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HEARING ON PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

MAY 24, 2016

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HEARING ON PENDING LEGISLATION

TUESDAY, MAY 24, 2016

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:15 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Heller, Tillis, Sullivan, Blumenthal, Brown, Tester, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call to order this hearing of the Veterans' Affairs Committee of the U.S. Senate.

In my opening statement, I want to address a subject which became prominent yesterday in remarks made by the Secretary to *The Christian Science Monitor*, which I quote from what I read in the media was said at the meeting. '"When you go to Disney, do you measure the number of hours you wait in line or what is important," McDonald told reporters at *The Christian Science Monitor* in Washington. "What is important is your satisfaction with the experience."'.

That is a quotation that was, I am sure, not intended to send the message that it sent, but at least in part, it sent a more trivial message than I think it should have. I think the Secretary owes the veterans of the United States of America and this Committee an apology for making that reference.

We all make mistakes. I ran a big company. I have been a U.S. Senator. I have been a politician for 38 years. I have said things and I have had to say I am sorry before. The quicker you say it, the better off you are to put behind you something that may not have been intended, but, in fact, once it was out, your message became fact.

So, as Chairman of the Committee, and I have not had a chance to talk with the Ranking Member yet, but I think every Member of the Committee probably feels the same way I do. We are so close to reforms in the VA to further expedite the products of the Veterans Administration in terms of taking care of our veterans that for us to lose our inertia by quotes that send the wrong message would just be terrible. So, it is my hope the Secretary will correct what was obviously not the intent of the statement, make sure the veterans know that their service first is what is most important to us, and that waiting in line does mean something. It is one thing

to wait for a roller coaster. It is another thing to wait for a blood transfusion. The two should not be comparable in one way or another.

With that said, I will turn to the Ranking Member.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. I want to thank the Chairman for his remarks, which I think capture the feelings of a lot of our reaction to the remarks that we read without knowing in advance they were going to be made. They were unfortunate. I certainly hope and believe they do not reflect the intentions and dedication of Secretary McDonald to continue efforts to improve the VA's delivery of services that our veterans need and deserve, and part of delivery is doing it without delay. Time is a critical factor, as well as the quality of service.

My hope is that we can work together, as we have done on a bipartisan basis for the Veterans First Act, which will bring fundamental reform to assure accountability in the VA as well as improving the delivery of education and health care, Caregivers' and other truly important programs.

I want to thank the Chairman for having the hearing today and for our colleagues who will be testifying before us.

We must reform the appeals process. We have to improve VA's programs for providing care in the community as well as make sure that VA's construction program is managed well. We have to do more to ensure that women veterans, the fastest growing population at the VA, have access to the care they deserve and need. Those measures are before us today.

My hope is we will look forward and seek to improve and continue the vital and significant work that we are doing together to those ends and to the goals that we share in the Veterans First Act. I am very hopeful, in fact, optimistic, that we can bring the Veterans First Act to a successful conclusion if we continue working together as we have done on a very bipartisan basis.

Thank you, Mr. Chairman.

Chairman ISAKSON. Just an editorial comment. Senator Blumenthal is exactly correct. We passed the Veterans First bill out of this Committee unanimously, and we want to get it to the floor and get it passed, because it deals with correcting all those things in terms of policies and procedures that the VA itself has asked for or that we have seen fit: to expedite appointments, to expedite health care, and improve the veterans services to our veterans. So, I want to at the beginning compliment all our Members of the Committee for the work they did on Veterans First. We are going to work hard to get it to the floor and make it happen.

With that said, Senator Tester.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Well, if I might, since Senator Boxer and Senator McCain are not here, I just might say a couple things.

Chairman ISAKSON. Absolutely.

Senator TESTER. First of all, thank you for your leadership, Senator Isakson and Ranking Member Blumenthal.

I would just like to say a few comments about Secretary McDonald. You pointed it out, Mr. Chairman. People say things they regret later, and I think that he is in that boat. If he has not apologized already, I am sure he will shortly.

I have had the opportunity on this Committee to serve under some really quality people as head of the VA, Secretary Peake, Secretary Shinseki, and now Secretary McDonald. I will tell you that each one of those people had strengths and each one of them had weaknesses, but they all had one thing in mind, I believe, and that is what is best for our veterans.

This Committee has done such great work in a bipartisan manner that I hope we can continue down that line moving forward, keeping the Veterans First Act in mind and keeping politics out of this Committee, because our veterans deserve a hell of a lot more than playing politics.

Thank you, Mr. Chairman.

Chairman ISAKSON. Well, I completely concur with your remarks and I thank you for your work in helping bring about the cooperation that made Veterans First come to reality.

Senator Sullivan.

STATEMENT OF HON. DAN SULLIVAN ,
U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Mr. Chairman, I just want to associate myself with your remarks. I appreciate your leadership, Senator Blumenthal's leadership, on the legislation we have been working on.

I agree with Senator Tester, and as you also mentioned, there are times we all make mistakes. I think that is obvious. But when you are in a leadership position, particularly in an organization where we are trying to change the culture—I think everybody here thinks we need to change the culture—those kind of comments, they are going to be noticed by tens of thousands, if not hundreds of thousands of veterans.

I think your wise counsel about coming out, apologizing as soon as possible, is what needs to happen.I certainly hope the Secretary takes you up on that wise advice.

Chairman ISAKSON. Thank you, Senator Sullivan. Thank you for your leadership on Veterans First. We appreciate it.

We have two distinguished Members of the Senate here. Our Committee procedure is when members who are not Members of the Committee testify, we will give them a few minutes at the beginning of our hearing to state their case for their legislation. Then as is our practice, we do not engage them in questions when it is over.

So, Senator Boxer and Senator Klobuchar, both of you may make your statements, then you can remain as long as you want to, but we are not going to subject you to any inquisition nor questions.

To begin, I will go with seniority. I will start with Senator Boxer from California.

STATEMENT OF HON. BARBARA BOXER,
U.S. SENATOR FROM CALIFORNIA

Senator BOXER. Thank you, Mr. Chairman. I would certainly love to have your questions, but I know you have a lot to get through. I thank you so much, all of you, particularly, Mr. Chairman and Ranking Member Blumenthal, plus every member who is here.

I am pleased that the Female Veteran Suicide Prevention Act, which I introduced with Senators Blumenthal, Brown, and Ernst, is on today's agenda. This bill addresses a very important issue that deserves our continued attention, the tragic epidemic of suicide among veterans, especially among our female veteran population.

Last year, a VA study found that female veterans commit suicide at nearly six times the rate of non-veteran women—six times the rate of non-veteran women—and the rates are even higher among younger veterans. For women between the ages of 18 and 29, the rate increases to nearly 12 times the civilian rate. Something is horribly wrong here. It is heartbreaking. It is unacceptable. We are in a position, I think, to address it in this bill.

There are now more than two million women veterans in the United States and that number is growing. As we encourage and welcome more brave women into the service, we must remember that their health care needs often differ from men's, and that includes mental health care. Women veterans have different life experiences and gender-specific concerns that may well require different treatments. We know that many experience physical or mental trauma as a result of their service, and women veterans are more likely than their civilian counterparts to have experienced harassment or sexual assault, something that I know we all care about. When these women leave the service, the transition can be difficult.

That is why we must increase our understanding of the unique experiences of female veterans and ensure that they know that the mental health care and support they need is waiting for them at the VA.

Our legislation would build on previous efforts to examine the services we are providing our veterans. It would take a very hard look at which programs are working and which are not working for our at-risk female veterans. I think it is important to know that we are spending taxpayer dollars. We should spend the taxpayer dollars wisely and not waste it on programs that may work well for certain other categories, but not these particular women. Our legislation requires the VA to identify the programs that are the most effective and that have the highest satisfaction rates among female veterans in its annual evaluation of mental health and suicide prevention programs.

It would also require them to include specific metrics on women veterans. Our daughters, our sisters, our wives, and our mothers who have served our country courageously deserve the best possible care we can provide.

The VA, I know, is doing everything it can to help prevent suicides, but we know we can do better. We can always do better. That is why our Founders said "a more perfect Union," and they did not say that we have a perfect Union. We can do better on this.

We have to do better. It is wrong that our female veterans have a higher rate of suicide than the civilian sector, up to 12 times more.

We owe our veterans, I think, at least this bill, which will give us the information we need to prevent this horrible crisis.

Thank you very much.

Chairman ISAKSON. Thank you very much, Senator Boxer. We appreciate it.

Senator McCain, you have been deferred to by Senator Klobuchar. Amy told us it is always important to remember that age comes before beauty. [Laughter.]

Chairman ISAKSON. To that end, I——

Senator MCCAIN. Has she already finished? [Laughter.]

Senator KLOBUCHAR. No, I want to get to you. [Laughter.]

Chairman ISAKSON. I tell you, you can never one-up John McCain, I am going to tell you that. [Laughter.]

