Eye Injury Vision Registry (DVEIVR), which is responsible for the electronic coordination of data on patients who have eye injuries within DOD and VHA.
- We recommend that defense appropriations committees include \$20 million for the DOD-peer reviewed Vision Research Program (VRP) in FY 2020.

Background and Justification

Vision is a critical sense for optimal military performance in combat and support positions and is vulnerable to acute and chronic injury in those environments. One consequence of today's battlefield conditions is that 14.9 percent of those who are evacuated due to wounds resulting from an improvised explosive device (IED) blast forces have penetrating eye injuries and traumatic brain injury (TBI)-related visual system dysfunction. Upwards of 75 percent of all TBI patients experience short- or long-term visual disorders (double vision, light sensitivity, inability to read print, and other cognitive impairments). With the continued presence of the U.S. in Afghanistan, as well as other global threats, such eye injuries will continue to be a challenge.[1] The VHA Office of Public Health has reported that for the period of October 2001 through June 30, 2015, the total number of Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans enrolled in VA with visual conditions was 211,350; including 21,513 retinal and choroid hemorrhage injuries (including retinal detachment); 5,293 optic nerve pathway disorders; 12,717 corneal conditions; and 27,880 with traumatic cataracts. The VA continues to see increased enrollment of this generation with various eye and vision disorders resulting from complications from frequent blast related injuries. [2]

VHA data also reveals rising numbers of OEF/OIF/Operation New Dawn (OND)-era veterans with TBI Visually Impaired ICD-10 Codes enrolled in VHA for vision care. In FY 2013, the total number was reported to be 39,908. By FY 2015, that number increased to 66,968 with symptoms of visual disturbances enrolled for care. [3] With an increased number of service members in Iraq, Turkey, Afghanistan, and the war region, we expect this trend to continue. VHA Blind Rehabilitation Services (BRS) also provided BVA with information indicating that as of August 2, 2016, a total of 17,014 OEF/OIF/OND-era veterans have ICD-10 diagnoses (Impairment codes) associated with

visual impairment, low vision, or blindness. [4] VA peer-reviewed research also notes that among OEF/OIF/OND veterans diagnosed with eye conditions, upward of 75 percent of all TBI patients experienced short- or long-term visual dysfunction, including double vision, sensitivity to light, and inability to read print, among other cognitive problems. [5]

DOD's Vision Research Program at Fort Detrick, Maryland, has studied the diagnosis, treatment, and mitigation of visual dysfunction associated with TBI in defense-related vision research, and has identified gaps in the ability to diagnose and treat visual impairments from blasts, along with inadequate treatments for eye-penetrating injuries, vision restoration, epidemiological studies on sight-injured patients, ocular diagnostics, vision rehabilitation strategies, computational models of combat-related ocular injuries, and vision care education and training.

The IBVSOs believe that the DOD Vision Research Program (VRP), existing within the Congressionally Directed Medical Research Programs (CDMRP), must be funded at \$20 million in FY 2020 in order to meet the challenges presented by deployment-related eye injuries. We point out that in addition to the long-term implications such injuries have for vision health, productivity, and quality of life for veterans and their families, they also have a high financial impact on society. VRP funds two types of awards: (1) hypothesis-generating, which investigates the mechanisms of corneal and retinal protection, corneal healing, and visual dysfunction resulting from TBI, and (2) translational research, which facilitates development of critical diagnostics, treatments, and therapies that can be employed on the battlefield to save vision.

In 2012, the National Alliance for Eye and Vision Research released its first-ever *Cost of Military Eye Injury and Blindness* study. Based on published data from 2000–10 and recognizing a range of

injuries from superficial to bilateral blindness, as well as visual dysfunction from TBI, it stated that the annual incident cost has been \$2.3 billion, yielding a total cost to the economy over this time frame of \$25.1 billion — a large portion of which is the present value of future costs such as VA and Social Security benefits, lost wages, vocational rehabilitation, and caregiver and family care benefits. Recently, John Hopkins University reviewed and updated this study to include all worldwide eye injuries and TBI vision disorders up through FY 2016. They found the total cost to the economy to be \$40 billion, and also noted that the number of eye injuries and instances of TBI vision dysfunction are increasing.

The DOD/VA Vision Center of Excellence (VCE) officially transitioned to the Defense Health Agency from Navy BUMED on August 6, 2018. The transition had been planned for the better part of a year and involved both BUMED and DHA. The VCE was transferred whole, without a change in staff makeup (12 DOD and five VHA personnel) or

positions. Col. Mark Reynolds, the director of Army Public Health and an Army ophthalmologist with a history of two combat deployments, was selected to lead the VCE and began August 6, 2018. He brings a strong background in ophthalmology, battlefield surgery, and epidemiology to the VCE. The IBVSOs are concerned about the continued level of operational funding and personnel assigned to the VCE under DHA, and we request congressional oversight by the Armed Services and Veterans' Affairs committees. The Defense Veterans Eye Injury Vision Registry (DVEIVR) started in 2011 and now has 30,000 identified service members' eye injury records. However, the DVEIVR has had challenges over the years related to the transfer of vital eye injury clinical records from VHA to the DVEIVR by VHA contractors. With the decision to implement the joint Cerner Electronic Health Record for DOD and VHA, the IBVSOs are concerned about the ability of not only the DVEIVR but all war related registries to have bidirectional ability to continue to operate during this transition period.



Sections 504 and 508 of the Rehabilitation Act of 1973

Recommendations

- Congress must conduct robust oversight of the VA's compliance with Sections 504 and 508 of the Rehabilitation Act of 1973.
- Congress must hold VA accountable for ensuring that information technology (IT) modernization provides VA with the capacity to communicate effectively with both veterans and VA employees who have reading disabilities.

Background and Justification

There are more than a million veterans in the U.S. who have diagnosed visual disabilities. Additionally, hundreds of VA employees and contractors who deliver programs and services to our nation's veterans also have visual disabilities. Both groups must rely upon the VA's IT infrastructure to make it possible for them to communicate with the VA. Section 508 of the Rehabilitation Act of 1973 directs federal agencies to insure that all electronic and information technologies developed, procured, maintained, or used in the federal environment provide equal access for federal employees and members of the public who have disabilities. VA employees and contractors, as well as veterans who have visual and other print reading disabilities, continue to face daunting challenges when attempting to utilize VA information technologies. The following compliance issues are areas of specific and ongoing concern:

- Inaccessible kiosks at VA Medical Centers, the use of which is required to check in for scheduled appointments.
- Inaccessible telehealth tools, namely the Health Buddy home monitoring station.
- VBA web pages containing eBenefits information that is presented in a manner that is not compatible with assistive technologies, such as screen readers, used by people with visual disabilities.
- The continuing accessibility barriers faced by VA employees with visual disabilities who are forced to use legacy systems that are largely incompatible with adaptive software to do their jobs.
- Inadequate staffing of the VA Office of Section 508 Compliance, to provide VA capacity to address internal and external accessibility issues in a timely manner.

The items listed above are representative of the barriers encountered by both internal and public users of VA's information technologies. We believe that as VA's effort to modernize its IT infrastructure moves forward, accessibility must be a consideration from inception through execution of all IT projects. Both financial and human capital resources are in short supply. The VA cannot afford to squander its resources by continuing the traditional agency practice of implementing inaccessible systems, then retrofitting later in order to make them accessible to intended users. We urge the House and Senate Committees on Veterans' Affairs to conduct robust oversight of VA's compliance with Section 508 of the Rehabilitation Act of 1973 as a key element of any assessment of the sustainability of VA's IT infrastructure.

Furthermore, the IBVSOs urge the members of the Veterans' Affairs Committees to hold VA accountable for adequately staffing their accessibility efforts. We urge VA to dedicate full-time employees to the Section 508 Compliance Office to insure its ability to provide timely responses to the agency's accessibility requirements.

Section 504 of the Rehabilitation Act of 1973 also directs federal agencies to modify their activities, programs, and services to insure they communicate effectively with persons who have disabilities. The VA currently provides a vast amount of information to its employees and to the veterans served by the VA in non-electronic, hard copy print format. In many cases, this print material is intended for and distributed to individuals whom the VA knows cannot and will not be able to read it, because the recipient has a documented visual disability that is known to the VA and which prevents the individual from reading printed material. To date, the VA has made virtually no progress toward building its capacity to communicate effectively with individuals who have such print reading disabilities. This failure can be life threatening to a veteran who is given discharge instructions by VA medical personnel

that he or she cannot read. Likewise, VA employees provided with memoranda in a format they cannot read may face consequences that seriously impact not only their own job performance, but the lives of the veterans the employee is supposed to serve.

As efforts get under way to re-design VA's databases and other information collection and sharing technologies, we urge the VA to build into these upgrades the capability to provide information to visually impaired veterans, as well as employees who have visual disabilities, in alternate formats such as large print, audio recording, email, braille, or other formats, so that the information can be accessed

independently by the individual who receives it.

IBVSOs believe there is no better time to establish policies and practices that would increase VA's capacity to engage in effective, accessible communications with individuals who have print reading disabilities. We urge Congress to conduct robust oversight of the VA's efforts to address this vital issue and hold VA accountable for the effectiveness of their communications with veterans, as well as the members of the VA workforce who have print reading disabilities that preclude their use of documents in standard print format.

Health Care Endnotes

Timely and Comprehensive Mental Health Services

[1] <https://www.va.gov/oig/pubs/VAOIG-17-01846-316.pdf>

[2] <https://www.vfw.org/media-and-events/latest-releases/archives/2015/9/vfw-report-veterans-prefer-va-care>

Electronic Health Record Modernization (EHRM)

[1] <https://www.ehrm.va.gov/library/files/factsheets/EHRMFactsheet.pdf>.

Strategies for Ending Veteran Homelessness

[1] <https://www.hudexchange.info/resources/dpuments/2017-AHAR-Part-1.pdf>.

[2] Disabled American Veterans (2014). Women Veterans: The Long Journey Home.

[3] <https://www.blogs.va.gov/VAntage/53117/va-homless-programs-training-strengthen-efforts-lower-veterans-suicide-rate/>.

[4] Tsai, J., Rosenheck, R.A., Kaspro, W.J., Kane, V. (2015). Characteristics and use of Services Among Literally Homeless and Unstably Housed U.S. Veterans with Custody of Minor Children. *Psychiatr. Serv.* 66(10): 1083-1090.

[5] The GPD program funds community agencies providing services to homeless veterans through grants that organizations may use to build or rehabilitate facilities for transitional housing and service centers, while the per-diem funds supportive services for homeless veterans.

[6] The HUD-VASH program is a collaborative program whereby HUD provides rental assistance through public housing authorities in the form of vouchers for privately owned housing, while VA provides case management services to homeless veterans.

[7] The SSVF program is a VA program that provides grants to community based programs to provide supportive services to very low-income veterans' families who are at risk of losing stable housing or are transitioning to permanent housing.

[8] The Health Care for Homeless Veterans (HCHV) program connects homeless veterans with VA health care and other needed services. This program also provides outreach and case management for special populations such as chronically homeless veterans with serious mental health and SUDs.

Spinal Cord Injury and Disorder (SCI/D) Care

- [1] VA, VHA, *Spinal Cord Injury and Disorders System of Care*, VHA Handbook 1176.01, February 2011, 36, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2365.

Amyotrophic Lateral Sclerosis (ALS)

- [1] VA, Agent Orange Review 25, no.1 (July 2010), www.publichealth.va.gov/exposures/agentorange.

Reproductive and Sexual Health

- [1] PL 114-223, Sec. 260, www.congress.gov/bill/114th-congress/house-bill/5325/text.
- [2] 38 CFR 17.38(c)(2), <https://www.law.cornell.edu/cfr/text/38/17.38>.
- [3] 1074(c)(4)(A), Title 10, USC, “Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members,” April 3, 2012.
- [4] Beaulieu, G. R., Latini, D. M., Helmer, D. A., Powers-James, C., Houlette, C. and Kauth, M. R. (2015), “An Exploration of Returning Veterans’ Sexual Health Issues Using a Brief Self-Report Measure.” *Sexual Medicine*, 3: 287–294. doi:10.1002/sm2.92.

American Indian and Alaska Native Veterans

- [1] U.S. Census Bureau, American Community Survey, Public Use Microdata Sample, 2010. Prepared by the National Center for Veterans Analysis and Statistics.
- [2] Indian Health Service Fact Sheet, <https://www.ihs.gov/newsroom/factsheets/disparities/>
- [3] National Congress of American Indians, November, 2013, <http://files.ncai.org/broadcasts/2013/November/bb%20-%20Veterans.pdf>
- [4] Ibid.
- [5] Broken Promises: Evaluating the Native American Health Care System, U.S. Commission on Civil Rights (September 2004): 77-80; and Frequently Asked Questions about the Native Domain, Veterans Health Administration: Office of Rural Health, <http://www.ruralhealth.va.gov/native/faqs.asp>, accessed June 2, 2014.
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- [8] Department of Veterans Affairs, Office of Tribal Government Relations, 2017 Executive Summary Report

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- [2] <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0029>
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Benefits

Implementation and Modernization of Claims and Appeals Processing

For a long time, the Department of Veterans Affairs (VA) had a complex claims and appeals system. This “legacy” system divided jurisdiction amongst VA’s three administrations and the Board of Veterans’ Appeals (BVA), creating a confusing process with many unnecessary steps. Over time, this complex process contributed to lengthy waits for veterans with appeals before the Board.

To address this untenable situation, *The Independent Budget* veterans service organizations (IBVSOs) worked closely with VA and Congress to develop the Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act), which was enacted in August 2017. The law creates a new system with three review options:

- A “higher-level review” by a more senior claims adjudicator
- A “supplemental claim” option for new and relevant evidence
- An “appeal” option for review by the Board of Veterans’ Appeals

Under the new framework, claimants may choose the option that meets their needs. If properly implemented, this new framework will reduce the time it takes to process, review, and make a final determination, all while ensuring veterans receive a fair decision. Additionally, the new framework includes safeguards to ensure claimants receive the

earliest effective dates possible for their claims.

The Appeals Modernization Act is scheduled to become fully effective February 14, 2019, and vigilant oversight is required for successful implementation. The new Act sets forth specific elements that VA must address in its comprehensive implementation plan. The IBVSOs believe that a continued, strong and close collaboration with VA and Congress is vital to ensuring the implementation and utilization of the new appeals system is conducted with maximum transparency and effectiveness. VA must also provide clear metrics to measure the progress and success of appeals and claims reform and strengthen Congress’s ability to hold VA accountable for meeting targets and goals.

VA has met with stakeholders repeatedly as the agency works toward implementation. We view this as a positive sign and encourage VA to continue including the IBVSOs and other stakeholders in developing, implementing, and overseeing any new or existing transformation initiatives. As the representatives of more than a million veterans, veterans service organizations (VSOs) have tremendous experience and expertise in claims and appeals processing through service programs, and are active partners inside VA Regional Offices (VAROs) helping to improve the quality and accuracy of decisions. Neither veterans nor VA can afford appeals reform to fail. We urge Congress to use its oversight authority to make sure stakeholder voices continue to be heard.

Culture

Changing the law is one thing, changing the culture in VA workplaces is another. VA has used production goals and other metrics to drive down the backlogs of claims and appeals and

provide timely decisions. We strongly caution VA against placing too much emphasis solely on quantity without equal emphasis on comprehensive training and quality review.

As evidenced by the Office of the Inspector General’s report of July 18, 2018, *Unwarranted Medical Reexaminations for Disability Benefits* and the reports of August 21, 2018, *Denied Post-traumatic Stress Disorder Claims Related to Military Sexual Trauma*, and *Processing Inaccuracies Involving Veterans’ Intent to File Submissions for Benefits*, lack of training and improper quality review of claims decisions led to multiple denied claims, reduced benefits, unnecessary examinations, and inaccurate effective dates for claimants. The IG recommended, and we agree, that mandated training and improved quality review would correct many of these issues as well as help to reduce appeals.

Veterans Benefits Administration (VBA) and BVA should collaborate over training on key issues that seem to be denied by the VARO only then to be granted by the Board. For example, many VARO employees indicate that the holdings of the Court of Appeals for Veterans Claims (CAVC) do not apply to their decisions at the VARO and that the Board has more latitude in applying these precedent opinions. However, VA’s M21-1 Manual instructs VARO employees to carefully review the appeal

and correct any errors or deficiencies that may exist based on the cited CAVC decision. When adjudicators are not correctly applying the M21-1, proper and more frequent training provided to VARO employees could reduce future appeals.

BVA recently announced plans to reorganize the role of BVA chief judges who provide oversight, quality review, and training to other BVA judges and attorneys. While we support the Board using its resources efficiently, the IBVSOs are concerned that the elimination of the chief judge role may create a knowledge, training, and oversight vacuum within the Board.

VA, at all claims and appeals levels, must simultaneously focus on timeliness, accountability, the overall claimant experience, and a heightened emphasis on quality. Training and feedback are instrumental in shifting VA’s culture to one primarily driven to achieve quality, rather than merely productivity. After all, proper quality review, training, and feedback will lead to more claims decisions being made right the first time, and thereby lead to a reduction of appeals.

Disability Benefits Questionnaires (DBQs)

In 2010, VA developed DBQs to streamline the collection of medical evidence necessary for processing veterans’ claims and now uses DBQs for all VA Compensation and Pension examinations. DBQs also provide claimants with an improved means to submit private medical evidence to support their claims. Clinicians who are treating veterans and are familiar with their conditions can speed up the claims process by completing DBQs for their patients. By using standardized “check-the-box” DBQs rather than generating long narrative summaries, VBA has been able to reduce the time it takes to make a claims decision.

DBQs used by VBA are separate and distinct from the publicly available “public-facing DBQs”

(as termed by the VA). Claimants and VSOs can use public-facing DBQs for private medical examinations. VBA DBQs are consistently updated to reflect any changes to the VA Schedule for Rating Disabilities. Publicly available DBQs for private exams are not consistently updated, in part because they must be submitted to and approved by the Office of Management and Budget (OMB), which can be a time-consuming process.

To avoid overburdening the public with federally sponsored data collections, the Paperwork Reduction Act (PRA) of 1995 requires that U.S. federal government agencies obtain OMB approval before requesting or collecting most types of information from the public. This process includes

publication in the Federal Register for public review and comments before final approval.

VBA has indicated an intention to eliminate publicly available DBQs used by veterans for private exams due to the time and resources required to gain OMB approval and keep them updated. Additionally, VBA officials have stated that there is a significant level of fraud in private DBQ submissions. The IBVSOs are deeply troubled by VBA's decision to eliminate public-facing or the publicly available DBQs for private medical exams. DBQs were intended to simplify the documentation of medical conditions and eliminate, in some instances, the need for a VA Compensation and Pension Examination, thereby removing workload

from VBA and allowing quicker decisions.

The IBVSOs have not seen any credible evidence that there is either widespread or systemic fraud resulting from private physicians completing DBQs, and we reject this rationale for eliminating public-facing DBQs. To address concerns about the regulatory burden and delays required to update DBQs, we recommend that Congress enact legislation to exempt DBQs from the PRA. DBQs have proven successful in standardizing medical evidence and allowing veterans to participate in the development of their claims, and the IBVSOs strongly believe that this ability must be protected and preserved.

Quality Control for Board Remands After Appeals Modernization Act Implementation

The Appeals Modernization Act will eliminate remands by the Board except when necessary to correct duty to assist errors as noted in 38 U.S.C. § 5103A. However, unlike the legacy appeals system, these remands will not be returned to the Board when the duty to assist errors have been addressed by the VA Regional Office (VARO) of jurisdiction. We are concerned that without verification of the completeness of the remand, it will be difficult for veterans and their representatives to be sure duty to assist errors are corrected in this new system.

Under the legacy appeals system, there will continue to be remands for specific reasons set forth by the Board decision, and these remands will return to the Board for action. The Court of Appeals for Veterans Claims held in *Stegall v. West*, 11 Vet. App. 268, 271 (1999), that in general, a remand by the Board confers upon the veteran, as a matter of law, the

right to compliance with Board remand directives and imposes upon VA a concomitant duty to ensure compliance with the terms of the remand.

The Board reports that for Fiscal Years (FY) 2016, 2017, and 2018, of the 87,848 remanded cases, 37,489 were remanded multiple times due to non-compliance with the original Board remand. For the last three years, nearly 35 percent of the remanded cases were improperly addressed. There is no reason to believe that VAROs will not continue to make such errors in fulfilling remand orders.

The IBVSOs are concerned with the potential for multiple *Stegall* violations if remands do not have a consistent quality review, and we recommend that VA develop programs to review how BVA remands are treated and to provide feedback to adjudicators to minimize future repeat remands.

VA Must Notify Claimants on Evidence Received After Decision and Outside Appeals Modernization Time Limits

As required by the Appeals Modernization Act, the evidentiary record for a claim before the agency of original jurisdiction (AOJ) closes when VA issues notice of a decision on the claim. The AOJ will not consider, or take any other action, on evidence submitted by a claimant after notice of decision on a claim.

Under 38 U.S.C. § 5103A(e)(1), the duty to assist a claimant “shall apply only to a claim, or supplemental claim, for a benefit under a law administered by the Secretary until the time that a claimant is provided notice of the agency of original jurisdiction’s decision with respect to such claim, or supplemental claim....”

We do not disagree with the evidentiary record closing after a notice of a decision on a claim as the statute requires. The IBVSOs do take issue with the VA choosing not to notify the claimant of the receipt of the evidence if the evidence is submitted outside the statutory periods. VA still has a responsibility to notify the claimant separate from the duty to assist. VA should be required to notify the claimant when the evidence is received after the decision, and to advise on the types of actions or claims they can take based on the submission of such evidence.

As part of the Appeals Modernization Act, a Notice of Disagreement (NOD) will now be filed directly

with the Board of Veterans’ Appeals. Appellants may choose one of three options or dockets when filing their NOD. They can choose not to submit any new evidence and not to elect a hearing; they can choose to submit new evidence only but not request a hearing; or they can choose to elect a hearing at which they may also submit new evidence.

If the appellant elects to submit evidence only, they will have 90 days from the date the Board received the NOD to submit evidence. If the appellant elects a BVA hearing, they will be able to submit evidence at the hearing and for 90 days thereafter.

We understand the evidentiary record will be closed with the expiration of 90 days after the NOD and 90 days subsequent to a hearing. However, the IBVSOs take issue with the Board remaining silent and choosing not to notify the appellant of the receipt of the evidence prior to a Board hearing or subsequent to the expiration of the 90-day period.

The Board should be required to advise the appellant on the types of actions available based on the evidence submission or if the evidence needs to be presented at the hearing to be considered by the Board. The VA’s obligation to notify does not apply solely to the development of a claim but applies to the overall VA claims process, thus, the VA has a responsibility to notify the appellant of any evidence they receive outside of the required time limits.

Amend Appeals Modernization Act to Require VA Have “Clear and Unmistakable Evidence” to Overturn Previous Favorable Finding

Once the Appeals Modernization Act becomes fully effective on February 14, 2019, 38 U.S.C. §5104A will require that: “any finding favorable to the claimant as described in section 5104(b)(4) of this title shall be binding on all subsequent adjudicators within the Department, unless clear and convincing evidence is shown to the

contrary to rebut such favorable finding.”

Therefore, any finding favorable to the claimant can be changed by the VA on a lesser evidentiary standard than required for a claimant to change a previous finding.

The Court of Appeals for Veterans Claims in *Fagan v. West*, 13 Vet. App. 48, 55 (1999), clarified the definition of “clear and convincing” evidentiary standard of proof as an intermediate standard between preponderance of the evidence and beyond a reasonable doubt.

For a claimant to change previous decisions or findings, they must do so with “clear and unmistakable” evidence as noted in the current provisions of 38 C.F.R. § 3.105(a). The Court held in *Vanerson v. West*, 12 Vet.App. 254, 258-59 (1999), “clear and unmistakable” evidence means that the evidence “cannot be misinterpreted and misunderstood, i.e., it is undebatable.” This is the highest evidentiary standard used by the VA.

The clear and convincing standard requires proof to a “reasonable certainty” but not necessarily that it

be “undebatable.” Once this statute and subsequent regulations take effect, it would allow the VA to change a claimant’s previous favorable finding with a lower burden of proof, “clear and convincing” evidence, while requiring a claimant to provide the highest burden of proof to overcome VA decisions, “clear and unmistakable” evidence. This creates an inequity that benefits the VA and not the claimant. We do not believe it was Congress’s intent to place claimants at a disadvantage, yet that is the result, and we urge an expeditious resolution to this issue.

The IBVSOs recommend that Congress amend the Appeals Improvement and Modernization Act to change the evidentiary requirement of “clear and convincing” evidence to “clear and unmistakable” evidence so the same legal standard is applied to both claimants and VA.

Properly Implement and Utilize IT

Updated and modern IT is critical to the smooth implementation and ultimate success of appeals and claims reform. 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 them with streamlined business processes supported by modern IT systems. The Board too must rely on new and customized IT solutions to support its transition to the new appeals system as well as maintain a legacy system for years to come. However, unless VBA and the Board are provided sufficient resources to fully implement and program new IT systems at the front end of these transformations, both productivity and quality will continue to suffer, resulting in more veterans waiting longer to receive their earned benefits.

Over the past several years, both VBA and the Board have developed and implemented new IT systems to support the transformations, including the Veterans Benefits Management System (VBMS), National Work Queue (NWQ), Case Flow and

eBenefits. Unfortunately, VBA and the Board must compete with other offices and agencies within VA for the limited IT funding available each year, delaying development and deployment of critical IT systems and programming. As a result, critical IT systems are rarely fully developed before business process changes are implemented. Instead, they are phased in over several years, forcing VBA and the Board to rely on an inconsistent mix of old and new IT systems, as well as an endless stream of suboptimal “work around” solutions. While it may be understandable from a purely budgetary view to stretch out development and deployment of new IT systems, it is a failure from a functional perspective.

Providing only partial IT solutions inevitably results in a loss of productivity, and often leads to lower quality and less accurate decisions on claims and appeals by veterans. Similar problems caused by inadequately developed technology can be seen in the VA’s Vocational Rehabilitation and Employment’s (VR&E) \$12 million IT debacle and the Education Service’s continuing problems in

making accurate payments under the new GI Bill program.

IT requirements to allow VSO stakeholders to have full and seamless access to veterans' files are typically relegated to the end of the IT funding priority list. This often results in long delays by VA in recognizing power of attorney (POA) representation by VSOs, hindering our ability to effectively represent veterans, and further lowering quality and productivity. VA must place greater priority on VSO requirements. VA must implement all changes necessary to ensure that when a veteran gives POA to a VSO to represent them, that VSO must receive immediate access to all relevant VBA IT systems and databases.

VBA and the Board must also ensure that new IT systems and technologies are “smartly implemented.” For example, the National Work Queue (NWQ) provides VBA the ability to quickly move and balance workload among VAROs and employees to increase productivity. As the recent IG report on military sexual trauma (MST)-related claims found: When these complex claims are randomly distributed to the next available Veterans Service Representative (VSR) or Rating Veterans Service Representative (RVSR) through the

NWQ, without consideration of their applicable expertise and experience with this sensitive issue, the quality of decisions suffered. Recent OIG reports cited above also offer examples of how “smart” use of technology can improve quality. For example, the OIG has reported on a number of errors committed in VAROs that could and should have been prevented, such as unwarranted medical reexaminations for disability benefits and processing errors involving veterans' Intent to File (ITF) submissions. Better IT development and programming could reduce these types of errors.

Unfortunately, both VBA and the Board have long lists of pending IT funding requests forcing them to prioritize and thereby delay many IT projects that could have led to better, more timely decisions for veterans. In order to achieve the full gains in both productivity and quality possible during claims and appeals modernization, the IBVSOs recommend that Congress provide VBA and the Board with full funding upfront to develop new IT systems and reprogram existing ones. Further, VBA and the Board must constantly review IT systems and technologies to ensure they are being “smartly” used to achieve the highest quality and accuracy of decisions possible, and not just focused on increasing speed or productivity.

VA Must Notify Claimants on Duplicate Intent to File (ITF) Forms

A claimant may indicate their desire to file a claim for benefits by submitting an ITF to VA. If VA receives a complete application appropriate to the benefit sought within one year of receipt of the ITF, VA will consider the complete claim filed as of the date the ITF was received. Upon receipt of the ITF, VA provides the claimant with the appropriate application form and a notice of receipt.

VA will not recognize more than one ITF concurrently for the same benefit (e.g., compensation, pension). If an ITF has not been followed by a complete claim, a subsequent ITF

regarding the same benefit received within one year of the prior ITF will have no effect. Currently, if the claimant submits another ITF within the one-year period, VA does not provide any notification of the duplicative ITF and the claimant and their representative may falsely believe that they have one year to file a completed claim.

There are multiple ways for a claimant to present an ITF to the VA and each method may lead to inaccurate information being relayed to the claimant. For example, if a claimant calls the VA at 1-800-827-1000, he or she may initiate an ITF.

Should the same claimant then access his or her eBenefits account six months later, he or she would acknowledge a page that indicates they will have one year from the date they access that page to formalize the claim, which is inaccurate as the VA will recognize this as a duplicate ITF.

In many cases, this has led claimants to submit their claim after the expiration of the one-year timeline from the first ITF. This has resulted in claimants

receiving less retroactive benefits since the effective original ITF is not honored, and a duplicate ITF does not start a new timeframe or extend any initial time frame. The IBVSOs are deeply concerned over VA's decision to remain silent upon the receipt of a duplicate ITF within the one-year period, and we believe VA should be required to notify all claimants when a duplicate ITF is received, and any actions necessary on the claimant's part to protect their effective date.



Burn Pit Exposures

Recommendations

- Congress, Department of Defense (DOD), and VA should continue to advance research, commission studies, and maintain registries of veterans exposed to burn pits. The risks of the exposure needs to be continually reviewed and studied to determine any diseases or long-term health effects resultant of exposure to burn pits.
- Veterans from all eras and conflicts who served in areas where burn pits were known to have operated including veterans of the Operations Desert Shield/Desert Storm and veterans of Operation Joint Endeavor, those who served in Southwest Asia prior to September 11, 2001, and those who served in Djibouti after September 11, 2001, should be considered for inclusion, if appropriate, in all legislation regarding burn pit exposures.
- Congress should enact legislation to concede certain veterans' exposure to burn pits.