But, let me just say this on behalf of myself and, I think, Senator Blumenthal, who is a veteran like so many in the U.S. Senate, but the veteran's veteran in the U.S. Senate is John McCain. We are honored to have him here today.

Senator McCain, the floor is yours.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA

Senator MCCAIN. I thank you, sir, and I thank my friend from Minnesota on the great job and effort she is making.

By the way, on the suicide issue, I agree with the Senator from California. But I also would point out we did pass unanimously the Clay Hunt Suicide Prevention Act, which I think addressed many of the concerns. I will be glad to have additional legislation, but I think it is only about a year-and-a-half old. We might give that Act a chance to see if it is going to work or not. But all of us, including the Senator from California, are very concerned about this terrible issue of veteran suicides.

I want to thank all my colleagues regarding the legislation called the Care Veterans Deserve Act. The bill would make the Veterans Choice Card easier for our veterans. Today, the only veterans who are eligible, as the Committee knows, are those who are waiting more than 30 days or live more than 40 miles from a VA health care facility. The bill would make the Choice Card universally available to all disabled or eligible veterans, no matter where they live or how long they are waiting for care so they can get the flexible quality they want and need.

The legislation provides greater certainty to our veterans and doctors currently enrolled in the Veterans Choice Card program. Many people are not aware that if Congress does not act soon, the Veterans Choice Card program will expire next summer. Some doctors are refusing to serve veterans under the Choice Card until they are certain it will be extended for the long term. The bill provides both veterans and doctors the certainty they need by making this vital program permanent.

Mr. Chairman, we have been working in the Senate on a 3-year extension of the card under existing rules for eligibility. I will continue to work with you and the Committee to pass that extension.

I strongly believe the best way to improve veterans health care is to enable all eligible veterans to access the Choice Card.

The bill that we have put forward includes a number of other provisions, for example, allowing veterans who develop a cold or the flu to visit walk-in clinics without preauthorization from the VA. Today, veterans with non-urgent medical conditions must call the VA for an appointment, which could take weeks to schedule, and if veterans complain about the wait, the VA tells them to go to an overcrowded emergency room. Senator Flake and I heard testimony from a number of veterans who have sat in the ER for up to 14 hours without being seen. Veterans told us that for minor illnesses, they just wanted a way to see a health care provider on the same day and this legislation would do that.

This legislation would require VA clinics and pharmacies to extend their operating hours to nights and weekends in order to provide comparable pharmacy services offered by retail pharmacies. Currently, only a small number of VA facilities offer evening or weekend options for veterans, which makes it difficult for working veterans who often cannot take the entire workday off in order to see a doctor and obtain a prescription.

We know the VA has a long way to go to eliminate the never-ending wait times. The Congress provided the VA an extra $5 billion in emergency funding to hire doctors, nurses, and medical support staff. The VA needs to use this money to hire or contract for doctors to eliminate the wait times that are still as high, or in some cases higher, than they were during the scandal.

Critically, this legislation would allow the health care professionals licensed, registered, or certified in one State to use telemedicine to provide treatment to veterans in other States.

We encourage the VA Health Care System to undergo a best practices peer review. I want to just emphasize, if I could—Mr. Chairman, why do we not get organizations like the Cleveland Clinic or Mayo or others to come in and look at these VA facilities to see how they are doing business to say, here is how you can improve. There are some outstanding examples all over the country of health care providers that really know their business, so why not have a peer review and send them in? It would be very inexpensive. In fact, I know that the Mayo Clinicwould do it for free because of their dedication to our veterans. Mayo would go see how they are doing business; show them how they can improve. I think that is pretty obvious.

I just want to point out that because of the Choice program, so far 1.4 million appointments for veterans who would otherwise wait for delayed care, over 2.5 million separate payments to doctors and hospitals were made, and over 450,000 Choice health care providers across the Nation have joined to date for veterans to choose from. The Choice Card triples the number of health care providers that can care for our Nation's veterans. One hundred seventy thousand medical appointments for veterans under Choice were made last month alone, more than 7,500 per work day.

So, Mr. Chairman, I want to thank the Members of this Committee on both sides for their bipartisan effort on behalf of our veterans. Senator Blumenthal and you, I think, represent the best of us in the U.S. Senate in working together, and I think that that—

and all members—has led to favorable outcomes for our veterans. So, I want to thank you for that and I want to thank you for the work you have done so far.

Chairman ISAKSON. Senator McCain, I just want to add that in August 2014, you led the conference committee that created the Veterans Choice program. In the 2 years since it has been implemented, it has been a force multiplier for physicians being able to be available for our veterans. It has begun to deliver on the promise that you led us to, which came out of the terrible tragedy that started in your State in terms of wait times. So, your leadership is appreciated. What you have done is appreciated and we will give it thorough consideration.

Senator MCCAIN. I want to thank you, and I would like to mention the product of that was negotiations with Senator Sanders, who was then-Chairman of the Committee. I would also allege that I am one of the first to feel the Bern. [Laughter.]

Senator BLUMENTHAL. Mr. Chairman, I hate to follow that remark with anything——

[Laughter.]

Senator BLUMENTHAL [continuing]. As you said at the outset, there is no one-upping Senator McCain. I just want to personally thank Senator McCain for his leadership on the amendment that hopefully we will consider to the NDAA. I am very proud to be the lead Democrat supporter of that amendment, which will extend community choice and care in the community. I look forward to working with him on this proposal, as well. Thank you for the leadership, Senator.

Chairman ISAKSON. Thank you, Senator McCain.

Senator Klobuchar.

STATEMENT OF HON. AMY KLOBUCHAR, U.S. SENATOR FROM MINNESOTA

Senator KLOBUCHAR. Thank you very much, and thank you, Senator McCain, for your service and your good work.

I want to also thank the Chairman and Ranking Member Blumenthal, to walk in here and hear the rather calm discussion about the Secretary's remarks. I share your sentiments about the need for an apology, but I appreciated your thoughtfulness in how you approached this, Mr. Chairman, as you do so many issues. I know from having co-chaired the National Prayer Breakfast with you, that you show great leadership, so thank you for that.

I am here on two bills, both of whom I am leading with Senator Tillis. The first, actually—Senator McCain's service in the Vietnam War reminds us of what happened during the Vietnam War when the U.S. sprayed 80 million liters of Agent Orange and Vietnam vets came home with nerve, skin, digestive, and respiratory disorders. Thousands of veterans asked for help, but it took the government years to recognize that link.

We have something else going on right now and we do not really know the scope of it, but we know there is an issue, and that is the issue of burn pits. At military sites across Iraq and Afghanistan, burn pits were used for waste disposal, old batteries, aerosol cans, tires, dead animals, and even human waste. Oftentimes, jet fuel was used as an accelerant. The volumes and types of minerals

varied by site, but the Department of Defense has estimated that between 65,000 and 85,000 pounds of solid waste were burned each day at large bases. One joint base burned up to 147 tons of waste per day, and these open air pits would frequently burn 24 hours a day, exposing thousands of soldiers.

I have heard personally from hundreds of constituents, as has Senator Tillis. One of them, Melissa Gillett from Minnesota, was a member of the 148th Fighter Wing based in Duluth. She got into the National Guard with a plan to stay in the National Guard for 20 years. She was very healthy. Then she was exposed to burn pits in Afghanistan. She experienced a host of negative health effects, like asthma, sinus issues, and because of her breathing issues, she was not able to pass her fitness test and could no longer serve in the National Guard.

There has been a study on this, a 2011 Institute of Medicine report that has been inconclusive about the long-term effects. As you all know, there is a registry. Sixty-five thousand Iraq and Afghanistan veterans have begun the process of filing reports with the VA's voluntary registry. Of vets who completed the questionnaire, 30 percent stated that they have been diagnosed with respiratory diseases.

What our bill does is to create a Center of Excellence in the VA to better understand the health effects. Senator McCain is a cosponsor as well as Senator Rounds, Senator Gillibrand, and Senator Franken. It has received the support of Iraq and Afghanistan Veterans of America and the American Lung Association. It really points us in the right direction of looking at dedicating staff and resources to exploring, diagnosing, treating, and rehabilitating. We are hopeful that it will receive the support of this Committee.

For the second bill, I will be more brief, which is the Newborn Care Improvement Act. This is a bill, again with Senator Tillis—oh, here he is. This bill actually has already passed the House back in February without any controversy. What it does is it doubles the number of days from 7 to 14 that a veteran's newborn baby can get post-delivery care services.

Right now, a qualifying veteran must find outside health care for her child within 7 days of birth or the baby will not be covered for care. Factors like PTSD and combat injuries mean many female vets face high-risk pregnancies and this time of 7 days is simply not enough, even for a birth without complications. The standard of care for healthy newborns is 14 days. Nearly all pediatricians require newborns to return to the hospital at 2 weeks for a check-up.

As I said, the House passed this without controversy, and as Senator Boxer was just talking about in a different context, women represent the fastest growing group of veterans who are enrolled in VA health care.

I have introduced this legislation as an amendment to NDAA and I hope that we can work together, either pass this legislation that way, as well as the burn pit bill, or pass it some other way.

I thank you very much, Mr. Chairman, for allowing me to speak today and all the good work, bipartisan work, you do on this Committee.

Chairman ISAKSON. Thank you very much, Senator Klobuchar. We appreciate your help and your testimony and we will be with you soon.

It is now time for our first panel to come forward. Sloan Gibson, the Deputy Secretary of the Department of Veterans Affairs; Laura Eskenazi will accompany him, as will David McLenachen and Baligh Yehia.

Michael Michaud, Assistant Secretary of Labor for Veterans Employment and Training, U.S. Department of Labor; accompanied by Patricia Shiu, Director, Office of Federal Contract Compliance Program, will also be on the first panel.

Let me acknowledge before I start that Deputy Secretary Sloan Gibson has asked to have a few more than the standard 5 minutes, so we will give him eight, and if he goes too far past that, we will go get him. [Laughter.]

Deputy Secretary Gibson.

STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LAURA ESKENAZI, EXECUTIVE IN CHARGE AND VICE CHAIRMAN, BOARD OF VETERANS APPEALS; DAVID McLENACHEN, DEPUTY UNDER SECRETARY FOR DISABILITY ASSISTANCE, VETERANS BENEFITS ADMINISTRATION; AND BALIGH YEHIA, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION

Mr. GIBSON. Thank you, sir.

Let me briefly address the attention that has been generated by Secretary McDonald's comments yesterday. First and most importantly, anyone who knows Bob McDonald knows that he would never, ever diminish the importance of improving veterans' access to care. Bob has made improving access to care for veterans the number 1 priority of VA since he arrived almost 2 years ago.

He has worked tirelessly to lead and inspire the Department to improve the timeliness of care and the provision of benefits to veterans. He has repeatedly indicated to all kinds of audiences that our goal is to ensure that VA becomes the number 1 customer service organization in the Federal Government. He is doing everything he can and we are working with him to make VA more veteran-centered and increase veteran satisfaction.

He is leading the Department in following the best practices of the private sector health care providers who recognize that there is more to patient satisfaction and a great health care experience than wait times.

I was reminded recently, it was almost 2 years ago that an acting Secretary, who I know well, said before this particular committee, and I quote, "I think as we move forward, what we are going to find is that average wait times are a very poor gauge for timeliness of care for a large integrated health system. You do not really find that out in the private sector. That is one of the reasons we are boosting our patient satisfaction measurement activities, because I think patient satisfaction is going to become central. Even at a 14-day standard, if the veteran needs to be seen today, we have failed that veteran." That statement was made before this

Committee on July 16 back in 2014. It was true in 2014. It is true today. We know we have work to do to improve access to care.

Bob and I deeply regret the distraction from the veterans' work that has been caused by these remarks and the perception that was created that veterans' access to care is anything other than our absolute top priority.

Second, a quick comment. I would be remiss if I did not express my appreciation to the Committee and especially to you, Mr. Chairman, for your leadership on the Veterans First Act. We strongly support that legislation. We are grateful for the opportunity we had to work collaboratively with you and the Committee, and I have at least some small sense of the effort that you personally have put into navigating this legislation through the process. Thank you, sir, and thank other Members of the Committee.

With all that said, thank you for presenting our views on several bills. I will really focus on just two elements here.

I am joined today, as you introduced Laura Eskenazi, the Vice Chairman of the Board of Veterans Appeals, Dave McLenachen, Deputy Under Secretary in VBA in the benefits area, and Dr. Baligh Yehia, who has been driving our processes in VHA around community care consolidation for the last number of months.

I also would be remiss if I did not acknowledge our partners from the various Veterans Service Organizations that worked so closely with us on the appeals reform draft legislation.

Appeals reform is a top priority for VA and we fully support the bill that is under consideration. It is critical to remember that the cost associated with implementing the new legislation is essentially zero. The additional funds that we hope Congress will provide year by year to reduce the inventory in the current system is separate from the legislation to modernize the process.

The current appeals process leaves veterans frustrated and waiting far too long. It was conceived some 80 years ago and has become a collection of processes that have accumulated over time, unlike any other appeals process in the Federal Government. Layers of additions to the process have made it more complicated, more opaque, more unpredictable, and less veteran-friendly. It makes adversaries of veterans and VA and it is slow as molasses, using a good Southern term that we are both familiar with, sir.

The average processing time for all appeals is about 3 years. For an appeal that goes to the Board for approval, the average time to decide is about 5 years. Many appeals are much older. Last year, the Board was still adjudicating an appeal that originated 25 years ago which had been decided 27 times in that 25 years. That is not right for veterans and it is not right for taxpayers, and it is only going to get worse unless we tackle this and make change.

We now have over 450,000 appeals pending, and without major reforms, average wait times will grow to somewhere in the neighborhood of 10 years instead of 3 to 5 years. We are working within existing restraints and resources to try to respond to the problem. We are upgrading technology, applying lessons that we have learned from VBA's automation and transformation of the claims process. We have adopted a standard notice of disagreement form to initiate an appeal. VBA has added 300 additional staff just for appeals work in the last year, and they have allocated $10 million

for appeals work in overtime—just appeals work in overtime during 2016.

The Board is doing their part. The appeals decision output has increased by one-third since 2013. They are now processing appeals at the highest rate since 1988.

Yet, despite these best efforts, veterans keep waiting longer for an appeals decision, and without action and reform, we will see that wait grow even longer. The problem is rooted in the fact that our antiquated, complex, and inefficient appeals process has made it impossible for us to keep up with the growing workload. As some younger veterans are surviving devastating wounds and returning home with higher levels of disability, it is no surprise we are seeing record numbers of disability claims with more medical issues per claim.

Looking back from 2010 to 2015, VBA has completed more than a million claims, disability claims, each of those years. In 2015, they completed 1.4 million claims, an all-time record. But more claims decided means more appeals, 35 percent more appeals in just the last 3 years. This dramatic increase in the volume of appeals is directly proportional to the increase in claims. We have seen, on average, over a period of time, about 11 to 12 percent of claims decisions wind up being appealed.

The appeals process is not working and the status quo is not an option. The solution is fundamental reform, and that is what we need to tackle now.

We strongly support this legislation, which has already brought VA, Veterans Service Organizations, and other stakeholders together in support of the bill. We should not burden veterans for a moment longer than necessary. The time to act is now.

The second bill on the agenda, S. 2896, would extend the Veterans Choice program and essentially remove all eligibility criteria built into the current law. It may make for an appealing sound bite to say you are giving every veteran a choice, but I would urge the Committee to listen to VSOs, to veterans, and to others who are deeply involved in the process who have the greatest stake in maintaining and improving the health care system that was built for them.

If this bill is enacted, we believe it would inevitably transform VA largely into an insurance provider and greatly erode our strengths as a health care provider centered on a continuing relationship with veterans and their entire spectrum of health care needs.

We are not against care delivered outside VA. Long before Veterans Choice, we were purchasing billions of dollars of care in the community because it was the right thing for veterans. We would be purchasing care in the community at an even higher rate in the future, but we believe that if this bill is enacted, the projected increases will drive budget increases that will be truly staggering. I would urge the Committee and all members to carefully consider the consequences of the provision.

We note that some concerns about other provisions, such as requiring VA to enter a nationwide contract with urgent care providers and expand the operating hours at VA pharmacies. These

are appealing notions at first glance, but we believe that they have unsustainable expenses as outlined in my written testimony.

Last, on the positive side, the change proposed in Section 4 would greatly help VA telehealth efforts by eliminating a significant legal roadblock. We also agree with requiring best practice reviews set out in Section 6 of the bill. The only point we would make is that we are already doing that based on some practices we put in place recently.

Mr. Chairman, I appreciate the opportunity to testify. We look forward to working with this Committee and our VSO partners to fix the broken appeals system, and we look forward to your questions.

[The prepared statement of Mr. Gibson follows:]

PREPARED STATEMENT OF HON. SLOAN GIBSON, DEPUTY SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Laura Eskenazi, Executive in Charge and Vice Chairman of the Board of Veterans Appeals (the Board), David McLenachen, Deputy Under Secretary for Disability Assistance for the Veterans Benefits Administration (VBA), and Baligh Yehia M.D., Assistant Deputy Under Secretary for Health for Community Care.

Thank you for the opportunity to come before you today to discuss the Department's legislative priorities, along with additional pieces of introduced legislation. I know the Committee has introduced an "omnibus" measure which will address many of the immediate needs of the Department of Veterans Affairs (VA) in serving Veterans.