Background and Justification

Continued Research, Studies and Registries

DOD has acknowledged the vast use of burn pits to dispose of nearly all forms of waste. Several studies have indicated that veterans were exposed to burned waste products including, but not limited

to: plastics, metal/aluminum cans, rubber, chemicals (such as paints, solvents), petroleum and lubricant products, munitions and other unexploded ordnance, wood waste, medical and human waste,

and incomplete combustion by-products. The pits did not effectively burn the volume of waste generated, and smoke from the burn pit blew over bases and penetrated all living areas/quarters.

DOD has performed air sampling at Joint Base Balad, Iraq and Camp Lemonier, Djibouti. Most of the air samples have not shown individual chemicals that exceed military exposure guidelines. The air sampling performed at Balad and discussed in an unclassified 2008 assessment tested and detected all of the following: (1) Particulate matter; (2) Polycyclic Aromatic Hydrocarbons (PAH); (3) Volatile Organic Compounds (VOC); and (4) Toxic Organic Halogenated Dioxins and Furans (dioxins).

Twenty-two of the VOCs and PAHs affect the respiratory system; 20 affect the skin; at least 12 affect the eyes; and others affect the liver, kidneys, central nervous system, cardiovascular system, reproductive system, peripheral nervous system, and GI tract. In at least seven, dermal exposure can greatly contribute to overall dosage.

The National Academy of Medicine's (NAM), formerly the Institute of Medicine, October 31, 2011, report, *Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan*, found limited but suggestive evidence of a link between exposure to combustion products and reduced lung function. The report also found inadequate or insufficient evidence of a relation between exposure to combustion products and cancer, respiratory diseases, circulatory diseases, neurological diseases, and adverse reproductive and developmental outcomes.

The VA launched the Airborne Hazards and Open Burn Pit Registry in June 2014 to allow eligible veterans and service members to document their exposures and report health concerns through an online questionnaire. As of December 10, 2018,

163,935 veterans and service members completed and submitted the registry questionnaire.

In February 2017, the National Academies of Sciences, Engineering, and Medicine released the congressionally-mandated report, *Assessment of the Department of Veterans Affairs Airborne Hazards and Open Burn Pit Registry*. The conclusion noted, "As its analysis has made clear, though, there are inherent features of registries that rely on voluntary participation and self-reported information that make them fundamentally unsuitable for addressing the question of whether these exposures have, in fact, caused health problems." This clearly indicates the Airborne Hazards and Open Burn Pit Registry alone is insufficient to link any long-term health effects to burn pits exposure.

The Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act 2019, signed into law by President Trump on September 21, 2018, provides \$5,000,000 for Veterans Health Administration (VHA) clinical proposals, developed in conjunction with research, focusing specifically on post deployment health for veterans exposed to airborne hazards and open burn pits.

In October 2018, the VA announced they are contracting with the NAM to provide a comprehensive study of burn pit effects. The study is expected to be issued in 2020.

As evident by the numerous toxins and hazardous chemicals emitted by burn pits, the limited but suggestive findings of the NAM 2011 study, *Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan*, and the continuing and new studies being undertaken, the risks of the exposure to burn pits needs to be continually reviewed and studied to determine any diseases or long-term health effects resulting from exposure to burn pits.

Veterans From All Eras Exposed to Burn Pits

Concerns about possible health risks associated with smoke from open-air waste burning can be traced back to Operations Desert Shield/Desert Storm in 1990–1991. During Operations Desert Shield/Desert Storm, burn pits were utilized not only in Iraq but also in Kuwait, Oman, Qatar, United Arab Emirates, Saudi Arabia, and Bahrain. In response to a constellation of unexplained symptoms and illnesses reported by returning Persian Gulf War veterans, DOD, VA, and Congress sponsored a series of studies to examine these symptoms. These studies indicated that exposures to smoke from oil-well fires and from other combustion sources, including waste burning, were stressors for troops.

During Operation Joint Endeavor in Bosnia in 1995–1996, military preventive-medicine personnel recognized that open burning of waste might be an operational necessity during combat operations. They recommended that burning should be limited, and open-air waste burning in Bosnia and Kosovo was eventually replaced with incinerators.

The VA Airborne Hazards and Open Burn Pit

Registry notes that eligible veterans are those who served in:

- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn.
- Djibouti, Africa on or after September 11, 2001.
- Operations Desert Shield and/or Desert Storm.
- Southwest Asia theater of operations on or after August 2, 1990.

Several pieces of past and current legislation have been specific to post-9/11 veterans. As noted, however, veterans of Operations Desert Shield/Desert Storm and Operation Joint Endeavor, and veterans who served in Djibouti after September 11, 2001, have been acknowledged by the DOD as being exposed to burn pits. Congress needs to include these groups of veterans and those veterans from all eras and conflicts who served in areas where burn pits were known to have operated when considering legislation for burn pits exposures.

Legislation to Enact A Concession Burn Pit Exposure

The National Academy of Medicine (NAM) 2011 study, *Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan*, found limited but suggestive evidence of a link between exposure to combustion products and reduced lung function. The report also found inadequate or insufficient evidence of a relation between exposure to combustion products and cancer, respiratory diseases, circulatory diseases, neurological diseases, and adverse reproductive and developmental outcomes.

VA currently does not provide presumption of service connection for diseases related to burn pit exposure. Continuing research may establish such

links and should be pursued. Existing statutes do not concede exposure to toxins from burn pits. The 2011 NAM study did not provide sufficient evidence of links between burn pit exposure and resultant diseases or illnesses. Thus, veterans must establish direct service connection for their illnesses or diseases related to burn pit exposure.

In order to establish direct service connection for a related illness or disease, there must be (1) medical evidence of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury, or evidence of exposures; and (3) evidence of a nexus between the claimed in-service disease or injury or

exposure and the current disability.

This criteria requires veterans to prove their exposure and to obtain medical opinions linking their diseases or illnesses to burn pit exposures. As the VA does not even concede exposure to burn pits, veterans must provide proof of their exposure. If a veteran is able to prove exposure to burn pits, then they must obtain a medical opinion linking their disease or illness to the exposure. Obtaining a medical opinion with a medical or scientific rationale can be difficult if medical professionals are not aware of the actual chemicals and toxins emitted from burn pits. Both of these requirements can create significant obstacles for veterans obtaining direct service connection for diseases and illness due to burn pit exposures.

The VA is seeking from NAM an additional comprehensive study on the long-term health effects of burn pits with any correlating illness or diseases. It is expected to be completed in 2020. This means that we are still years away from potentially establishing presumptive diseases related to conceded burn pit exposures.

In the interim, Congress should enact legislation to concede burn pit exposure. A concession of burn pit exposure will not establish presumptive service

connection. It will, however, remove the obstacles of veterans proving their individual exposure to burn pits and the types of toxins emitted for claims based on direct service connection.

The concession of exposure should include the same veterans currently eligible to join the VA Airborne Hazards and Open Burn Pit Registry. It should concede their exposure to burn pits and to the same chemicals and toxins noted in VA's M21-1 Manual, including but not limited to:

- (1) Particulate matter;
- (2) Polycyclic Aromatic Hydrocarbons (PAH);
- (3) Volatile Organic Compounds; and
- (4) Toxic Organic Halogenated Dioxins and Furans (dioxins).

Congress should enact legislation to concede burn pit exposure as it will remove the obstacles of veterans proving their individual exposure to burn pits and the types of toxins emitted for claims based on direct service connection. A concession of exposure will also ease potential presumptive service connection implementation by having defined those veterans exposed and the location of exposure.



Agent Orange: Exposures, Presumptive Diseases, and Definitions

Recommendations

- Congress should enact legislation to concede herbicide exposure to Vietnam War veterans who served in the waters offshore of Vietnam, commonly referred to as Blue Water Navy veterans.

Recommendations continues

- The VA should, by regulation, include the additional presumptive diseases for Agent Orange exposure as recommended by the National Academy of Medicine (NAM).
- Congress should enact legislation to concede Agent Orange exposure for veterans who served on or near the Korean Demilitarized Zone (DMZ) earlier than April 1, 1968, and later than August 31, 1971.
- Congress should enact legislation to concede Agent Orange exposure to Vietnam era veterans with service on military bases in Thailand.
- Congress must not redefine herbicides as those solely used in Vietnam.

Background and Justification

Blue Water Navy Vietnam Veterans

In 1990, the Center for Disease Control (CDC) concluded the Selected Cancer Study which showed that Vietnam veterans are at a 50 percent increased risk for non-Hodgkin's lymphoma. The risk was even higher with those who served in the U.S. Navy offshore. Subsequently, VA published 38 C.F.R. § 3.313 that recognizes non-Hodgkin's lymphoma for those who served in the waters offshore of Vietnam.

When the VA implemented the Agent Orange Act of 1991, they determined that veterans who received the Vietnam Service Medal, including those who served in the waters offshore, were exposed to Agent Orange. In 1993, a VA General Council Opinion held that veterans with service in the waters offshore were exposed to Agent Orange.

The Veterans Benefits Improvements Act of 1996 extended the war-time period for service in Vietnam. Subsequently, a VA General Council Opinion in 1997 determined that this implied that only veterans who physically served in Vietnam were exposed to Agent Orange. In 2002, the VA

updated its manual reiterating that exposure to Agent Orange was conceded only to those physically in Vietnam. The decision to exclude Blue Water Navy veterans from exposure to Agent Orange was not based on science.

The NAM's 2008 update to its study, *Veterans and Agent Orange* stated that, "given the available evidence, the committee recommends that members of the Blue Water Navy should not be excluded from the set of Vietnam-era veterans with presumed herbicide exposure."

In 2011, NAM convened the Blue Water Navy Vietnam Veterans and Agent Orange Exposure Committee to address Agent Orange exposure for Blue Water Navy veterans. Its report found that, "information to determine the extent of exposure experienced by Blue Water Navy personnel was inadequate, but that there were possible routes of exposure."

In 2016, NAM determined that, "the observed distributions of these most reliable measures of

exposure [to TCCD] make it clear that they cannot be used as a standard for partitioning veterans into discrete exposure groups, such as service on Vietnamese soil, service in the Blue Water Navy, and service elsewhere in Southeast Asia.”

Based on a 1990 CDC Study, the VA conceded Agent Orange exposure to Blue Water Navy veterans. For a decade, Blue Water Navy veterans were eligible for and received presumptive service-connection. The VA administrative decision

in 2002, not based on science or law, chose to eliminate Agent Orange exposure to the waters offshore of Vietnam. However, now, the VA states there is a lack of science to concede Agent Orange exposure to Blue Water Navy veterans.

Congress should enact legislation to concede herbicide exposure to Vietnam veterans who served in the waters offshore of Vietnam to address the inequity and injustice for Blue Water Navy veterans.

Additional Presumptive Diseases for Agent Orange Exposure

To address diseases related to herbicide exposure, Congress passed the Agent Orange Act of 1991. The act directed VA to presume a service-connected disability for conditions the National Academy of Sciences deemed related to Agent Orange exposure. However, in October 2015, the Agent Orange Act of 1991 expired and it was not renewed by Congress.

The National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM), published the *Veterans and Agent Orange* update in 2016. The committee concluded that the information assembled constituted compelling evidence for adding bladder cancer and hypothyroid conditions. Further, the study clarified that Vietnam veterans with “Parkinson-like symptoms”, but without a formal diagnosis of Parkinson disease, should be considered under the presumption that Parkinson’s disease.

The report noted that although VA has not found hypertension to be presumptively related to service in Vietnam, the committee reaffirmed the conclusions of previous studies that hypertension should be placed in the category of limited or

suggestive evidence of association. On November 1, 2017, the VA issued a press release noting they were exploring these new presumptive conditions related to herbicide exposure. To date, the VA still has not added the NAM recommended presumptive diseases, nor has the VA provided an update to its 2017 press release.

In November 2018, NAM released the report, *Veterans and Agent Orange: Update 11*. The report concludes that there is sufficient evidence of an association between Agent Orange and the development of hypertension and monoclonal gammopathy of undetermined significance (MGUS).

The VA should include bladder cancer, hypothyroidism, “Parkinson-like symptom” hypertension, and MGUS as additional presumptive diseases for Agent Orange exposure as recommended by NAM. Since the Agent Orange Act of 1991 has expired, we urge Congress to enact legislation to establish a presumptive disability decision-making process that will effect Agent Orange exposure and all future exposures and resultant presumptive diseases or illnesses.

Agent Orange on the Korean Demilitarized Zone (DMZ)

Agent Orange was also used on the Korean DMZ. The DOD defoliated the fields of fire between the front line defensive positions and the south barrier fence. The size of the treated area was a strip of land 151 miles long and up to 350 yards wide from the fence to north of the civilian control line. Herbicides were applied through hand spraying and by hand distribution of pelletized herbicides. Although restrictions were put in place to limit potential for spray drift, run-off, and damage to food crops, records indicate that effects of spraying were sometimes observed as far as 200 meters down wind.

In 2003, Public Law 108-183 established spina bifida as a presumptive disease for children of veterans exposed to Agent Orange in or near the DMZ. It defines potentially-exposed veterans as those who served in the active military, on or near the DMZ, as determined by the Secretary of VA in consultation with the Secretary of Defense, during the period beginning on September 1, 1967, and ending on August 31, 1971.

Currently, there are no laws conceding Agent Orange exposure for veterans who served on or near the Korean DMZ. However, regulations published in 38 C.F.R. § 3.307(a)(6)(iv) note that if a veteran served on or near the Korean DMZ between April 1, 1968, and August 31, 1971, exposure is conceded and thus the veteran can establish service connection for the established presumptive diseases.

The U.S. Military Advisory Group's Vegetation Control Plan (CY-68) reveals that Agent Orange was used in 1967 and 1968 in trial application in the U.S. Army 2nd Infantry Division and Republic of Korea Army 21st Infantry Division regions between October 9 and 19, 1967. Based on the U.S. Military Advisory Group's Vegetation Control Plan, the Republic of Korea recognizes October 9, 1967 as the earliest date of exposure to Agent Orange on the DMZ for their veterans.

In July 2016, the South Korean Daejeon District Court determined that this includes the 3rd Infantry Division GOP region in 1967 with evidence in the form of a Class 3 confidential military document reporting "suspected application" of Agent Orange.

As noted, children of veterans with spina bifida are eligible for benefits based on the veteran's exposure as early as September 1, 1967. The VA currently only recognizes April 1, 1968, as the earliest date of exposure for a veteran to establish their own presumptive service connection. Congress needs to enact legislation to establish an exposure date earlier than April 1968, as the earliest date of exposure to Agent Orange on or near the Korean DMZ. This would alleviate the inequity created by regulation and be consistent with evidence of Agent Orange use in 1967 on the Korean DMZ.

In reference to the end date of Agent Orange exposure on the Korean DMZ, VA regulatory provisions currently recognize August 31, 1971. For Vietnam veterans, the current law concedes exposure to Agent Orange in Vietnam from January 9, 1962, to May 7, 1975. The end date is four years after the last application of Agent Orange. For exposure to Agent Orange on or near the Korean DMZ, the end date of exposure is August 31, 1971, which is two years after last application.

Research has shown that the dioxin in Agent Orange has a half-life of one to three years in surface soil and up to 12 years in interior soil. The toxicity of dioxin is such that it is capable of killing newborn mammals and fish at levels as small as five parts per trillion (or one ounce in six million tons). Dioxin's toxic properties are enhanced by the fact that it can enter the body through the skin, the lungs, or through the mouth.

Agent Orange used on the Korean DMZ did not lose its efficacy on August 31, 1971. It continued to be absorbed into the bodies of the troops who

were operating on or near the Korean DMZ. The end date of exposure should be later than August 31, 1971. It should be at least four years after the

last date of application as this is in line with the end date of exposure conceded in Vietnam.

Agent Orange in Thailand

A DOD 1973 report, *Contemporary Historical Examination of Current Operations (CHECO) Southeast Asia Report: Base Defense in Thailand 1968-1972*, acknowledges the use of tactical herbicides on Thai Royal Air Force and Army bases. The report notes the significant use of Agent Orange to remove foliage that provided coverage for enemy forces on the fenced-in perimeters of military bases in Thailand.

There are no current statutes or VA regulations to automatically concede veteran exposure to Agent Orange while serving in Thailand during the

Vietnam era. VA's manual (M21-1) does recognize herbicide exposure for specific military occupational specialties on the perimeter of eight Thai Royal Air Force bases.

Congress should enact legislation to codify the concession of Agent Orange exposure to all Vietnam era veterans with service on military bases in Thailand, regardless of military occupational specialty. This will remove the obstacle the VA has placed for presumptive service connection for Thailand veterans.

Defining Herbicides and Agent Orange

In February 2018, the Administration's proposed budget for FY 2019 included their request for legislation seeking to clarify the chemicals at issue for presumptive service connection for herbicide exposure.

The proposed budget noted, "VA seeks to amend 38 U.S.C. § 1116 to define the harmful chemicals, specifically Tetrachlorodibenzo-p-dioxin (TCDD), used in herbicides. IOM has determined that the only chemical in herbicides for which there are adverse health effects is TCDD. The Department knows that TCDD was not used in commercial herbicides on bases outside of Vietnam. Defining the harmful chemical (TCDD) used in herbicides

within the Republic of Vietnam would allow VA to clarify complex rules for exposure claims outside Vietnam."

The DOD has acknowledged that herbicides with TCDD were used in Vietnam, on the Korean DMZ, and at Royal Thai Air and Army bases. To change the definition of herbicides to specifically limit its use within Vietnam clearly goes against the information provided by the DOD. If enacted, VA would be able to deny all claims based on Agent Orange exposure outside of Vietnam and this proposal appears to be an attempt by the VA to limit presumptive service connection based on herbicide exposure outside of Vietnam.



Improve Survivor Benefits

Recommendations

- Dependency and Indemnity Compensation (DIC) benefits should be indexed to 55 percent of VA disability compensation for a 100 percent service-connected disabled veteran.
- Reduce the 10-Year Rule for DIC.
- Congress must enable eligible surviving spouses to retain DIC upon remarriage at age 55.
- Congress must repeal the DIC and Survivor Benefits Plan (SBP) offset.

Background and Justification

Increase DIC Rates

The rate of compensation paid to survivors of service members who die in the line of duty or veterans who die from service-related injuries or diseases was created in 1993 and has been minimally adjusted since then. In contrast, monthly benefits for survivors of federal civil service retirees are calculated as a percentage of the civil service retiree's Federal Employees Retirement (FERS) or Civil Service Retirement System (CSRS) benefits, up to 55 percent. This difference presents an inequity for survivors of our nation's heroes compared to survivors of federal employees.

DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved

ones. Survivors who rely solely on DIC benefits face significant financial hardships at the time of their spouse's death. The IBVSOs believe the rate of compensation for DIC must be indexed to 55 percent of a 100 percent disabled veteran's compensation.

Survivors who are dual DIC and SBP recipients may be adversely impacted by an increase in DIC compensation. To ensure such a change does not diminish benefits for dual recipients, the IBVSOs urge Congress to eliminate the SBP-DIC offset or establish an equal increase to the Special Survivor Indemnity Allowance, which was established to alleviate the impact of the DIC and SBP offset.

Reduce the 10-Year Rule for DIC

DIC benefits can be approved for surviving spouses and minor children in two separate ways:

1. If the veteran's death is a result of their service or service-connected disabilities.
2. If a veteran is 100 percent disabled, to include individual unemployability, for 10 consecutive years prior to the veteran's death.

The intent of 38 U.S.C. § 1318 is to provide DIC benefits for surviving spouses and minor children based on the length and severity of the veteran's total disability rating. The financial status of surviving spouses, many who act as primary caregivers, can

be limited for those who put their careers on hold to care for the veteran. The requirement of 10 years seems arbitrary given the severity of many disabilities and the impact on veterans and their families.

The IBVSOs agree that the 10-year rule should be reduced to include consideration of replacing it with a graduated scale. We support a graduated scale that would apply to veterans rated totally disabled for five years or more. For example, if a veteran is rated as totally disabled for five years and dies, a survivor would be eligible for 50 percent of the total DIC benefits increasing until the 10-year threshold and the maximum DIC amount is awarded.

Eliminate DIC and SBP Offsets

When a veteran's death is the result of a service-connected injury or illness, or following specific periods of total disability due to service-connected causes, eligible survivors or dependents can receive DIC from VA. Career members of the armed forces earn entitlement to retired pay after 20 or more years of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay after his or her death, unlike many retirement plans in the private sector. To ensure their survivors receive an annuity after their death, active duty service members pay a monthly premium for SBP. The SBP is not a gratuitous benefit. It is purchased by the military retiree.

Upon a retiree's death, the SBP annuity is paid monthly to eligible beneficiaries. If the military retiree's death was unrelated to any service-connected injury or illness, or if the veteran was not totally disabled due to a service-connected disability for the requisite period of time preceding death, beneficiaries receive their full SBP payments. However, if the retiree's death was due to an injury

or illness related to military service, or the retiree was rendered 100 percent total and permanently service-connected disabled for a certain period of time, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity payments, beneficiaries lose SBP annuity payments in its entirety.

DIC and SBP are distinct and unique benefits that veterans receive for very different reasons. It is unjust and malicious to require survivors of military retirees to sacrifice more because their loved ones dedicated their careers to military service and died from injuries or illnesses they sustained while wearing our nation's uniform.

Additionally, SBP is an opt-in option for military retirees when they are leaving military service, at which time the majority of them have no idea if they will receive disability compensation benefits, or that their survivors may be unjustly impacted by the SBP-DIC offset.

Congress must act to repeal this unjust offset that is based on the false premise that receiving both is a

duplication of benefits.

Remarriage

Current law allows a surviving spouse to reestablish entitlement to DIC benefits if they remarry at age 57 or older. The IBVSOs appreciate congressional action that was taken to allow certain survivors to reestablish entitlement to this rightful benefit; however, the current age threshold of 57 years remains arbitrary and imposes an unnecessary burden upon those seeking to remarry.

Remarried survivors of retirees of CSRS, for example, obtain a similar benefit at age 55. This change in eligibility would also bring DIC in line

with SBP rules that permit continued entitlement when remarriage occurs at the age of 55.

No eligible surviving spouse should be penalized because of remarriage. Congress should lower the remarriage age requirement from 57 to 55 to continue DIC payments for survivors of veterans who have died on active duty or from service-connected disabilities. Equity with beneficiaries of other federal programs should govern congressional action for this deserving group.



Special Adaptive Housing Program and Automobile Grants and Adaptations

Recommendations

- Congress should pass legislation to provide VA the authority to prioritize the Specially Adapted Housing (SAH) claims of terminally ill veterans. VA should also be required to expedite the SAH claims process and be authorized to exercise judgement at the local level in cases where the failure to act poses a significant risk to the life or health of a veteran.
- Congress should enact legislation to establish a supplementary housing grant that covers the cost of housing adaptations for eligible veterans who have reached the maximum amounts for each grant.
- Congress should authorize multiple automobile grants to eligible veterans in amounts equaling the current grant maximum, in effect at the time of vehicle replacement.
- VA must not eliminate reimbursement for certain adaptive equipment requirements now standard on most vehicles.

Expedite Special Adaptive Housing Applications for Terminally Ill Veterans

The SAH grant and the Special Housing Adaptation (SHA) grant processes have numerous requirements. Some requirements have cumbersome and lengthy procedures. Once eligibility has been established, VA assigns an SAH agent to each veteran to provide guidance and assistance in preparing and collecting required documents and exhibits.

During the initial interview, the SAH agent assesses the veteran's exterior surroundings, interior living conditions, and overall physical condition and maneuverability. During this initial interview, the SAH agent will also complete a feasibility study. The minimum property requirements (MPRs) focus on safety and sanitation. Some MPRs address how these two items can best be achieved.

Once the feasibility study is completed, the veteran can be given conditional approval. Conditional approval is a status based only upon the SAH program's feasibility and suitability requirements and prior use. This approval is not a final grant approval nor is it an authorization for construction to commence. Approval must also include a determination on ownership.

Veterans who have amyotrophic lateral sclerosis (ALS) and other terminal illnesses who satisfy eligibility requirements dealing with medical feasibility, property suitability, and financial feasibility can be granted conditional approval that would authorized them to incur certain preconstruction costs for home adaptation.

The next step requires the veteran to obtain three bids from separate builders. This can add time and out of pocket expenses since many areas may not have the builders or contractors available who specialize in special adaptations, and many of these contractors charge a site visit or quote fee from potential clients. Once the veteran has selected the builder with whom he or she wishes to work, the project planning phase may begin. Contracts, plans, and specifications must be approved by the VA. The VA must determine that the plans and specifications

for the proposed adaptations demonstrate compliance with the MPRs, and the SAH agent will review all final construction documents to ensure compliance. With the exception noted, all of the above steps need to be completed generally before construction can be started.

SAH agent staffing shortages compound the problem by limiting the amount of time and effort employees are able to dedicate to assisting veterans in navigating all the red tape in order to fully address their unique situations. Furthermore, in some areas SAH agents are routinely tasked with performing other duties not related to the SAH program. When there are only a few agents covering a large geographic area, performing non-related duties severely affects the quality of work provided by these agents. Consequently, the veterans are ultimately the ones who pay the price.

The SAH grant and the SHA grant processes can take an extraordinary amount of time. These time requirements become of great concern for veterans with severely restricting disabilities and terminal illnesses. Veterans who have been diagnosed with ALS and other terminal illnesses often do not survive long enough to benefit from the improvements that an SAH grant could afford them.

Although VA will expedite the claims for veterans who have terminal illnesses, they will not prioritize one veteran's case over another's. Congress should pass legislation to provide VA with the authority to prioritize the SAH claims of terminally ill veterans.

Additionally, while the required SAH modifications must be compliant with both local municipalities building codes and VA's own code, there must be a balanced focus on the immediate needs of the veteran. VA should also be required to expedite the SAH claims process and be authorized to exercise judgement at the local level in cases where the failure to act poses a significant risk to the life or health of a veteran.

Establish a Supplementary Housing Grant

VA provides grants to service members and veterans with certain permanent and total service-connected disabilities to help purchase or construct an adapted home, or modify an existing home to accommodate a disability. Two grant programs exist: the SAH grant and the SHA grant.

The SAH grant helps veterans with certain service-connected disabilities live independently in a barrier-free environment. SAH grants can be used in one of the following ways:

- Construct a specially adapted home on land to be acquired.
- Build a home on land already owned if it is suitable for specially adapted housing.
- Remodel an existing home if it can be made suitable for specially adapted housing.
- Apply the grant against the unpaid principal mortgage balance of an adapted home already acquired without the assistance of a VA grant.

The FY 2019 maximum SAH grant amount is \$85,645. It must be used for the purpose of constructing or modifying a home to meet adaptive needs. The maximum grant amount adjusts annually. The grant benefit cannot be used more than three times up to the maximum dollar amount allowable.

The SHA grant helps veterans with certain service-connected disabilities adapt or purchase a home to accommodate the disability. The SHA grant can be used in one of the following ways:

- Adapt an existing home the veteran or a family member already owns in which the veteran lives.
- Adapt a home the veteran or family member intends to purchase in which the veteran will live.
- Help a veteran purchase a home already adapted in which the veteran will live.

The FY 2019 maximum SHA grant amount is \$17,130. The grant benefit cannot be used more than three times up to the maximum dollar amount allowable.

Veterans can use the VA adapted-housing grants, not to exceed the maximum amount at the time of the grant. Once the maximum amount is reached, these veterans must bear the full cost of continued accessible living should they move, need to modify a home, or suffer an increase in the severity of their service-connected disabilities. These veterans should not have to choose between surrendering their independence by moving into an inaccessible home or staying in a home simply because they are unable to afford the cost of new modifications.

A supplementary grant should be established for these eligible veterans. The supplementary grant would be available for veterans needing to relocate and for veterans experiencing an increase in the severity of their service-connected disabilities. The IBVSOs recommend that the supplementary grant amounts be at least half of the maximum amount at the time of application for the supplementary grant.

Establish Multiple Automobile Grants

Congress authorizes VA to provide financial assistance to eligible veterans through an automobile grant in the amount of \$21,058.69. This one-time grant is used toward the purchase of a new or used automobile to accommodate a veteran or service member with certain disabilities that resulted from a condition incurred or aggravated during active military service.

The Department of Transportation (DOT) reports the average useful life of a vehicle is 11.5 years. Vehicles that have been modified structurally, including modifications to accommodate the weight of a veteran and their wheelchair, can have an accelerated depreciation of usefulness.

On average, the cost to replace modified vehicles ranges from \$40,000 to \$65,000 when the vehicle is new and \$21,000 to \$35,000 when the vehicle is

used. These substantial costs, coupled with inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches its life of service.

Unfortunately, the cost of replacing modified vehicles purchased through the VA automobile grant program presents a financial hardship for veterans who must bear the full replacement cost once the adapted vehicle has exceeded its useful life. The divergence of a vehicle's depreciating value and the increasing cost of living only compounds this hardship.

We ask Congress to establish multiple automobile grants, for veterans to use once every ten years, equaling the current grant maximum in effect at the time of vehicle replacement.

Reimbursement for Certain Adaptive Equipment Requirements

Under current law, VA reimburses eligible veterans for necessary adaptive equipment required to operate a vehicle safely and effectively. In its 2017 budget proposal, VA proposed to eliminate reimbursement for certain adaptive equipment requirements now standard on most vehicles as a cost-saving mechanism. In reality, this proposal only further erodes the value of the automobile grant by removing the veteran's purchasing power to a level inconsistent with Congress's original intent.

This is a surreptitious proposed reduction in benefits for veterans with serious service-connected disabilities. VA is not looking to "modernize the law" to reflect the fact that certain equipment on automobiles that used to be optional is now standard.

The true intent behind this proposal is to give VA broader discretion to determine "necessary equipment" for veterans to safely operate vehicles. It

would create a scenario where VA could determine that features such as air-conditioning, power steering, power windows, and other equipment that is now standard on nearly all vehicles, are no longer "necessary" for veterans to operate vehicles, because they are now considered a standard vehicle feature. For veterans who have incurred spinal cord injuries and who have lost the ability to regulate his or her body temperature, air conditioning is a necessity. Furthermore, leather seats allow the veteran to more easily transfer in and out of the vehicle.