Our pressing needs are items that we have outlined in letters to the Committee, in previous testimony, and in countless meetings with the Committee and members staffs, which support the *MyVA* Breakthrough Priorities. Some of these critical needs are addressed in bills you are considering in today's hearing, but we'd like to work with you on the particular language to ensure that, as enacted, the language will have the desired effect of helping the Department best serve Veterans. In particular, the legislation being considered today to address consolidation of community care presents challenges and concerns.

I believe it is critical for Veterans that we all work together and gain consensus on a way forward for these pieces of legislation that will provide VA with the tools necessary to deliver care and benefits at the level expected by Congress, the American public, and deserved by Veterans.

S. ____, A BILL TO REFORM THE RIGHTS AND PROCESSES RELATING TO APPEALS OF DECISIONS REGARDING CLAIMS FOR BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS

Addressing the appeals claims process is a top priority. The draft bill being considered today would provide much-needed comprehensive reform for the VA appeals process. It would replace the current, lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. VA fully supports this bill.

The current VA appeals process, which is set in law, is broken and is providing Veterans a frustrating experience. Appeals have no defined endpoint and require continuous evidence gathering and readjudication. The system is complex, inefficient, ineffective, confusing, and splits jurisdiction of appeals processing between the Board of Veterans' Appeals (Board) and the Veterans Benefits Administration (VBA). Veterans wait much too long for final resolution of an appeal. We face an important decision about the future of appeals for Veterans, taxpayers, and other stakeholders.

Within the current legal framework, the average processing time for all appeals resolved in FY 2015 was 3 years. For those appeals that reach the Board, on average, Veterans are waiting at least 5 years for an appeals decision, with thousands of Veterans waiting much longer. As Secretary McDonald noted in his February 23, 2016 testimony, in 2015, the Board was still processing an appeal that originated 25 years ago, even though the appeal had previously been decided by VA over 27 times. VA continues to face an overwhelming increase in its appeals workload. Look-

ing back over FY 2010 through 2015, VBA completed more than 1 million claims annually, with nearly 1.4 million claims completed in FY 2015 alone.This reflects a record level of production. As VA has increased claims decision output over the past 5 years, appeals volume has grown proportionately. Since 1996, the appeal rate has averaged 11 to 12 percent of all claims decisions. The dramatic increase in the volume of appeals is directly proportional to the dramatic increase in claims decisions being produced, as the rate of appeal has held steady over decades. Between 2012 and 2015, the number of pending appeals climbed by 35 percent to more than 450,000 today. VA projects that, by the end of 2027, under the current process, without significant legislative reform, Veterans will be waiting on average 10 years for a final decision on their appeal.

Comprehensive legislative reform is required to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair. This bill would provide that necessary reform. The status quo is not acceptable for Veterans or for taxpayers. Without legislative change, providing Veterans with timely answers on their appeals could require billions of dollars in net new funding over the next decade. By contrast, with legislation and a short-term increase in funding to address the current pending workload, VA could resolve the pending inventory, provide most Veterans with an appeals decision within 1 year by 2021, and greatly improve the efficiency of the Appeals process for years to come. We believe this can be done for net additional costs over 10 years in the millions of dollars, not the billions required by the status quo, saving money in the long-term compared to where we are headed without reform. If we fail to act now, the magnitude of the problem will continue to compound.

A wide spectrum of stakeholder groups recently met with VA to reconfigure the VA appeals process into something that provides a timely, transparent, and fair resolution of appeals for Veterans and makes sense for Veterans, their advocates, stakeholders, VA, and taxpayers. We believe that the engagement of those organizations that participated ultimately led to a stronger proposal, as we were able to incorporate their input and experience having helped Veterans through this complex process. The result of that summit was a new appeals framework, virtually identical to the draft bill, that would provide Veterans with timely, fair, and quality decisions. VA is grateful to the Veterans Service Organizations and other stakeholders for their contributions of time, energy, and expertise in this effort.

The essential feature of this newly shaped design would be to step away from an appeals process that tries to do many unrelated things inside a single process and replace that with differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The result of the draft bill would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

Though some may view this reform effort as too accelerated, we would like to reiterate that the topic of "fixing the appeals problem" has been debated and studied by experts in the field for many, many years. The draft bill would solve the problem. The time to act is now. We are excited to be part of this work and to have the potential to lay down a path for future Veterans' appeals that is simple, timely, transparent, and fair. We owe it to our country to put in place a modernized framework for Veterans' appeals which we believe will serve Veterans, taxpayers, and the Nation well for years to come.

CONSOLIDATION OF COMMUNITY CARE

We need your help, as discussed on many occasions, to overhaul our Care in the Community programs. Our Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (the Plan) as required by Title IV of Public Law 114–41, the VA Budget and Choice Improvement Act, was delivered on October 30, 2015.

Determining the details of a program that could replace the current and temporary Veterans Choice program enacted in August 2014 will require close study and collaboration with Veterans, Veterans Service Organizations (VSO), the Congress and other stakeholders and experts.

That is why VA staff and subject matter experts have communicated regularly with Committee and Member staff to further discuss concepts and specific concerns. While we know further discussions are required to get us to a fully streamlined program, we have identified components of the plan that could be enacted now and would improve Veterans experiences' with, and VA's performance under, the existing Veterans Choice Program.

We believe that together we can accomplish the necessary legislative changes to streamline the overwhelming number of varying Care in the Community programs before the end of this session of Congress. Many of the concepts are addressed in some way by the bill under consideration today.

VA's intense focus, and our mission, is to provide high quality health care that is tailored to the special needs of Veterans and that is accessible to Veterans. Part of that effort is to secure care through community providers when VA is not in a position to provide that care itself that meets our goals for reasonable access. The current Veterans Choice Act represents an effort to set rules to define the right balance in legislation.

S. 2896—CARE VETERANS DESERVE ACT

The Department has serious concerns with the potential consequences of section 2 of S. 2896, which eliminates the existing sunset date for the Veterans Choice Program and removes the current eligibility criteria without providing any additional resources. About 80% of Veterans have some other form of health insurance and have a choice today about where to seek their health care. If Veterans who currently do not use the VA health care system begin to seek community care through the Choice Program, VA will have to divert resources away from the provision of internal VA care, dramatically undercutting our ability to provide care that is tailored to the unique health care needs of Veterans. The erosion of funding for internal VA care would in turn strike at the foundation of VA's other missions, notably training U.S. medical professionals, supporting the Department of Defense in readiness, and conducting ground-breaking research.

While it may be an appealing notion to make Veterans Choice universal, we believe such legislation would create a dynamic that could lead to serious erosion in VA's ability to address the critical special needs of Veterans, in a system that was created to serve their needs. Sections of this bill would render VA functionally as a health care insurer, rather than a health care provider. As noted, about 80% of Veterans have some other form of health insurance. When service-connected care is

provided under the Choice Program, VA is the only payer for the care. For non-service-connected care, VA is secondary to other health insurance except for Medicare, Medicaid and TRICARE, from which VA cannot seek reimbursement. A Veteran may choose to use the Choice Program for care, due to low or no cost-sharing requirements in the VA system, even if they otherwise would never come to the VA. This essentially utilizes VA resources for a portion of the Veteran population that wants to use VA as a health care insurer, rather than an integrated health care system. VA may never have a relationship with this Veteran other than paying their health care bills. This would weaken the VA health care system, which has a unique understanding of the consequences of military exposure, posttraumatic stress (PTS), polytrauma care, prosthetics, spinal cord injuries, and other types of care that are unrivaled by any other health care system in the world. Any recommendation for reform must be sure not to impede the contract VA has with Veterans to translate that understanding into state-of-the-art care that helps Veterans manage illness and achieve their highest level of health and well-being. We want to ensure that our services are available for those Veterans who need and want that type of care.

VA believes that there needs to be the right balance of community care access especially when VA cannot provide the care or is not geographically accessible to Veterans. VA is open to reform and is indeed making key advances in access, quality, and patient satisfaction as part of the larger transformation called *MyVA*. VA is also continuing to develop a truly integrated community-based network of providers that can evolve and improve. By allowing all Veterans to opt to use community providers, some areas may be overwhelmed with demand, generating delays in care for both Veterans and non-Veterans if there are not enough community providers to support all types of patients. This could adversely affect continuity of care for Veterans if we no longer have insight or relationships with community providers. The added value provided to the Veterans through the larger VA community, including such unique features as the network of peer specialists and other social services, would no longer be available if enough Veterans no longer relied on the VA system to support these services. We put forward an Administration proposal that better meets our needs and continue to believe that is the right approach.