For those less nuanced with the adaptive equipment needs of seriously disabled veterans, something like leather seats and air-conditioning would seem like nothing more than luxury items. However, these features, although standard on most vehicles today, are in fact critical components to facilitate safe, efficient, and comfortable operation for some veterans.

VA should not be denying veterans' reimbursement for certain components that are considered "standard equipment," but are vital for the veterans operating these vehicles. Congress must resist, and

the IBSVOs will strongly oppose, any effort or proposal to eliminate reimbursement for certain adaptive equipment now standard on most new vehicles.



PTSD Claims

Recommendation

- The VA should focus processing of certain post-traumatic stress disorder (PTSD) claims related to military sexual trauma (MST) and "fear-based" stressors to a specialized group of Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs), require an additional level of review, and update current PTSD training.

Background and Justification

PTSD claim adjudication has had a series of regulation changes since its inception. In particular, the regulations for PTSD due to MST and "fear-based" stressors have been adjusted and modified repeatedly due to the relative difficulty of verifying the stressor events. In March 2002, VA had revised its PTSD regulation to provide examples of the types of evidence that may be relevant in corroborating a veterans' statement regarding the occurrence of a stressor in claims for service connection for PTSD resulting from personal assault to include MST, as well as an overview of the adjudicative rules for such PTSD personal assault claims.

Section 3.304(f)(5) requires a threshold of evidence to proceed with scheduling a PTSD examination and adjudicating the claim. Objective documentation of the actual stressor is not necessary. A VA examination can be scheduled and a medical opinion requested when there is evidence

of a "marker" found in service records or post-service records indicating that the stressor may have occurred. Markers include evidence of certain types of reports, lay statements, or behavioral changes that can be associated with the approximate time frame of the claimed stressor. The acceptance of markers as sufficient evidence to proceed with the VA examination and claim adjudication is based on the fact that MST victims often do not directly report or document the stressor at the time it occurs. As a result, evidence must be sought that is indirect, secondary, or circumstantial in nature. Such evidence can reasonably be associated with occurrence of the claimed MST stressor. The initial development of claims for PTSD due to MST or "fear-based" stressors is complex and evidence can be easily missed if a VSR is not sufficiently trained or experienced enough to know what to look for.

In 2010, the PTSD regulation at 38 CFR 3.304(f)(3) was adjusted to allow a veteran's lay statement

alone to establish the occurrence of a claimed in-service stressor when it meets certain criteria. Specifically, this regulation includes “an event or circumstance that involved actual or threatened death or serious injury [involving]... fear, helplessness, or horror.”

By definition, PTSD symptoms result from a fear associated with actual or threatened death, or serious injury. The threshold for scheduling a VA examination in “fear-based” PTSD claims is relatively low, but VA Regional Offices (VAROs) are obligated to first verify that the places, types, and circumstances of the veteran’s service are consistent with an environment where a fear stressor associated with hostile military or terrorist activity may have occurred. This is a case-by-case determination based on duty locations and service, or campaign medals received, among other factors.

In August 2018, the VA Office of Inspector General (OIG) released a report titled, *Denied Post-traumatic Stress Disorder Claims Related to Military Sexual Trauma*. The report found that the Veterans Benefits Administration (VBA) had incorrectly processed approximately half of the 5,500 denied PTSD MST claims in FY 2017. The most commonly encountered errors in processing included:

- Evidence was sufficient to request a medical examination and opinion, but staff did not request one (28 percent of cases);
- Evidence-gathering issues existed, such as VSRs not requesting veterans’ private treatment records (13 percent of cases);
- MST coordinators did not make the required telephone call to the veteran, or VSRs did not use required language in the letter sent to the veteran to determine whether the veteran reported the claimed traumatic event in service , and to obtain a copy of the report (11 percent of cases); and
- RVSRs decided veterans’ claims were based on

contradictory or otherwise insufficient medical opinions (10 percent of cases).

The OIG report noted that the old Segmented Lanes model of claims processing required VSRs and RVSRs in special operations teams to process all claims VBA deemed highly complex, such as MST-related claims. The OIG review team concluded that staff on the special operations teams developed subject matter expertise on these difficult claims due to focused training and repetition.

Under the new National Work Queue (NWQ), VBA no longer required the special operations teams. Under this new model, the NWQ distributes claims daily to each VARO and the VARO determined the distribution of MST-related claims. As a result, MST-related claims could potentially be processed by any VSR or RVSR regardless of their experience and expertise. As a result, the OIG review team determined VSRs and RVSRs at offices that did not specialize in, lacked familiarity with, and were less proficient at processing MST-related claims. The OIG recommended that VBA bring back the specialized teams to work on complex claims such as PTSD based on MST and “fear-based” stressors, and the IBVSOs agree. By returning to these specialized teams we can better assure increased quality outcomes. Further, utilizing the best aspects of the NWQ could enhance the capabilities of these special operations teams by streamlining the delivery of complex claims to the respective subject experts.

Additionally, the OIG reported that RVSRs, quality review personnel, and supervisors interviewed at the four VAROs visited generally thought an additional level of review would be helpful and could improve accuracy. An additional level of review serves as an internal control and quality check to help ensure:

- Claims processors followed all applicable statutes, regulations, and procedures;
- Evidence of record properly supports the decision; and

- RVSR adequately explained the decision.

The IBVSOs agree that an additional level of review would improve the quality of adjudicated claims and decrease the possibility of a wrongfully denied claim.

Furthermore, the OIG report noted that the PTSD training provided to the raters was outdated, included erroneous development procedures such as instructing claims processors to use incorrect

medical opinion language, and included incomplete information regarding what constitutes an insufficient or inadequate examination. These were just a few of the many inadequacies that were listed in the document.

The IBVSOs recommend VBA improve or create a new training program and make it an annual requirement that all VSRs and RVSRs have to undergo.



Improve Benefits for Persian Gulf War Veterans

Recommendations

- VA must develop a single Disability Benefits Questionnaire (DBQ) for disability compensation claims related to Gulf War Illness (GWI).
- Congress must expand the definition of Persian Gulf War veteran to include those who served in Afghanistan, Israel, Egypt, Turkey, Syria, and Jordan.
- VA must permanently extend the sunset date for presumptive disability compensation for Persian Gulf War veterans.

Background and Justification

Single Gulf War Illness DBQ

Unlike nearly all other service-connected conditions, GWI is intrinsically difficult to diagnose and treat. GWI has no clear and concise set of rules. In other words, no singular set of symptoms allows for an unmistakable diagnosis. GWI presents itself as a conglomeration of possible symptoms to which countless members of the general public with no military experience can also be subject. As such, Persian Gulf veterans have a steeper hill to climb in relating the symptoms to service — the most critical link in establishing

service-connection.

As a component of the VA disability compensation claims process and to better manage its workload, VA developed DBQs to assist in adjudicating claims. Since GWI is constituted by medically unexplained chronic illnesses, VA adjudicators often order examinations for each GWI symptom before considering the indicators that one illness is connected to the multiple symptoms.

The IBVSOs are concerned that the current system of assigning separate DBQs for each symptom being claimed in association with GWI is the leading cause of high denial rates for GWI claims. VA must be required to provide additional testing and examinations deemed necessary by this examination. The Government Accountability Office (GAO) has found that GWI claims are more likely to take longer and get denied than other service-related disabilities. The IBVSOs firmly believe that the creation of a singular DBQ for GWI claims would facilitate more timely and accurate consideration

of disability compensation claims for veterans who suffer from GWI.

GAO also identified that an overall lack of training for VHA medical staff who conduct medical examinations leads to inaccurate processing of GWI disability compensation claims. To improve accuracy of claims and to ensure Persian Gulf War veterans receive accurate decisions, the IBVSOs urge VA to require medical staff to complete periodic GWI-specific training before being authorized to conduct medical examinations for GWI disability compensation claims.

Expand the Definition of Persian Gulf War Veteran

Service members have served and continue to serve in the Afghanistan theater of operations since the start of Operation Enduring Freedom and have served under circumstances similar to those serving in Operation Iraqi Freedom, Operation New Dawn, Operation Desert Shield, and Operation Desert Storm.

Several scientific studies have found that veterans who have served in Afghanistan suffer from undiagnosed conditions at similar rates as those who have served in the Iraq. Additionally, veterans who served in support of Operation Desert Shield and Operation Desert Storm while stationed in Israel, Egypt, Turkey, Syria, and Jordan have also presented similar symptoms as veterans who served in Iraq. However, current law limits the definition of Persian Gulf War veteran to those who served on active duty in the Armed Forces in the Southwest Asia theater of operations, which is limited to Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab

Emirates, Oman, Gulf of Aden, Gulf of Oman, and the waters of the Persian Gulf, the Arabian Sea, and the Red Sea.

As a result, veterans who have served in Afghanistan, Israel, Egypt, Turkey, Syria, and Jordan are denied access to presumptive disability compensation benefits afforded to Persian Gulf War veterans, despite evidence which shows such conditions are common among them. Furthermore, they are being considered Gulf War veterans for reporting and demographic purposes. Veterans who served in Israel, Egypt, Turkey, Syria, and Jordan in support of Operation Desert Shield and Operation Desert Storm are even eligible for the Southwest Asia Service Medal, but are denied access to streamlined disability compensation for disabilities they incurred during their service in Southwest Asia. For this reason, the IBVSOs urge Congress to expand the definition of Persian Gulf War veterans to include such veterans.

Permanent Extension of Presumptive Disability Compensation Benefits

Section 1117 of title 38, United States Code, authorizes VA to “prescribe by regulation the period of time following service in the Southwest Asia theater of operations during the Persian Gulf War that the Secretary determines is appropriate for presumption of service connection for purposes of this section.” As a result, VA has continuously set and extended the sunset date for considering certain disabilities experienced by Persian Gulf War veterans as being presumed to have manifested during military service.

The IBVSOs believe the current sunset date established in regulation (2021) creates an unfair discrepancy between veterans who served early in

the Persian Gulf War and those who served later or are still serving in Southwest Asia. If presumption ends in 2021, and troops are still in Southwest Asia, they will not yet have exhausted their five years of VA health care before they can no longer establish service connection for an undiagnosed or chronic multi-symptom illness. Yet, other veterans would have had over 30 years in which to establish service connection. Failure to extend the sunset past 2021 would deny such veterans access to the health care and benefits they need and deserve. For this reason, the IBVSOs urge VA to permanently expand presumptive disability compensation benefits for Persian Gulf War veterans.



Eliminate the Disability Compensation and Military Retirement Offset

Recommendation

- Congress must establish a phase-in Concurrent Retirement Disability Pay (CRDP) program for all military retirees who were injured or made ill due to military service.

Background and Justification

Military retirees, based on longevity, may qualify for retirement pay based on their dedicated service to our nation. These same veterans may also qualify for disability compensation for any injuries or illnesses that were caused or aggravated by their military service. Prior to 2004, military retirees could not receive both retirement pay and disability pay because it was erroneously perceived as a duplication of benefits. In 2004, Congress

authorized a phase-in of full concurrent receipt for certain military retirees. The CRDP program now rightfully exempts disabled military retirees who have received a service-connected disability rating of 50 percent or higher from having to offset their retirement pay with their disability compensation.

Retirement pay and VA disability compensation are fundamentally different benefits, granted for

different reasons. Military retired pay is typically earned by at least 20 years of honorable and faithful military service. VA compensation is paid solely because of disability resulting from military service, regardless of the length of service. Most non-disabled military retirees pursue second careers after military service, thereby enjoying a full reward for completion of a military career with the added reward of full civilian income. In contrast, military retirees with service-connected disabilities do not enjoy the same right. Their earning potential is reduced commensurate with the degree of service-connected disability.

Veterans who devoted their careers to military service and sustained service-connected disabilities must not be penalized for becoming injured or ill while in service to our country. It is also inequitable and completely arbitrary for only certain military retirees to have the ability to receive the full benefits they have earned. No service-connected disabled military retiree should suffer a penalty for choosing a military career over a civilian career, especially when, in all likelihood, a civilian career would have involved fewer sacrifices and quite likely, greater financial rewards.



Reform VA Debt Collection Processes

Recommendations

- VA must ensure veterans receive clear debt notifications that detail the reasons for the debt and how they can payoff such debts.
- VA must halt the accrual of debt once a beneficiary notifies VA of an improper payment or overpayment.
- Congress must enact legislation to reform debt collections and repayments.

Background and Justification

VA recovered more than \$1.5 billion through debt collection in FY 2017, much of which were erroneous debts that caused harm to the veterans VA is charged with serving. Common reasons overpayments or debts are created by veterans include failing to pay health care co-pays, not reporting changes in family structures or income which impacts benefits, or dropping classes and causing an overpayment in education benefits. When this occurs, a debt notice is sent by VA to the debtor. Such notices are often ambiguous, give no

clear options to request recourse, or mailed to the incorrect address — which leads to inaction by the veteran.

The IBVSOs understand that overpayments must be recouped in order for benefit programs to work efficiently, however, it is important for VA to ensure veterans receive such notices in a timely manner with clear and concise information regarding the steps veterans must take to resolve any outstanding debts. Ultimately, a veteran should be responsible

for repaying the overpayment, if it is indeed legitimate. Due to the inconsistencies regarding communication from VA, as well as the general lack of information regarding the nature of the debt, many veterans are simply unable to meet the deadline imposed on them by VA. As a result, veterans have their benefits garnished with little to no ability to rectify errors. For veterans who rely on earned VA benefits, having these benefits cut off for repayment puts them and their families in financial hardship.

Additionally, overpayments or debts may be caused by VA administrative errors or VA's inability to halt an overpayment after being notified of such overpayments by beneficiaries. For example, an administrative error by VA triggered a \$32,000 education benefits overpayment notification to a former California National Guardsman. The veteran did everything that he could do on his own to rectify the situation, including notifying VA that he was being overpaid. Despite this, VA continued to pay him at an incorrect rate. In another case, a widow receiving DIC remarried in 1986 and notified the VA of the marriage in April 1995, and again in March 2003. However, the VA did not terminate benefits until January 7, 2004, altogether resulting in an overpayment of \$179,966. Had VA acted promptly on the first notification, \$104,866 (58 percent) of the \$179,966 overpayment and debt could have been avoided.

The IBVSOs firmly believe beneficiaries must promptly notify VA of changes or administrative errors that may cause overpayments. Once sufficient

notification is made by beneficiaries, however, VA has the obligation to ensure it has processes and systems in place to halt overpayment in a timely manner. Veterans who fulfill their obligations to promptly notify VA should not be punished for VA's inaction or ineffective processes. Thus, the IBVSOs recommend that Congress require VA to waive overpayments that are accrued after a veteran provides VA sufficient notification of an overpayment. Doing so would also incentivize VA to fix its systems and processes to avoid overpayments altogether.

When a VA health care debt goes unpaid for 180 days, VA refers it to the Department of the Treasury which initiates garnishment of federal benefits until the debt is satisfied or until the veteran can prove that the debt is erroneous. When a VA compensation or pension debt is created, the claimant has 30 days to respond to the Debt Management Center before the entire debt is collected from the monthly compensation or pension payment. In many cases, these collections will engulf the entire monthly payment, thus creating a financial hardship on the veteran and their family.

The IBVSOs urge Congress to enact legislation to reform the collection and repayment of debts. The VA should not be able to collect debts incurred more than five years prior; that debt collection from monthly compensation or pension payments should not exceed 25 percent of the monthly payment, and the VA should waive all additional debt created by their lack of action.



Protecting Benefits from Erosion

Recommendations

- Congress must act to ensure that Total Disability Based on Individual Unemployability (TDIU) remains available for all veterans, regardless of age or receipt of any other earned federal benefits.
- Congress should not round-down veterans' and survivors' cost-of-living adjustments (COLAs).
- Congress should reject proposals that would narrow the definition of service connection for veterans' disabilities and cause of death.

Background and Justification

Protecting Total Disability Based on Individual Unemployability

When a veteran's disability is rated less than 100 percent, but he or she is unable to obtain or maintain substantial gainful employment, VA regulations allow the veteran to apply for TDIU. TDIU is based on the severity of the individual veteran's unique disability picture and its impact on the veteran's ability to obtain and maintain substantial gainful employment. Generally, the veteran must have a single disability rated at 60 percent or a combined evaluation of 70 percent to be eligible for TDIU.

Reports published by the Congressional Budget Office (CBO) in November 2013, August 2014, and December 2016, as well as the GAO report in June 2015, made recommendations to limit TDIU based on age and entitlement to additional earned federal benefits.

The Administration's proposed 2018 Budget contained a proposal of limiting TDIU. It proposed to terminate IU ratings for veterans at age of 62 and cut off TDIU benefits for any veteran already in receipt of Social Security retirement benefits. The Administration, however, later backed away from this proposal.

In December 2018, CBO published a report recommending that VA stop all TDIU benefits to veterans age 67 or older, as this is the full retirement age for Social Security.

Over four million veterans are currently receiving VA compensation benefits. Of those, approximately 350,000 veterans are in receipt of TDIU, commonly referred to as IU, and roughly 200,000 of those veterans are over the age of 65. Important factors regarding TDIU:

- A veteran who is awarded TDIU receives the same level of compensation and ancillary benefits as a veteran in receipt of a total 100 percent rating.
- VA regulation 38 C.F.R. § 4.19, states the VA is precluded from considering the veteran's age in their determination of TDIU.
- TDIU is **not** a retirement or pension program and is neither similar to nor related to Social Security Retirement benefits.

- A VA determination of TDIU is **not** the same **nor** is it similar to Federal Unemployment Insurance; it is a disability compensation benefit.

Congress must enact legislation to protect TDIU for it to remain available for all eligible veterans regardless of age or receipt of any other earned federal benefits.

Protecting Benefits from Long-Term COLA Round-Down

In 1990, Congress mandated veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress continued it until 2014. While not significant at the onset, the overwhelming effect of 24 years of round-down resulted in veterans and their beneficiaries losing millions of dollars.

In the administration's proposed budget for FY 2019, the Administration sought legislation to round-down the computation of COLA for service-connected compensation and dependency and indemnity compensation (DIC) for 10 years.

The cumulative effect of this proposal would have levied a tax on disabled veterans and their survivors, costing them money each year. All

told, the government estimates that it would cost beneficiaries \$34.1 million in 2019, \$749.2 million for five years, and \$3.11 billion over 10 years. The IBVSOs greatly appreciate the passage of H.R. 4938, the Veterans' Compensation Cost-of-Living Adjustment Act of 2018, which did not contain such a provision.

Veterans and their survivors rely on their compensation for essential purchases such as food, transportation, rent, and utilities. Any COLA round-down will negatively impact the quality of life for our nation's disabled veterans and their families, as well as have an overall effect on local economies. The Administration should not seek to make financial savings or address budgetary concerns at the expense of benefits earned by wartime disabled veterans and their families.

Protecting the Definition of Service Connection

Service connection means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. Compensation payments are paid to veterans based on the severity of the disabilities VA has determined to be service-connected. Compensation may also be paid to National Guard and Reserve service members who suffer disabilities resulting from injuries while undergoing training.

Periodically, a committee, commission, government agency, or member of Congress proposes that

military service should be treated as if it were a civilian job. This issue was again raised recently in the December 2016 CBO biennial report entitled *Options for Reducing the Deficit: 2017 to 2026*.

The CBO report recommended to narrow eligibility for veterans' disability compensation by excluding disabilities they deem are unrelated to military duties. The report asserts, "not all service-connected medical conditions and injuries are incurred or exacerbated in the performance of military duties. For example, a qualifying injury can occur when a service member was at home or on leave, and a qualifying medical condition, such as multiple

sclerosis, can develop independently of a service member's military duties." CBO estimated that by narrowing eligibility and effectively removing disabilities from service connection, it would reduce the national deficit by \$26 billion over eight years.

The 2016 CBO report noted that this would make the disability compensation system for military veterans more comparable to civilian systems and that few civilian employers offer long-term disability benefits. Among those that do, benefits do not typically compensate individuals for all medical problems that developed during employment.

Prior to the publication of *The Independent Budget, CBO released its Options for Reducing the Deficit: 2019 to 2028*. This new report once again proposes to scale back veteran's disability compensation to lessen the national debt. In fact it goes even farther by suggesting to eliminate compensation benefits for seven specific diseases and to reduce all compensation payments by 30 percent when a veteran reaches the full retirement age for Social Security, currently age 67. It even proposes to eliminate disability compensation payments for veterans receiving less than 30 percent combined evaluation.

Military service is neither similar to, nor equivalent

to, a civilian job. It confers unique benefits to society and imposes extraordinary risks to those who served. The men and women who served made incalculable sacrifices and in many instances, endured unimaginable hardships that cannot be quantified as similar to a civilian job. The compensation and benefits veterans receive reflect their sacrifices and should never be limited or narrowed for the sake of budgetary savings.

Congress created the Veterans' Disability Benefits Commission (VDBC) to carry out a study of "the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service." After more than 30 months of hearings, study, analysis, and debate, the VDBC unanimously endorsed the current standard for determining service connection.

Current law requires that an injury or disease be incurred or aggravated coincident with active military service. This remains sound public policy. Any change would only impose additional hardship on the men and women who have already given so much. Congress should reject proposals that would narrow the definition of service connection for veterans' disabilities and cause of death.



Hearing Loss, Tinnitus, and Impairment Requiring Sensory Aids

Recommendations

- Congress should enact legislation to establish a presumption of service connection for hearing loss and tinnitus for combat veterans and other groups of veterans whose military duties exposed them to high decibel levels of traumatic acoustic noise, and who subsequently suffer from tinnitus or hearing loss.

Recommendations continues

- VA should amend its Schedule for Rating Disabilities (VASRD) to provide a compensable evaluation of at least 10 percent for any service-connected hearing loss medically requiring hearing aids.

Presumption of Service Connection for Hearing Loss and Tinnitus

The National Academies of Medicine (NAM) issued a report in September 2005 entitled, *Noise and Military Service: Implications for Hearing Loss and Tinnitus*. The report determined that all DOD efforts providing hearing protection and hearing conservation have been inadequate from World War II to the present. The study further notes the DOD conducted inadequate induction audiometric testing including the Whisper Test, had poor record keeping, and lax audio examination practices.

Many veterans are exposed to acoustic trauma and increased noise exposure due to the nature of job requirements while on active duty. Combat veterans are typically exposed to prolonged, frequent, and exceptionally high decibel levels from gunfire, tanks, artillery, explosive devices, aircraft, and other equipment used in the performance of their military occupations.

Types of acoustic trauma include impulse noise and impact noise. Impulse noise is high-level, short-duration noise, which is the product of explosive devices (e.g., gunfire), and impact noise is generated by the forceful meeting of two hard surfaces (e.g., a hammer to a nail, impact wrenches). Of note, impulse/impact noise with peak levels exceeding approximately 140 decibels (dB) may be hazardous even for a single exposure. For example, a 9 mm pistol and M-16 rifle both produce impulse noise over 150 decibels. The report concludes that a single impulse/impact noise exposure can cause noise-induced hearing loss and tinnitus. Many veterans are routinely exposed to these impulse/impact noises including daily exposure over prolonged periods

of time with inadequate noise protection in some instances.

In many cases, VA denies these veterans service connection for hearing loss and tinnitus due to problems identified above, as well as the 2005 NAM study's conclusion that traumatic noise exposure in service cannot be related to hearing loss diagnosed after service. The study made this determination even though there have been no studies conducted to prove or disprove this theory. The Court of Appeals for Veterans Claims held in *Hensley v. Brown*, 5 Vet.App. 155, 158-59 (1993), that traumatic noise exposure in-service, even with hearing within normal limits at separation from service, can be related to post service diagnosed noise-induced hearing loss. In *Peters v. Brown*, 6 Vet. App. 540, 543 (1993), the court held the absence of service medical records showing hearing difficulties was insufficient to overcome the veteran's testimony of exposure and medical evidence of a present hearing loss consistent with noise exposure.

Given the recognized inadequate hearing protection and conservation efforts by the DOD, the consequences and frequency of traumatic impulse noise exposure, and the unsubstantiated theory in the 2005 NAM report regarding long-term effects, as well as the irreversibility of noise-induced hearing loss and tinnitus, Congress should establish presumptive service connection for hearing loss and tinnitus for combat veterans and those veterans the VA has recognized as having military occupational specialties with traumatic noise exposure.

Compensable Evaluations for Hearing Loss Requiring Hearing Aides

Within the VASRD, hearing loss is evaluated on audiogram testing. The current evaluation system does not contemplate the medically required use of hearing aids. Veterans can be rated at 0 percent based on their audiometric results and still be required to use hearing aids due to their specific type of loss.

The VASRD is predicated on the industrial impairment that each disability provides to the disabled veteran. Hearing loss can impact a veteran's ability to communicate and negatively affect relationships, school/work performance, safety, and emotional well-being. However, the rating schedule does effectively consider the industrial impact of hearing loss severe enough to require hearing aids.

As noted in 38 C.F.R. 4.10, "The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment." The VASRD does not apply this to hearing loss at 0 percent with required hearing aids.

Furthermore, a National Institutes of Health study, *The Socioeconomic Impact of Hearing Loss in US Adults*, published in March 2014 noted, "even after controlling for education and important

demographic factors, hearing loss is independently associated with economic hardship, including both low income and unemployment/underemployment. The societal impact of hearing loss is profound."

The VASRD does account for required prosthetics or required medication for control. It provides a 10 percent evaluation for over fifteen different disabilities that require daily medication for control of said disability. However, this concept is not applied to hearing loss at 0 percent with required hearing aids.

Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device. A disability severe enough to require use of a prosthetic hearing device should be compensable.

Assigning a compensable rating for medically required hearing aids would be consistent with minimum ratings otherwise provided throughout the rating schedule. This change would be consistent with 38 CFR 4.10, and the findings of the aforementioned National Institutes of Health study. Such a change would be equitable, fair, and recognize the societal and functional impact caused by hearing loss rated at 0 percent disabling.



Expand the Definition of Wartime Service

Recommendation

- Veterans who receive hostile fire pay, imminent danger pay, expeditionary medals, or campaign medals must be eligible to receive non-service connected VA pension benefits.

Background and Justification

A non-service connected VA pension is income-based and is available to a veteran who is at least 65 years of age or is permanently and totally disabled as a result of non-service-connected disabilities, and served at least one day of active duty during a designated period of war.

The Constitution grants Congress the sole authority to declare war, yet the president, as commander-in-chief, may send US forces into hostile situations without a formal declaration. While some of these incidents occur during defined periods of war (e.g., Somalia, 1992–95), many other military actions take place during periods of “peace” (e.g., Grenada, 1983; Lebanon, 1982–87; Panama, 1989) including the Mayaguez Incident (May 12–15, 1975).

The sole service criterion for eligibility for non-service connected VA pension — at least one day of service during a period of war — too narrowly defines military activity in the last century. Expeditionary medals, combat badges, and the like

can better serve the purpose of defining combat or warlike conditions when Congress does not declare war or the president neglects to proclaim a period of war for VA benefits purposes.

For example, between 5,000 to 10,000 US military personnel were estimated to have served with the US Military Assistance Advisory Group in Vietnam between November 1, 1955, and February 27, 1961. However, veterans who served in Vietnam before February 28, 1961, are not considered to have served during the Vietnam era period of war despite facing war-like conditions and receiving the Armed Forces Expeditionary Medal.

Congress must expand the definition of “period of war” to include veterans who receive hostile fire pay, imminent danger, an expeditionary medal, or campaign medal. This action would ensure low-income veterans who deployed to hazardous and warlike conditions become eligible for non-service connected VA pension benefits.



Service-Disabled Veterans' Insurance Reform

Recommendation

- Congress should enact legislation that authorizes VA to reform the Service-Disabled Veterans Insurance (S-DVI) by increasing the face value of the benefit, providing an open-ended period to apply for the benefit, and reducing the premiums for S-DVI to make it consistent with life expectancy.

Background and Justification

The S-DVI program was designed to provide affordable life insurance coverage to disabled veterans unable to purchase private insurance due to their service-connected disabilities. Over the past 60 years, its cost and benefits have been seriously eroded. At the program's outset in 1951, rates were based on contemporaneous mortality tables and remained competitive with commercial insurance. Legislation is needed that will modernize the S-DVI program by using current actuarial data to lower premiums as well as adjusting for inflation to significantly increase the benefit payout.

In the six decades since the creation of this benefit, inflation has increased significantly, which has diminished the value of the insurance since the maximum coverage was set by law at \$10,000. The IBVSOs recognize that Congress has attempted to address this in authorizing an increase from \$20,000 to \$30,000 in the supplemental amount available with the passage of Public Law 111-275, the Veterans Benefits Act of 2010. This is still an inadequate sum of money when one considers that many of these veterans cannot purchase supplemental commercial life insurance due to their service-connected disabilities. If the original amount of \$10,000 offered in 1951 were adjusted for

inflation, it would be closer to \$100,000 in 2018.

Additionally, the application period needs to be addressed. Currently, service connected veterans are entitled to apply for S-DVI insurance within two years from the date the VA grants service connection for any disability. However, many of these veterans are having financial difficulties and problems readjusting to civilian life after initial service connection. Therefore, the IBVSOs recommend Congress enact legislation that would authorize an open period for eligible service-connected disabled veterans to apply for coverage under the S-DVI program.

Lastly, the premiums to S-DVI should be lowered in accordance with current insurance data. When Congress created S-DVI, the premiums were based on rates a healthy individual would have been charged when the program was established in 1951, in accordance with 1941 mortality tables. Because life expectancy is much higher in 2018 than in 1951, the veteran is left paying much higher rates for insurance premiums while receiving fewer benefits. We recommend Congress enact legislation lowering the premiums using current mortality tables.

VA Treatment for Presumptive Diseases

Recommendation

- Congress should enact legislation to establish a date of claim based on VA health care treatment and diagnosis for recognized presumptive diseases.

Background and Justification

Title 38 of the Code of Federal Regulations recognizes over 125 different types of presumptive diseases based on several different types of exposures, places of service, and chronic diseases diagnosed within 12 months of service.

Veterans suffering from diseases such as cancer, diabetes, and other chronic diseases may not be aware that the conditions may be eligible for presumptive service connection. Many VA medical facilities are not currently staffed or equipped to provide appropriate counseling to veterans or their families on how to file a claim for service-connected benefits, specifically for presumptive diseases.