Specifically concerning section 3, of S. 2896, which requires VA to contract with a nationwide chain of walk-in clinics to provide care to enrolled Veterans, VA understands and appreciates the value in expanding VA's use of urgent care centers for Veterans who need such services, but this provision is too broad and does not include any feature, such as the inclusion of copayments, to ensure that it is used in a measured way that would not overrun the funds appropriated by Congress. The use of measured cost-sharing is well-recognized in the private sector as a way to help ensure management of costs while providing patients the care they need. VA of course uses copayments under current law for certain veterans and certain types of care. More critically, section 3 would also create an inequity where Veterans using these services do not owe a copayment, while comparable Veterans who use VA could be subject to a copayment, when both Veterans receive essentially the same treatment. Having no cost-share may increase a Veteran's utilization of the cost-free services. This may move more Veterans to care outside of the VA, disrupting continuity of care if a Veteran chose to receive limited care through walk-in clinics instead of more comprehensive visits at VA that would address his or her conditions systematically.

VA supports enactment of a Federal law authorizing the provision of health care via telehealth or mobile technologies as appropriate regardless of where the Veteran or the provider is located. Section 4 of S. 2896 would eliminate one of the last roadblocks to VA's expansion of the provision of telehealth services. This would save Veterans the trouble of having to drive to a clinic hours away (even to use telehealth services) and instead could allow them to be seen in the comfort and security of their own home. Additionally, allowing VA providers to be able to deliver care from alternate work sites, even outside the State where the Veteran is located, could expand our capacity to deliver health care.

We do not expect enactment of section 4 would result in any costs.

VA would appreciate the opportunity to have further discussions on this legislation especially related to VA's Plan to Consolidate Community Care Programs. VA believes sections 2 and 3 would result in extremely large costs, and would be glad to discuss that aspect of the legislation with the Committee as well.

VA does not support section 5 to expand the operating hours for VA pharmacies. There is no evidence that pharmacies at VA medical facilities are not meeting the prescription needs of Veterans within the current hours of operation. Pharmacies at VA facilities have processes in place to provide urgent and emergent pharmacy services during times outside normal hours of operation. These services include on-call

pharmacy staff, use of contracted pharmacies for urgent and emergent prescription needs, and dispensing of urgent and emergent medications by a VA provider in the emergency department; many VA facilities have inpatient pharmacies that are always open or have extended hours of operations compared to the outpatient pharmacy and can provide urgent or emergent prescription needs for Veterans.

Additionally, there is independent evidence that VA's Pharmacy Benefits Management program continues to provide industry leading customer service year after year for the entire pharmacy industry in the United States. The VA Pharmacy Consolidated Mail Outpatient Pharmacy (CMOP) provides approximately 80 percent of the total number of prescriptions dispensed by VA to our Nation's Veterans. The VA CMOP has achieved the J.D. Power highest score for customer satisfaction for the mail-order pharmacy market segment in the United States for the last 6 consecutive years. This repeated achievement is a direct reflection of VA pharmacy staff's commitment and dedication to VA's mission to serve our Nation's Veterans.

The pharmacists at VA facilities provide counseling and education to Veterans on their new prescriptions, and then the facility pharmacy transmits the prescriptions to the VA CMOP or to the local VA pharmacy for dispensing to Veterans. Pharmacy staffs at VA facilities are responsible for answering Veterans' questions related to prescription refills and other medication related questions. These services provided by VA facility pharmacy staffs allow VA CMOP staff to focus on prescription fulfillment activities.

VA does not have a cost estimate for this provision at this time.

VA strongly agrees that identifying and spreading best practices is crucial for continuing VA's transformation to a high performing health care organization, but we do not support section 6 which would require an additional review of efficacy at each VA Medical Center. We concur that it will be important to engage leading private sector hospital and health care organizations to share best practices with VA and learn about best practices VA has developed. In fact, we are well underway in achieving the very goals and objectives of this bill. Last summer, the Under Secretary for Health? made best practice consistency one of VHA's top priorities for transformation, launching the Diffusion of Excellence Initiative to identify and diffuse best practices systematically across VHA. The initiative is a systematic way that VHA continuously identifies best practices in care delivery from the field and diffuses them across the system. The diffusion process helps minimize variability and empowers employees to share innovations. We would be happy to update the Committee on our progress and accomplishments in this area.

While VA greatly appreciates the goals of the legislation, we believe that, as drafted, the bill would both duplicate current efforts and prove to be cost-prohibitive. We do not have a specific cost estimate at this time, as the actual costs to implement this provision could vary greatly depending upon the scope of the reviews and the timing of implementation.

OTHER HEALTHCARE BILLS

VA is serving a growing number of women, and ensuring that women receive appropriately tailored, safe, and effective mental health and substance use disorder services, including the screening for substance use disorders, is consistent with VA's core mission and values. S. 2487, THE FEMALE VETERAN SUICIDE PREVENTION ACT, would require the tracking and measuring of specific metrics applicable to women, and which are most effective for women Veterans and those having the highest satisfaction rates among women Veterans.

VA supports S. 2487, but would require additional appropriations to implement the legislation as written. Women Veterans have been found to be at higher risk for suicide than women non-Veterans, which further supports the need to ensure that strong and effective mental health and substance use disorder services are available in VA for women Veterans.

VA estimates this bill would cost $2.2 million in fiscal year (FY) 2017 and $6.6 million over 3 years.

S. 2520, THE NEWBORN CARE IMPROVEMENT ACT, would increase from 7 to 14 the number of days after the birth of a child for which VA may furnish covered health care services to the newborn child of an eligible woman Veteran receiving maternity care and delivery services through VA.

Although VA supports this bill, VA would require additional appropriations to implement this legislation as written. If a full term newborn has fever or respiratory distress after delivery, they may need additional inpatient treatment to manage these complications. This treatment may extend beyond the current 7 days that are allowed in the VA medical benefits package. Additionally it is standard of care for further evaluations during the first 2 weeks of life to check infant weight, feeding,

and newborn screening results. Upon review of these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment, or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g., withdrawal for maternal drug use during pregnancy) and screening and referral for substance use disorder services. VA must carefully consider the resources necessary to implement this bill, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services.

On July 14, 2015, before the House Committee on Veterans' Affairs, Subcommittee on Health, VA testified that the companion bill, H.R. 423, would cost $2.3 million in the first year, $12.7 million over 5 years, and $28.2 million over 10 years. VA would be happy to update these cost estimates at the Committee's request.

S. 2679, THE HELPING VETERANS EXPOSED TO BURN PITS ACT, would require VA to establish a Center of Excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of health conditions relating to exposure to burn pits and other environmental exposures. The requirements in this bill would be met through the further expansion of the existing VA Airborne Hazards Center of Excellence (AHCE) at the War Related Illness and Injury Study Center (WRIISC), East Orange Campus, VA New Jersey Health Care System.

Although VA supports this bill, VA would require additional appropriations to implement the legislation as written. The VA AHCE was established in 2013 to provide an objective and comprehensive assessment of Veterans' cardiopulmonary function, military and non-military exposures, and health-related symptoms for those with airborne hazard concerns. In addition, consistent with the mission of the WRIISC, the AHCE conducts clinical and translational research and actively develops and delivers new educational content for health care providers, Veterans, and other stakeholders. As planned, the AHCE has expanded in phases to become the Veterans Health Administration's (VHA) only comprehensive clinical assessment program for airborne hazards concerns of deployed Veterans.

VA estimates this bill would cost approximately $4 million in FY 2017, $20.3 million over 5 years, and $40.7 million over 10 years.

THE DRAFT BILL ON HEALTH CARE FOR RURAL VETERANS would expand the Veterans Choice program to include Veterans who have received care under the Access Received Closer to Home (ARCH) program. VA supports this bill however, we recommend some technical revisions to define the scope of this eligibility to ensure that only veterans who received care under ARCH and who still reside in an area where they would be eligible to participate in ARCH would qualify; essentially, if a Veteran received care under ARCH previously and subsequently moved to another location that was not participating in Project ARCH, that Veteran would not be eligible to participate in the Choice Program on this basis.

VA supports efforts to share continuing medical education (CME) programs for non-VA medical providers who treat Veterans and their family members under laws administered by VA, and runs several programs of the type referenced in S. 2049. VA established VHA TrainingFinder Real-time Affiliate Integrated Network (TRAIN), an external learning management system to provide valuable, Veteran-focused, accredited, CME at no cost to community healthcare providers. Since the launch of VHA TRAIN on April 1, 2015, more than 14,000 people have created an account or subscribed to VHA content through a previously established account. VHA TRAIN reports more than 7600 completions from healthcare and public health providers.

S. 2883, THE APPROPRIATE CARE FOR DISABLED VETERANS ACT OF 2016 would make permanent the requirement of the Secretary to submit a report on the capacity of VA to provide for the specialized treatment and rehabilitative needs of disabled Veterans. VA recommends against using "recidivism" as a metric. While "recidivism" meaning a return to substance use services after an intensive treatment episode, could be measured, it is conceptually at odds with medical understanding of substance use disorders as a chronic disease of the brain requiring on-going monitoring and treatment to avoid a return to substance use. VA attempts to engage stable, abstinent patients in on-going services to prevent return to substance use, and has no way of distinguishing this follow-up care for secondary prevention from care for symptom recurrence.

In general, the majority of the new requirements of S. 2888, THE JANEY ENSMINGER ACT OF 2016, would fall to the Secretary of Health and Human Services, through the Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR). VA appreciates the work and collaboration with ATSDR, and defers to that agency on views. We note that CDC receives funding through a separate appro-

priation to carry out activities under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and would require funding accordingly.

However, VA does not support the provisions of this bill which would effectively defer Veteran eligibility decisions to ATSDR. It would also require VA to continue providing hospital care and medical services to Veterans who have received such care or services under section 1710(e)(1)(F) notwithstanding a determination that the evidence of connection of an illness or condition and exposure is not categorized as sufficient or modest.

This legislation would require VA to recognize new conditions that are not currently listed in 1710(e)(1)(F) if ATSDR places them in the "sufficient" or "modest" evidence of connection categories. We recommend that the ATSDR reports be submitted to VA in an advisory capacity only, as has been done with previous reports from the Institute of Medicine and National Research Council. If enacted, VA may require additional resources to assist the Veterans and family members who would become eligible for hospital care and medical services.

As a technical matter, we note that the time period specified in section 1710(e)(1)(F) of title 38, United States Code, ends on December 31, 1987, whereas the time period in proposed section 399V–6(a)(1)(A) of the Public Health Service Act would end on December 21, 1987.

VA cannot provide a cost estimate for the bill because it is unknown what illnesses and conditions, if any, for which ASTDR would find that there is evidence that exposure to a toxic substance at Camp Lejeune during the specified time period may be a cause of such illness or condition at the "sufficient" or "modest" standard. The cost to VA of implementing this provision will depend upon which conditions ATSDR finds satisfy these requirements, how many Veterans and family members will qualify for hospital care and medical services for those conditions and illnesses, and the average cost for the necessary hospital care and medical services of those conditions or illnesses.

BENEFITS LEGISLATION

VA supports the DRAFT BILL RELATED TO THE COMPENSATION AND PENSION EVIDENTIARY THRESHOLD. This legislation would promote consistency of adjudications and reduce delays in processing claims due to the need to obtain an examination or report.

As a result of current law, medical examiners are required to provide an opinion regarding the etiology of a claimed disability or symptoms in cases in which there is little or no objective evidence concerning in-service incurrence of an injury, symptoms, or event that could cause the disability or symptoms. In such cases, an examiner's opinion is likely to be based on speculation rather than objective findings. Providing an examination in such cases also leads to unnecessary delay in finally resolving Veterans' claims for compensation.

The draft bill would amend section 5103A(d)(2) to add a requirement that VA would request a medical examination or opinion for purposes of a claim for disability compensation only if there is objective evidence in the record, except for certain circumstances.

Mandatory cost savings for the first year are expected to be $93.1 million. Five-year cost savings are estimated to be $504.3 million and 10-year cost savings are estimated to be $1.1 billion.

S. ____, AUTOMOBILE ADAPTIVE GRANTS (DRAFT BILL). While VA appreciates the intent of this bill, which would ensure Veterans are able to make personal selections related to automobiles receiving modifications, VA does not support this legislation as it is unnecessary. VA already has a policy for the Automobile Adaptive equipment program which establishes uniform and consistent system-wide procedures when furnishing automobile adaptive equipment. In addition, VA does not manufacture or install adaptive equipment on a beneficiary's vehicle. Rather, VA pays for automobile adaptive equipment that accommodates beneficiaries' driving and/or passenger needs as identified by a VHA certified Drivers Rehabilitation Specialist.

THE DRAFT BILL ENTITLED "SOLVE ACT OF 2016" would amend section 4102A of title 38 to provide greater flexibility to States in carrying out the Disabled Veterans' Outreach Program (DVOP) and employing Local Veterans' Employment Representatives (LVER), and it would direct the Secretary of Labor to encourage Governors to co-locate DVOP specialists and LVERs with one or more Department of Labor one-stop centers.

Respectfully, we defer to DOL's views on the bill.

THE CONSTRUCTION REFORM ACT OF 2016 draft bill would require the Secretary to use industry standards, standard designs, and best practices to carry out the construction of medical facilities, and then to contract to conduct external forensic au-

dits of the expenditures relating to any major medical facility or super construction project where the total expenditures exceed the amount specified in the law for that project by more than 25 percent.

VA generally supports the intent of the draft bill but offers some technical assistance. VA agrees with the use of standard designs and best practices in carrying out the construction of medical facilities. We would like to clarify, however, that there are no official "industry standards" for health care facilities. Private facilities usually rely on the technical advice of their individual Architects/Engineers regarding best practices. VA already uses various specific industry recommendations, which we adapt as necessary for our project location, climate and site, to accommodate VHA's functional programs for each project. We use standard design templates for all outpatient clinics. We also use standard Design Guides and Space Planning criteria for health care departments and specialty functions. Of course, VA follows all Federal regulations regarding construction, including physical security, sustainability, energy use, renewable energy, accessibility, and environmental/cultural compliance.

VA notes that in views on a House bill, H.R. 3106, that established the "super construction" threshold at $100 million, VA suggested substituting a threshold of $250 million. VA noted that the majority of active major projects are in fact over that threshold, but this allows for a better work distribution between VA and outside Federal entities. Congress established the threshold at $100 million in Public Law 114–58, and VA is of course implementing that law in concert with the United States Army Corps of Engineers. VA notes for the record that we believe a $250 million threshold would still present those advantages.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other members may have.

Chairman ISAKSON. Thank you very much.

Michael Michaud. Welcome, by the way.

STATEMENT OF HON. MICHAEL H. MICHAUD, ASSISTANT SECRETARY OF LABOR FOR VETERANS EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR; ACCOMPANIED BY PATRICIA SHIU, DIRECTOR, OFFICE OF FEDERAL CONTRACT AND COMPLIANCE PROGRAMS

Mr. MICHAUD. Thank you very much, Mr. Chairman, Ranking Member Blumenthal, and distinguished Members of the Committee. It is a privilege to return back to the Hill. While I was a Member of Congress, I fondly remember the great work done by both the Senate and House Veterans' Affairs Committees. Now, as the Assistant Secretary of VETS at the Department of Labor, I appreciate the opportunity to discuss the pending legislation that impacts the quality of services delivered to our veterans.

I will limit my remarks to those bills directly impacting the programs administered by DOL: the SOLVE Act and the Care Veterans Deserve Act.

I am joined today by Director Pat Shiu of DOL's Office of Federal Contract and Compliance Programs. OFCCP has sole enforcement and compliance assistance authority for some of the most basic civil rights protection in Federal law.

The employment situation for veterans continues to improve. The unemployment rate for veterans fell from a high of 9.9 percent in January 2011 to 3.9 percent in April 2016. That is lower than the non-veteran unemployment rate of 4.5 percent in April 2016. The Gulf War-era II veterans' unemployment rate fell from a high of 15.2 percent in January 2011 to 4.1 percent in April 2016. While trends are favorable, no one at DOL will rest as long as one veteran needs assistance finding meaningful civilian employment.

Before I address the SOLVE Act and DOL's concern with this legislation, I want to provide some background on DOL's Jobs for Veterans State Grants (JVSG) and how it would ultimately be impacted. JVSG provides funding to 54 States and territories for Disabled Veterans Outreach Program Specialists, or DVOPS, and the Local Veterans Employment Representative staff, or LVERS.

DVOP specialists provide intensive service employment to veterans in eligible populations, including homeless veterans and formerly incarcerated veterans, through individualized case management. LVER staff promote the hiring of veterans by building a network with local employers. DVOPS and LVERS work in the American Job Centers (AJCS) across the country. The network of approximately 2,500 AJCs are operated in partnership with the local Workforce Development Boards and State Workforce Agency and DOL.

Consistent with the Vow to Hire Heroes Act of 2011, the Department released guidance in April 2014 refining the roles of JVSG staff. These changes improved workforce program service delivery strategies for veterans and eligible spouses. It addressed the anticipated demand for services from an increase in transitioning servicemembers and ensured that JVSG-funded State staff members perform their Congressionally intended functions. This guidance has improved the service for our veterans.

The percentage of participants receiving intensive service increased from 22 percent in program year 2009 to 81 percent in program year 2015. During that same timeframe, DOL has seen the entered employment rate of JVSG's participants improve from 48 percent in program year 2009 to 59 percent in program year 2015.

Veterans not served directly through JVSG receive other services from the workforce system. The Workforce Innovation and Opportunity Act, or WIOA, programs provided workforce service to over one million veterans last year. WIOA implementation and JVSG refocusing are two significant reforms currently underway in the workforce system, together enhancing employment and placement service for our veterans. The Department is concerned about the potential negative impact the SOLVE Act would have by disrupting these two reforms before they are fully implemented and evaluated.