The Court of Appeals for Veterans Claims held in *Bell v. Derwinski*, 2 Vet. App. 611 (1992), that VA is deemed to have constructive knowledge of all VA records and such records are considered evidence of record at the time a decision is made.

If the VA is providing treatment for a diagnosed recognized presumptive disease, they have constructive knowledge of the diagnosed disease and that it is a presumptive condition. Congress should enact legislation to establish a date of claim based on VA health care treatment and diagnosis for recognized presumptive diseases.

Court of Appeals for Veterans Claims (CAVC)

Recommendations

- Congress should provide all necessary funding and authority to construct a CAVC courthouse and justice center in a location of honor and dignity.
- Congress should clarify the CAVC's class action authority.

Background and Justification

A Dedicated CAVC Building

The IBVSOs believe the CAVC should be housed in its own dedicated building, designed and constructed to its specific needs, and in a location befitting its authority, status, and function as an appellate court of the United States. During the 30 years since the CAVC was formed, it has been housed in commercial office buildings. It is the only Article I court that does not reside in its own

courthouse.

The CAVC should be accorded the same degree of respect enjoyed by other appellate courts of the United States. The IBVSOs urge Congress to authorize and appropriate the resources and authority needed to secure a CAVC courthouse in a location befitting its authority and prestige.

Class Action Authority

In a recent Federal Circuit decision, *Monk v. Shulkin*, 855 F.3d (Fed. Cir. 2017), the Federal Circuit found that the CAVC has the authority to consider class actions, even though the CAVC had previously found it did not have such authority. Class actions are a way of aggregating claims to handle a similar concern amongst many claimants without each claimant having to prove similar facts or litigate the same case.

The Federal Circuit analyzed the CAVC's jurisdiction, created under the Veterans Judicial Review Act of 1988 (VJRA). The VJRA established the CAVC as a specialized appellate court that has the exclusive right to review decisions of the Board. Before the VJRA, veterans had no right to appeal decisions of the BVA.

The Federal Circuit found that under the VJRA, Congress did not exclude class actions for veterans, and gave the CAVC authority to prescribe "rules

of practice and procedure" including procedures for class actions or other methods of aggregation. The Federal Circuit discussed the benefits of class actions in reducing the delays associated with individual appeals, and correcting systemic errors to ensure that like veterans are treated alike. Ultimately, the Federal Circuit found that the CAVC has the authority to hear a class action, and remanded the case to the CAVC for determination on whether Monk's particular case, regarding timely adjudication of appeals, should be certified as a class action.

However, after the remand, the Court refused to consider it as a class action, in a lengthy and divided opinion that indicates further guidance may be needed. To ensure this new authority is carried out in the best interest of veterans, the IBVSOs urge Congress to clarify the CAVC's class action authority and to provide any additional funding to address increased workloads.

Create an Economic Opportunity Administration Within The Department of Veteran Affairs (VA)

Recommendation

- Congress should separate from the Veterans Benefits Administration (VBA) all programs related to economic opportunity and create a new administration within VA focused on economic opportunities for veterans.

Background and Justification

VA is comprised of three Administrations: VBA, Veterans Health Administration (VHA), and National Cemetery Administration (NCA). VBA is in charge of not only compensation and pension benefits for veterans, but also the GI Bill, vocational rehabilitation, housing and business loans, and the broadly defined transition assistance program, which is shared with the Department of Defense (DOD) and the Departments of Labor (DOL) and Homeland Security (DHS). Many of these programs are currently under the Office of Economic Opportunity (OEO), which is overseen by a deputy under secretary. However, this position has been left vacant for some time and it does not appear that the vacancy will be filled any time soon.

Currently, the OEO programs are enmeshed with the myriad of entities that makeup VBA. Compensation, being the largest program, dominates the attention of VBA which makes it difficult for the economic opportunity (EO) programs to get adequate funding, specialized resources, and other prioritization. For example, while VBA has been focused on the modernization and streamlining of the claims and appeals process, other important programs such as Vocational Rehabilitation and Employment (VR&E) have seen a stagnation of resources and oversight. Between 2014 and 2018, VR&E participation has increased by approximately 17 percent while its funding

has risen just under 2 percent despite a 2014 Government Accountability Office (GAO) report that recommended that further performance and workload management improvements were needed.

Without a deputy under secretary, there has been a lack of leadership, which has frustrated outside entities, such as veterans service organizations, who notice the lack of an advocate for EO programs. Additionally, the House Veterans' Affairs Committee has a subcommittee focused exclusively on EO programs further emphasizing the advantage of having a central point of contact for accountability and oversight. Furthermore, the DOD, DHS, and DOL collaborate to manage the Transition Assistance Program (TAP) for out-processing service members, but efforts have been hampered by the lack of a deputy under secretary of the OEO to act as a counterpart to coordinate their efforts at VBA. Since VA does not have the primary role in TAP, *The Independent Budget* veterans service organizations (IBVSOs) believe having an under secretary for EO would help ensure that VA's views on TAP initiatives and resources are enhanced.

This nation should have as much focus on the economic opportunities for veterans as it does for their health care and benefits. In reality, not all veterans are seeking VA health care when they are discharged, they are not needing assistance

from the NCA, nor are they all seeking disability compensation. However, the vast majority are looking for gainful employment and/or educational opportunities. Congress should recognize the value of these programs by separating them into their own Administration focused solely on economic utilization and growth.

The IBVSOs recommend that Congress enact

legislation to separate from VBA all programs currently in the OEO and create a fourth Administration under the VA with its own under secretary whose sole responsibility is the portfolio of EO programs. This new under secretary for EO would refocus resources, provide a champion for these programs, and create a central point of contact for veterans service organizations and Congress.



Ensure Veteran Success in Higher Education

Recommendations

- Congress, VA, DOD, and Department of Education (ED) must work together to ensure college-bound veterans have access to quality pre-enrollment consumer information and post-enrollment consumer protections when utilizing their earned education benefits at the college or university of their choice.
- VA must develop quality metrics with which to evaluate student veteran success in higher education, identify potential problems, and develop quantifiable solutions.
- Congress needs to continue investing in campus-based support resources for student veterans to include expansion of the VetSuccess on Campus program or additional programs that support peer-to-peer support or offer resources to develop Veteran Centers of Excellence.
- Congress must also work closely with ED and VA to ensure student veterans are utilizing their education benefits at institutions that are not seeking to prey upon them. Requiring transparency and solid reporting systems will ensure student veterans are given the right tools to utilize their benefits properly.

Background and Justification

In 2009, Congress made a significant investment in the future of our nation's veterans by commissioning the Post-9/11 GI Bill. In 2017, Congress added to the Post-9/11 GI Bill with the Forever GI Bill that upgraded an already amazing benefit for student veterans.

Nine years into the program, more than one million veterans have already chosen to take advantage of this generous benefit seeking to become our country's next generation of leaders. However, with the expected drawdown of our military's active duty forces, VA officials believe we have not yet seen the largest influx of post-9/11 veterans into America's classrooms.

With such a significant investment in the future success of today's warfighters, Congress, as well as VA and its partner agencies, have an obligation to ensure veterans not only enroll in college, but that they succeed when they get there. As a nation, we also have the responsibility to ensure veterans do not become victims of fraud, waste, and abuse when they seek to use their benefits. When bad acting institutions in higher education lose their accreditation, close, or go out of business, it is necessary that Congress does not turn its back on veterans enrolled in those schools.

By education industry standards, student veterans are often considered non-traditional students. Veterans often bring significant transfer credits and invaluable life experience to the classroom, and they must often balance significant life obligations that many of their college peers do not have. As a result of the unique characteristics and needs of veterans on campus, the education industry is often not equipped to serve the needs of veterans or to adequately track their progress.

If schools lose accreditation or close, or VA is slow in processing education claims, then veterans who have families are put in even worse situations. They are forced into a predicament where they may potentially be unable to feed their families, pay their bills, or finish their educational goals.

By implementing the IBVSO's recommendations, Congress and VA must work to ensure college-bound veterans and those already enrolled in higher education make informed decisions on how to best utilize their benefits. It will ensure campuses are prepared to best serve the unique needs of student veterans, and that student veterans are able to successfully obtain their academic goals.

Enhance Vocational Rehabilitation and Employment Services

Recommendations

- Congress must eliminate the 12-year delimiting period for VA Chapter 31 Vocational Rehabilitation and Employment (VR&E) services to ensure disabled veterans with employment handicaps, including those who qualify for independent living services, qualify for VR&E services for the entirety of their employable lives.

Recommendations continues

- Congress should study changing the current program eligibility standards to determine if doing so would streamline the process by expanding eligibility to all veterans who have been awarded service-connected disability ratings, regardless of the degree of disability.
- Congress should authorize VA to make available child care vouchers, linked to cost-of-living increases, for veterans who have families and are using a VR&E program.
- Congress must provide sufficient resources for VR&E to establish a maximum client-to-counselor standard of 125:1, or better, and explore new methodologies to formulate a proper client-to-counselor ratio based on the challenges associated with more severely disabled veterans. The IBVSOs recommend changing reporting of the ratio to reflect the VA Regional Offices (VAROs), instead of a nationwide client-to-counselor ratio. This will help address the needs of specific offices and more directly help veterans.
- Congress should authorize VA to create a monthly stipend for those participating in the employment track of VR&E's programs, creating incentives to encourage disabled veterans to complete their rehabilitation plans, and eliminate the current 12-year eligibility limit for veterans to take advantage of VR&E benefits.

Background and Justification

Vocational rehabilitation for disabled veterans has been part of this nation's commitment to veterans since Congress first established a system of veterans' benefits upon entry of the United States into World War I in 1917. Today, VR&E is charged with providing wounded, ill, and injured veterans with an array of services designed to enable veterans to obtain and maintain suitable and gainful employment. In the case of those veterans with more serious service-related disabilities, VR&E is authorized to provide independent living services.

Veterans are eligible for VR&E services and programs if their military discharge is other-than dishonorable and have a VA service-connected disability rating of at least 10 percent, or a memorandum rating of 20 percent or more from the VA. The VR&E program is also accessible to

active duty military personnel expecting to be medically discharged with the requisite discharge and anticipated disability rating of at least 20 percent or more from DOD and VA.

The period of eligibility to apply for VR&E services cannot currently exceed 12 years from either the date of separation from active duty, or the date veterans are notified by the VA of a service-connected disability rating. This 12-year application eligibility period can only be extended if a vocational rehabilitation counselor determines a veteran has a serious employment handicap. Participants in VR&E also cannot exceed 48 months of entitlement. The 48-month period of entitlement; however, may also be extended in unique circumstances.

While important adjustments were made in numerous areas, VR&E's incentive structure for veterans remains primarily aligned with education and training programs with no financial incentive for those seeking immediate employment. Considering the basic costs of living, veterans may be unable to wait until the completion of their program to begin working simply to generate some sort of income. They may be forced to leave the program prematurely simply to provide for themselves or their families. Childcare vouchers, linked to cost-of-living increases, for veterans who have families and are involved in VR&E could help these veterans remain in the program.

Congress must change the eligibility requirements for the VR&E program to increase access to services while increasing subsistence allowances for veterans with dependents. A veteran's service-connected illnesses and injuries are life-long consequences of service to our nation, and so too should veterans have the ability to utilize VR&E benefits throughout their lifetimes. Service-disabled veterans must be authorized to receive access to VR&E services at any point during their employable lives when service-connected disabilities interfere with their employment.



Disabled Veteran Unemployment

Recommendation

- Increase overall awareness and outreach concerning disabled veteran unemployment to include referring eligible veterans to VR&E services.

Background and Justification

Veterans with disabilities continue to struggle in the job market with lower labor force participation rates compared to veterans without disabilities. Employment challenges are even greater for veterans with the highest disability ratings. Veterans who have a disability rating of less than 30 percent were about 40 percent more likely to be engaged in the workforce than veterans with a 60 percent or higher disability rating. [1] Only about four in every 10 veterans with a 60 percent or higher disability rating participated in the labor force in 2017. [2] This growing labor force participation disparity exists for Gulf War-era II (post-9/11) veterans who have served on active duty since September 2001. Bureau of Labor Statistics

(BLS) data showed that Gulf War-era II veterans without a disability were 12 percent more likely to be in the labor force than Gulf War-era II veterans with disabilities. [3]

The total number of veterans with a service-connected disability increased from 2,225,289 in fiscal year (FY) 1986 to 4,356,443 in FY 2016. [4] However, in FY 2016, only around 135,000 veterans used the vocational rehabilitation benefit. [5] Veterans who have at least a 10 percent rating are eligible for vocational rehabilitation benefits. The number of veterans who are service-connected compared to the number of veterans who are receiving vocational rehabilitation benefits is

staggering. It is obvious VA must do a better job to address the lack of veterans using this benefit.



VA Pension/Work Disincentives

Recommendation

- Work disincentives in the VA pension program should be re-examined and policies toward earnings should be changed to parallel those in the Supplemental Security Income (SSI) program.

Background and Justification

Many veterans, who served honorably and were discharged in good health, later acquire significant disabilities. As a consequence, eligible veterans will qualify for VA's non-service-connected pension. VA pension is often likened to SSI under Social Security. However, SSI recipients have access to a work incentive program whereby their public benefit is gradually reduced as their earned income rises. Unlike SSI recipients, VA pensioners face a "cash cliff" in which benefits are terminated once an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may also receive a small Social Security Disability Insurance (SSDI) benefit that supplements their VA pension. If these individuals attempt to return to the workforce, not only is their SSDI benefit terminated but their VA pension benefits are reduced dollar for dollar by their earnings.

In 1984, under Public Law 98-543, Congress authorized VA to undertake a four-year pilot program of vocational training for veterans awarded

a VA pension. Modeled on the Social Security Administration's trial work period, veterans in the pilot program were allowed to retain eligibility for VA pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because, prior to VA eligibility reform, most catastrophically disabled veterans were reluctant to risk their access to VA health care by working. The VA Office of Policy, Planning and Preparedness examined the VA pension program in 2002 and, though small in number, seven percent of unemployed veterans on pension and nine percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work. Now that veterans with catastrophic non-service-connected disabilities retain access to VA health care, loss of access to medical care is no longer an impediment to work, but the VA pension "cash cliff" remains a barrier.



Strengthen Veteran-Owned Small Business (VOSB) Programs

Recommendations

- Congress must take the necessary steps to prevent excessive delays in awarding contracts to Service-Disabled Veteran-Owned Small Businesses (SDVOSBs) and VOSBs by requiring all federal agencies to use a single-source verification database.
- All federal agencies must meet the set-aside goal of not less than three percent of the total value of all prime and subcontract awards to businesses controlled by service-disabled veterans each fiscal year.
- DOL and VA must improve oversight and assist in development and implementation of stronger strategies to reach the federally mandated minimum three percent procurement goal.
- Congress should revise the enforcement penalties for misrepresentation of a business as a VOSB or SDVOSB from a reasonable period of time as determined by the VA Secretary to a period of not less than five years.
- Congress must establish a reasonable transition period for SDVOSBs to retain federal protected status following the death of the disabled veteran owner.

Background and Justification

The federal government's support of VOSBs and SDVOSBs contributes significantly to restoring veterans' quality of life while aiding in their transitions from active duty.