DOL is also concerned that the bill expressly prohibits new funding. If a State were to shift management of the JVSG program from a State workforce agency to another agency, there undoubtedly will be costs associated with that transition. Further, under the proposed language, approval of a State's proposal of additional populations to be served by JVSG staff would necessitate additional funding for it to meet that demand. The JVSG program funding is allocated on a formula basis and it is VETS experience that the existing DVOP staffing levels is insufficient to fully meet the demand for DVOP service already permitted by the law.

Last, I would like to briefly touch upon the Care Veterans Deserve Act, which extends the Veterans Access, Choice, and Accountability Act of 2014. The Choice Act contains an exemption for entities that contract with the VA to provide health care in the community from complying with a certain civil rights protection. These civil rights protections, which are enforced by DOL, prohibit Federal contractors and subcontractors from engaging in employment

discrimination, and it also requires them to take affirmative action to ensure that the job seekers and employees are treated equally without regard to: their status as a covered veteran, race, color, religion, sex, sexual orientation, gender identity, national origin, or disability. We cannot support the legislation that rolls back these key civil rights protections and urge the Committee to restore these important protections before lifting the Choice Act sunset.

With that, Mr. Chairman and Members of the Committee, this concludes my oral statement and I want to thank you for the opportunity to testify.

[The prepared statement of Mr. Michaud follows:]

PREPARED STATEMENT OF MICHAEL H. MICHAUD, ASSISTANT SECRETARY OF LABOR FOR VETERANS EMPLOYMENT AND TRAINING, U.S. DEPARTMENT OF LABOR

INTRODUCTION

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee. Thank you for the opportunity to participate in today's hearing. It is also my personal privilege to return to the Hill as a member of the executive branch. I have proud memories of the great work done by both the Senate and House Veterans' Affairs Committees while I was a Member of Congress. Now, as Assistant Secretary for the Veterans' Employment and Training Service (VETS) at the Department of Labor (DOL or Department), I appreciate the opportunity to discuss pending legislation that impacts the quality of services delivered to our veterans.

The employment situation for veterans continues to improve. The unemployment rate for veterans has fallen from a high of 9.9% in January 2011 to 3.9% in April 2016; lower than the nonveteran unemployment rate of 4.5% in April 2016. The Gulf War-era II veteran unemployment rate has fallen from a high of 15.2% in January 2011 to 4.1% in April 2016. While these numbers in aggregate continue to trend in a desirable downward direction, nobody at DOL will rest as long as any veteran needs assistance finding meaningful civilian employment.

Although this hearing is focused on several bills under consideration by the Committee, I will limit my remarks to discussing DOL's Jobs for Veterans State Grants (JVSG) program and the legislation that has a direct impact on the programs administered by DOL, specifically S. 2919, the "State Outreach for Local Veterans Employment Act of 2016" and S. 2896, the "Care Veterans Deserve Act of 2016."

JOBS FOR VETERANS STATE GRANTS (JVSG) PROGRAM

The Jobs for Veterans State Grants (JVSG) program, funded in recent years at $175 million, is VETS' biggest program. Our staff, led by a director in each of the 50 states plus the District of Columbia and Puerto Rico, oversees this program in partnership with our state grantees. I have made it a point in my first six months in office to visit JVSG programs in over a dozen states and in all of DOL's regions around the country. Earlier this month I also had the opportunity to visit the National Veterans' Training Institute in Denver, CO, to observe the training program for JVSG-funded staff (including Disabled Veterans' Outreach Program specialists and Local Veterans' Employment Representatives).

JVSG is the natural next step for our transitioning servicemembers when they complete the DOL Employment Workshop component of the Transition Assistance Program. JVSG also works in tandem with the Homeless Veterans Reintegration Program (HVRP) to help homeless veterans as well.

• have seen firsthand the real results that JVSG is yielding for our veterans with significant barriers to employment. Last Program Year, almost 200,000 veteran participants were served by the program, with 57% entering employment following intensive services.

S. 2919—"STATE OUTREACH FOR LOCAL VETERANS EMPLOYMENT ACT OF 2016"

The "State Outreach for Local Veterans Employment Act of 2016" (SOLVE Act) would, among other things, authorize states to select the implementation agency for the JVSG program. Before I discuss DOL's serious concerns with this legislation, I would like to provide some background on how JVSG operates within the public workforce system, and why the current structure is optimal for the program and veterans themselves.

The public workforce system includes a nationwide network of approximately 2,500 American Job Centers (AJCs), a network operated in partnership by Local Workforce Development Boards, State Workforce Agencies, and DOL, primarily the Department's Employment and Training Administration (ETA). As the Chairman knows from his work on the Senate Health, Education, Labor, and Pensions Committee, the Workforce Innovation and Opportunity Act (WIOA), which became law less than two years ago, is driving transformational updates and upgrades to this system.

WIOA established three hallmarks of excellence:

- The needs of businesses and workers should drive workforce solutions and local boards are accountable to the communities in which they are located;
- American Job Centers should provide excellent customer service to jobseekers and employers and focus on continuous improvement; and
- The workforce system should support strong regional economies and play an active role in community and workforce development.

AJCS staff are funded through a variety of Federal and state programs and are tasked with providing free services to American workers to assist them in obtaining and retaining meaningful employment. The JVSG program, funded and administered by VETS, is a required one-stop partner in the public workforce system and is enhanced through deeper integration into workforce system planning under WIOA.

JVSG provides funding to 54 states and territories for Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representative (LVER) staff, located in AJCs. DVOP specialists provide intensive services to veterans and eligible populations, including homeless and formerly incarcerated veterans, through individualized case management. This includes comprehensive and specialized assessments of skill levels and needs, development of individual employment plans, group and individual career counseling and planning, and short-term skills development (such as interview and communication skills). LVER staff promote the hiring of veterans in communities through outreach activities that build relationships with local employers, and provide training to workforce center staff to facilitate the provision of services to veterans.

In DOL's administration of employment and training functions for veterans, Congress has required, among other things, that the Secretary of Labor "ensure that employment, training, and placement activities are carried out in coordination and cooperation with appropriate State public employment service officials." 38 U.S.C. § 4102A(b)(4). In addition, Congress has conditioned each State's receipt of JVSG funds on a number of requirements, including that states describe "the manner in which [DVOP] specialists and [LVER] representatives are integrated in the employment service delivery systems in the State, " 38 U.S.C. § 4102A(c)(2)(A)(i)(II), and that each State "coordinate employment, training, and placement services furnished to veterans and eligible persons under this chapter with such services furnished with respect to such veterans and persons under the Workforce Investment Act of l998 and the Wagner-Peyser Act. " 38 U.S.C. § 4102A(c)(6).

A REFOCUSED SYSTEM

Consistent with the VOW to Hire Heroes Act of 2011, which clarified and limited the allowable activities of DVOP and LVER staff, the Department released a JVSG refocusing strategy in April 2014 that refines the roles of DVOP and LVER staff. Since 2002, DOL has been moving in this direction based on Congressional intent, GAO audits, DOL Office of Inspector General audits, and internal VETS reviews. These changes are intended to improve workforce programs' service delivery strategies for veterans and eligible spouses, meet anticipated demand for services from an increase in transitioning servicemembers, and ensure that JVSG-funded state staff members are performing their functions consistent with Congressional intent (38 U.S.C. §§ 4103A, 4104). As part of the implementation plan for this refocusing strategy, VETS and ETA issued joint guidance documents and conducted extensive technical assistance for state JVSG and AJC staff members.

The implementation of this guidance has been successful in improving the services to veterans and their employment outcomes. The percent of participants receiving intensive services increased from 22% in Program Year (PY) 2009 to 76% in PY 2015 (as of December 31, 2015). During that same time period, the entered employment rate for JVSG participants improved from 48% in PY 2009 to 57% in PY 2015. Similarly, the employment retention rate of these participants, or those who retained employment six months after program exit, increased from 74% in PY 2009 to 81% in PY 2015, and the average six-month earnings of these participants rose from $14,751 in PY 2009 to $16,903 in PY 2015.

We are committed to reaching and maintaining a rate of 90% of participants who receive intensive services from DVOPs. The rate of intensive services delivery is one of the Department's five Agency Priority Goals and is reported publicly every quarter. To achieve this 90% goal, VETS employs these strategies to increase intensive services to participants who have significant barriers to employment and who are served by DVOP specialists:

- Provide technical assistance and guidance to state workforce agencies;
- Conduct Federal oversight and monitoring to identify best practices that can be replicated nationwide;
- Conduct additional staff training and development for DVOP specialists;
- Analyze the entered employment rates of participants based on the types of services they receive (i.e. basic career services[1] versus intensive services);
- Collaborate with Veterans Health Administration's Compensated Work Therapy (CWT) staff at Veterans Affairs medical centers, to integrate employment services with clinical care; and
- Collaborate with ETA, which oversees other employment and training services at American Job Centers, to ensure veterans receive priority of service and are properly referred to the appropriate service program.