Section 502, Public Law 106-50, of the Veterans Entrepreneurship and Small Business Development Act of 1999, codified "the Government-wide goal for participation by small business concerns owned and controlled by service-disabled veterans shall be established at not less than [three] percent of the total value of all prime contract and subcontract awards for each fiscal year."

Many federal agencies have not reached the

government-wide three percent goal of set-aside contracts, therefore a veteran's ability to compete for contract awards remains problematic. Federal agencies must be held accountable to meet the federal procurement goals outlined by Executive Order No. 13360 and sections 15(g) and 36 of the Small Business Act, which gives agency contracting officers the authority to reserve certain procurements for SDVOSBs.

Congress should enact legislation requiring the federal government make set-aside goals of not less than three percent mandatory objectives rather than goals. Congress should require underperforming federal agencies to make up shortfalls in achieving

these objectives in the subsequent fiscal year.

Because of changes in the verification system, timely verification continues to be an issue for SDVOSBs and VOSBs. According to reports from both the GAO and VA's Office of Inspector General, fraud continues in the Veterans First Contracting Program. VA must hire and train a sufficient number of employees to quickly and effectively certify and re-certify veterans' small businesses.

Finally, while acquiring an initial federal contract and meeting its many prerequisites may be a big challenge for SDVOSBs, the death of a service-disabled business owner presents an even greater obstacle for their survivors. Surviving spouses or children may lose the SDVOSB or VOSB status in

its entirety when the veteran dies.

Currently, surviving spouses of 100 percent disabled veteran business owners have a 10-year period to re-categorize the business after the date of the veteran's death if the death is related to their service-connected disability. All other surviving spouses have one year to transition if the contract is through VA, and loss of status is immediate if the contract is held by any other federal agency.

Accommodations must be made so businesses built and operated by ill and injured veterans can continue to thrive and support not only the owner's family, but also the families of those who are employed through these SDVOSBs.

Employment and Education Endnotes

Disabled Veteran Unemployment

[1] News Release, U.S. Bureau of Labor Statistics, Employment Situation of Veterans – 2017 (Mar. 22, 2018) <https://www.bls.gov/news.release/pdf/vet.pdf>.

[2] Ibid.

[3] Ibid.

[4] National Center for Veterans Analysis and Statistics, Office of Enterprise Integration, Department of Veterans Affairs (2018) https://www.va.gov/vetdata/docs/utilization/SCD_Rating.xlsx.

[5] National Center for Veteran Analysis and Statistics, Office of Enterprise Integration, Department of Veterans Affairs (2018) https://www.va.gov/vetdata/docs/utilization/Summary_of_Veteran_Benefits.xls.

Infrastructure

Capital Infrastructure

Recommendations

- The Department of Veterans Affairs (VA) must prioritize new construction and renovation projects that increase long-term care and community living center capacity to meet the needs of the aging veteran population.
- VA must accomplish the most critical components of larger projects with smaller, more easily achievable and expeditious projects.
- *The Independent Budget* veterans service organizations (IBVSOs) recommend that VA immediately begin a review of its capital infrastructure priority lists and set in place a plan to work through the lists of current projects within 10 years, regardless of the outcome of the upcoming Asset and Infrastructure Review mandated by the VA MISSION Act.
- The IBVSOs also recommend shifting VA's construction model to an Integrated Design Build (IDB) model for its less technical projects in order to maximize efficiency and cost savings. This will allow the VA to shorten the overall length of major construction projects, by overlapping the three phases of the project. However, the IBVSOs still recommend utilizing the Design-Bid-Build process for complex medical facilities and inpatient health care units.
- VA needs to ensure all seismic and life safety issues are placed at the top of the Strategic Capital Investment Plan (SCIP) list and remain at the top until they are rectified. Having seismic deficiencies on the SCIP list year after year is unacceptable and could lead to catastrophic events if left unresolved.
- VA also needs to prioritize non-recurring maintenance (NRM) as these oftentimes represent critical deficiencies which directly affect patient safety on a daily basis. For example, the need for heating and cooling system repairs, or generator upgrades, may not immediately stand out as critical, but failures of these systems could lead to life safety issues. Additionally, deferring regular maintenance issues and upgrades is typically not prudent as this often exacerbates problems which necessitates more costly future remedies.

Background and Justification

For more than 100 years, the government's solution to provide health care for our military veterans has been to build, manage, and maintain

a network of hospitals across the nation. This model allows VA to deliver care at 1,753 facilities, but has left it with more than 5,600 buildings

and 34,000 acres, many of which are past their building lifecycle. Many of these facilities need to be replaced, some need to be disposed of, and others need to be upgraded and expanded. All buildings being utilized need to be regularly maintained.

The current process to manage this network of facilities is SCIP. SCIP identifies VA's current and projected gaps in access, utilization, condition, and safety. Then it lists them in order based on the gaps priority.

Major Construction

Congress must enact legislation and VA must promulgate regulations to facilitate public-private partnerships and sharing agreements to support VA's upcoming Asset Infrastructure Review (AIR) process. Additionally, Congress and VA must fully fund the projects that are currently partially funded, and begin the advanced planning and design phases of those projects it knows it will need to fund through the traditional appropriations process, regardless of the outcome of the AIR process.

Currently, VA has 24 major construction projects that are partially funded, some of which were originally funded in fiscal year (FY) 2004, that need to be put on a clear path to completion. There are also numerous additional projects that are in the design phase and have already received large expenditures in planning time, resources, and fees. Outside of the partially funded major projects list are major construction projects at the top of the FY 2018 priority list that are seismic in nature. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long-term.

Of those 24 partially funded projects, VA will need to invest more than \$3.5 billion to complete them all. Of the top five projects on the priority list, none of them are seismic corrections. Only one is core to the mission of VA – a spinal cord injuries and disorders center.

A significant time and cost-cutting measure the VA should use is moving its construction entirely to an Integrated Design Build (IDB) model for the less

technically demanding facilities such as outpatient clinics, administrative areas, parking structures, and other similar needs. This will allow the VA to shorten the overall length of major construction projects, by overlapping the three phases of the project. However, the IBVSOs recommend continuing to utilize the Design-Bid-Build" process for complex medical areas and inpatient healthcare units.

The largest added benefit of the IDB process is that it saves time over the entire length of the project. Currently, the three phases of building — the design, the bidding, and the building — happen sequentially. Integrating the three phases allows for some overlap of the different phases and shortens the entire length of the project, sometimes by as much as years. Another added benefit of the IDB is bringing the contractors on board during the design phase of the project. Allowing the builders and the designers to interact as a team helps to prevent future conflicts during the building phase. Teamwork in the design phase alleviates problems up front, which saves time and ultimately money.

The IBVSOs recommend VA explore using a more standardized modular design and building model. There always needs to be room for different buildings or layouts to be utilized in individual cases, but moving towards a standardized layout and construction could lead to a faster and more streamlined building of facilities. There is no need for VA facilities to be designed based on aesthetics. Facilities should be built with the patients in mind - meaning getting from ground-breaking to ribbon-cutting in the most effective and simplified manner

possible. The example of the Rocky Mountain Regional VA Medical Center must never be repeated. The impractical design of that facility did

not have the patients in mind. This type of mistake can be avoided by simplifying the design and construction of medical facilities.

Minor Construction

Currently, there are approximately 600 minor construction projects that need funding to close all current and future year gaps within 10 years. To complete all of these current and projected projects, VA will need to invest between \$6.7 and \$8.2 billion in minor construction over the next decade. In FY 2019, Congress requested \$706,889 million for minor construction projects. This amount was supplemented by \$2 billion in funding, mainly directed for minor construction projects and repairs

impacted by natural disasters in the southern region of the country.

While the supplemental funds have helped, there are still hundreds of minor construction projects that need expedited funding for completion. Congress must continue to provide adequate annual appropriations for minor construction and should consider additional supplemental appropriations as necessary to ensure VA's facilities remain safe.

Leasing

Historically, VA has submitted capital leasing requests that meet the growing and changing needs of veterans. In recent years, decisions by Office of Management and Budget (OMB) and Congressional Budget Office (CBO) have required that the 10-year cost of VA leases be considered as the "score" for Pay-As-You-Go (PAYGO) purposes for the first year of the lease, requiring enormous offsets to remain PAYGO compliant. As a result, many VA Community Based Outpatient Clinics

(CBOCs) have been unable to sign new, or renew existing leases. When VA requests adequate resources, Congress must find a way to authorize and appropriate leasing projects in a way that precludes the full cost of the lease being accounted for in the first year. Delays in authorization of these leases has a direct impact on VA's ability to provide on time care to veterans in their communities. Congress must adjust the leasing process in which leases are authorized.

Nonrecurring Maintenance

Even though non-recurring maintenance (NRM) is not funded as part of one of its construction accounts, NRM is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows

and equipment, and preserving roofs and floors. 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 veterans alike.

As VA works to close these gaps, they and Congress must make it a priority to maintain what we have, finish what has been started, and chart a long-term plan to effectively close future gaps.

Although VA's Strategic Capital Investment Planning program clearly identifies the current and projected 10-year gaps in delivery of health care,

historically VA has lacked a long-term funding strategy to effectively close these gaps in the most veteran-centric and cost effective way. With passage of the VA MISSION Act, Congress is now required to begin an Asset and Infrastructure Review (AIR) over the next 5-6 years. The IBVSOs recommendations on AIR are included in *The Independent Budget's* Critical Issue section.

National Cemetery Administration

Increase the Value of Veterans' Burial Benefits

RECOMMENDATIONS

- Burial and plot allowance must be increased to current costs and indexed to inflation.
- Burial benefits must be adjusted to ensure veterans who do not have access to national, state, or tribal cemeteries are able to afford a burial which honors their service.

Background and Justification

Burial and Plot Allowance

The burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In its early history, the burial allowance was paid to all veterans, regardless of whether or not they died of a service-connected condition. Then, in 1973, the burial allowance was modified to reflect the status of service connection by paying those who died of a service-connected condition an increased amount. Also in 1973, the plot allowance was introduced to provide burial plot benefits for veterans who did not have reasonable access to a national cemetery.

The current payment for burial expenses is \$2,000 for service-connected deaths and \$300 for non-service-connected deaths, along with a \$780 plot allowance regardless of service connection. At its inception, the benefit covered 72 percent of the funeral costs for a service-connected death, 22 percent for a non-service-connected death, and 54 percent of the cost of a burial plot. However, there is a serious deficit between the benefit's original value and its current value. In order to restore the

benefit to its original intended value and adjust for inflation, Congress should increase the burial benefits and plot allowances so they represent the same percentage of current costs that were intended to be covered in 1973.

Plot allowances do not vary depending on whether or not the veteran died of a service-connected condition. All veterans who are eligible to be buried in a national cemetery and who served during wartime can apply for the benefit. The plot allowance should be increased to \$1,327 to reflect current costs, which would approximate to 54 percent of what the average price for a plot would be today.

One of the National Cemetery Administration's (NCA) strategic goals is to provide reasonable access (within 75 miles of a veteran's residence) to a burial option in a national or Department of Veterans Affairs (VA)-funded state or tribal veterans' cemetery for 95 percent of eligible veterans. Currently, the NCA reports that they have reached 92 percent of this access standard.

Increased Benefit for Those Who Lack Access

Based on NCA's 75 mile access standard and the desire to provide quality burial benefits, IBVSOs recommend that the NCA separate burial benefits into two categories:

- 1.) Veterans who live within 75 miles of a VA, state, or tribal cemetery that has available plots; and
- 2.) Those who live more than 75 miles away from a VA, state, or tribal cemetery that has available plots.

The IBVSOs believe that those veterans who live more than 75 miles away, and therefore do not have reasonable options to use VA, state or tribal cemeteries, should be paid at a rate based on the cost of a private burial. To meet percentage levels from 1973, the burial benefit would need to be

\$7,107 for service-connected burials, and \$2,213 for nonservice-connected burials outside the accessibility model distances.

For those who live within 75 miles, we believe that an adjusted rate of benefits is warranted for veterans who elect to be buried in a private cemetery, regardless of their proximity to a state or national veterans' cemetery that could accommodate their burial needs. The veterans' burial benefits should be based on the average cost for VA to conduct a funeral. Using this formula, the benefit for a service-connected burial would approximately adjust to \$3,223; the amount for a non-service-connected burial would roughly increase to \$985. These changes would provide burial benefits at equal percentages, based on the average cost for a VA funeral, adjusted to 2018 inflated costs.



Expand Eligibility for Burial Benefits

RECOMMENDATIONS

- Congress should authorize VA to provide an allowance for transportation of veterans' remains to tribal cemeteries.
- Congress should give authority to VA to provide outer burial receptacles to state and tribal cemeteries.
- Congress should establish a grant to enable NCA to expand the Veterans Legacy Program.

BACKGROUND AND JUSTIFICATION

Transportation of Remains to Tribal Cemeteries

In 2017, there were 11 fully operational tribal cemeteries, two in development, and 10 pre-applications for tribal cemetery grants. Currently, VA will reimburse the cost of transporting a veteran's remains to the nearest national cemetery if the veteran died of a service-connected condition. If a veteran died while receiving or traveling at VA expense, VA will cover the costs to transport a veteran's remains from the place of death to the place of burial.

VA allows payment of the "charge for pickup of remains" on a round-trip or flat-charge basis. If the veteran dies while receiving authorized VA care, the remains are shipped to the place of

burial by rail, and the charge for transporting the body equals the cost of two first class tickets. Currently, VA will provide payment for transportation to a national cemetery; "nearest national cemetery" is defined in many ways but it does not currently include tribal cemeteries.

VA has made significant strides in providing support to Native American veterans to include grants for cemeteries, increasing outreach to tribal veterans, and tribal veteran service representatives. Furthermore, VA now provides healthcare to tribal veterans including extending beneficiary travel benefits. Congress should authorize VA to provide an allowance for transportation of veterans' remains to tribal cemeteries.

Outer Receptacles for State and Tribal Cemeteries

By VA definition, an outer burial receptacle is a grave liner, burial vault, or other similar type of container for a casket. VA will pay a monetary allowance for each burial in a VA national cemetery where a privately-purchased outer burial receptacle was used on and after October 9, 1996. For burials on and after January 1, 2000, the person identified in records contained in the NCA Burial Operations Support System as the person who privately purchased the outer burial receptacle will be paid the monetary allowance.

For burials during the period October 9, 1996 through December 31, 1999, the allowance will be paid to the person identified as the next of kin in

records contained in the NCA Burial Operations Support System, based on the presumption that such person privately purchased the outer burial receptacle. If a person who is not listed as the next of kin provides evidence that he or she privately purchased the outer burial receptacle, the allowance will be paid instead to that person. No application is required to receive payment of a monetary allowance.

The Independent Budget veterans service organizations (IBVSOs) agree that state and tribal cemeteries should be included as accepted places of burial.

Expand Veterans Legacy Program

The IBVSOs believe it is important to perpetuate the memory and history of our fallen heroes. The NCA's Veterans Legacy Program ensures the memories and stories of the brave men and women who have worn our nation's uniform are preserved in perpetuity. While it is still being fully developed, the program provides an avenue for students, descendants, friends, and fellow veterans to learn

about the contributions of veterans interred at VA national cemeteries made to their communities and the country.

The IBVSOs are strong proponents of the Veterans Legacy Program and urge Congress to establish a grant to help VA conduct research and produce educational materials for the program.



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