Additionally, veterans not served directly through JVSG still receive services from other facets of the workforce system. DOL's WIOA core programs (Adult, Dislocated Workers, Youth, and Wagner-Peyser) provided workforce services to over 1 million veterans last year. More than 400,000 previously unemployed veterans entered employment after receiving services through the American Job Centers.

WORKFORCE INNOVATION AND OPPORTUNITY ACT

In July 2014, after Congress passed the legislation by a wide bipartisan majority, President Obama signed into law the WIOA, the first legislative reform of the public workforce system in over fifteen years. This transformational legislation makes substantial changes in numerous DOL programs in order to modernize the workforce system to better meet the needs of workers and businesses alike. Specifically, WIOA brings together and enhances several key employment, education, and training programs and reaffirms the role of the AJC delivery system.

WIOA moves Federal and state governments toward an integrated workforce and education system to better serve America's job seekers, workers, and employers. WIOA requires the application of primary performance indicators to core workforce and education programs; the Department will apply those same indicators to other Department-administered programs, including JVSG. VETS has been in lockstep with our workforce and education partners to ensure that the JVSG program is included in all stages of this transformation.

WIOA implementation and JVSG refocusing are two significant reforms currently underway in the workforce system, together enhancing employment and placement services for veterans. The Department is concerned about the potential negative impact the SOLVE Act would have by disrupting these two reforms before we have a chance to fully implement and evaluate them.

IMPLEMENTATION OF THE SOLVE ACT

The JVSG program is already in the midst of significant programmatic changes due to WIOA and the JVSG refocusing that will require the time and attention of state and local workforce staff for their successful implementation. If a state were to transition the administration of its JVSG grants from its state workforce agency to its state veterans' agency, that transition would have the potential to magnify the complexity of the adoption of WIOA and compliance with JVSG refocusing, compounding the risks of significant challenges in delivering effective employment services to veterans for years to come.

DOL is also concerned about transition costs, particularly in light of the language expressly prohibiting additional funding. If a state were to shift management of the JVSG program from the State Workforce Agency to another agency, there would likely be costs associated with that transition. In reviewing State transition plans, we would need to ensure that the State's transition plan addresses such costs without sacrificing services to veterans.

Further, under the proposed language, approval of a state's proposal of additional populations to be served under the JVSG program would necessitate adding staff to meet this unanticipated workload. The JVSG program funding is allocated by for-

[1] Examples include labor exchange services, career guidance, job search assistance, and referrals.

mula and it is VETS' experience that the existing DVOP staffing levels are insufficient to fully meet the demand for DVOP services already permitted by law, as reflected in the difficulty some states are having in meeting the target intensive services rate of 90%. Allowing additional categories of veterans to receive JVSG services will either require additional staff or will result in a lower share of participants receiving intensive services. In addition, there would be an adjustment period as States may need to hire or retrain staff to ensure the specialized needs of these new populations are met. I raise these concerns about undertaking the changes outlined in the SOLVE Act at the same time as WIOA and JVSG refocusing are implemented as they are significant and I urge the Committee to take the time to fully consider them.

S. 2896—"CARE VETERANS DESERVE ACT OF 2016"

S. 2896 would, among other things, amend the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act), Pub. L. 113–146, to eliminate the sunset date for the Department of Veterans Affair's Veterans Choice Program and expand eligibility for the program. The Choice Act contains an exemption from the laws enforced by the Department's Office of Federal Contract Compliance Programs (OFCCP) for certain entities that enter into agreements with VA to provide health care through the Choice Program. Sec. 101(d)(3)(A) of Pub. L 113–146, as amended. The Department of Labor strongly supports providing the VA with the authority to purchase care and services in the community when such services are not reasonably available from the VA or through pre-existing contracting authority or sharing agreements. However, because simply extending the Choice Act would also extend the current exemption and leave veterans and other employees of Federal contractors without certain civil rights protections, we have serious concerns with the Care Veterans Deserve Act.

OFCCP is the only agency with enforcement and compliance assistance authority for these protections, which are some of the most basic civil rights protections in Federal law. They prohibit Federal contractors and subcontractors from engaging in employment discrimination and require them to take affirmative action to ensure that job seekers and employees are treated without regard to their race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or status as a covered veteran. These safeguards protect millions of workers, including those providing care for veterans. We cannot support legislation that rolls back these key civil rights protections, and urge the Committee to restore these important protections before lifting the Choice Act's sunset. The Administration has put forward a legislative proposal that would provide VA the authorities it needs going forward when it is working with providers in the community while maintaining these important protections. We believe that this balance is the right one for veterans seeking care, the workers serving or seeking to serve those veterans, our veterans' healthcare system, and the health care industry,

CONCLUSION

In light of our concerns as expressed above, and the Department's obligation to ensure effective coordination and integration of the JVSG program with the state public workforce system, we oppose the SOLVE Act. We believe we have made significant progress improving the employment outcomes of veterans, including through the more targeted provision of intensive services, and the SOLVE Act could reverse these trends. I remain committed to efforts to improve the administration of the JVSG program, and look forward to further dialog with the Committee in order to meet our shared goal of promoting full employment for the extremely deserving veterans and spouses covered by DOL programs.

In addition, while DOL supports providing the VA with the authority to purchase care and services in the community when such services are not otherwise reasonably available, the Choice Act contains an exemption from the laws enforced by OFCCP that would leave veterans and other employees of direct Federal contractors without basic civil rights protections. DOL cannot support this statutory roll-back of civil rights protections, and urges the Committee to delete the OFCCP exemption before lifting the Choice Act's sunset.

This concludes my written statement. Thank you for the opportunity to be a part of this hearing. I welcome your questions.

Chairman ISAKSON. Well, thank you for your testimony and the job that you are doing and the mention of WIOA. We are really proud of what we did when we reformed the Workforce Investment

and Opportunity Act and it is getting more training targeted at our veterans which is what it is all about, so thank you for doing that.

We will start our round of questioning and I will be the first one to question.

Secretary Gibson, correct me if I am wrong. You have provided the Committee with draft legislation, or draft language regarding changing the appeals process.

Mr. GIBSON. Yes, sir, we have.

Chairman ISAKSON. That is prospective in its nature, meaning it picks up with the first day it is enacted and it goes forward; it does not address the 445,000 waiting, is that correct?

Mr. GIBSON. That is correct, Mr. Chairman.

Chairman ISAKSON. What you sent us has not yet been scored, is that correct?

Mr. GIBSON. We are still waiting for CBO to reach their final conclusion. We continue to hear that any day now, we will have the scoring results in.

Chairman ISAKSON. At the risk of being redundant, but just to underscore what I have said from the beginning to Secretary McDonald, we need the exact language——

Mr. GIBSON. Yes, sir.

Chairman ISAKSON [continuing]. We need a score, and we need to know what we do with the 445,000 who are waiting, because if we change the appeals process prospectively, which we want to do to make it shorter and better and more responsive to our veterans——

Mr. GIBSON. Yes.

Chairman ISAKSON [continuing]. What happens to those 445,000, some of whom have been waiting 27 years for a determination of disability? So, when you bring us that package, it will be a trilogy. It is not just two chapters, it is three. What do we say to the veterans who have been waiting, 445,000 of them? How do we implement it? What is the cost of implementing the new program? You said you thought it was zero cost, but we have got to see that from CBO. And what is the final language? So, we are going to insist on all three of those things before this Committee moves forward.

Mr. GIBSON. I understand, Mr. Chairman. I believe we furnished cost estimates associated with resolving the 450,000 existing claims. That would extend over a 4- or 5-year period of time. We have also provided the draft language. I think we are at least two-thirds of the way there in terms of the requirements that you have requested, sir.

Chairman ISAKSON. Recognizing that your answer to my next question is going to be an estimated guess and not a fact——

Mr. GIBSON. Yes, sir.

Chairman ISAKSON [continuing]. Because before I ask the question, I am going to give you that much leeway.

Mr. GIBSON. Yes, sir.

Chairman ISAKSON. How much time do you think you are going to reduce appeals of disability in the future with the new language you are talking about?

Mr. GIBSON. The goal——

Chairman ISAKSON. Understanding that currently, now, how many days is the current one averaging?

Mr. GIBSON. Well, you know, on average, about 3 years. For an appeal that goes to the Board, about 5 years. The objective that we set out to achieve here is for most appeals to be resolved within a year or less. It will take several years to work through the existing inventory of appeals that are out there under the old law, under the old processes, to work through all of those and to get those resolved. So, by 2021, 2022, somewhere in that timeframe, we have worked through the substantial majority of the old appeals. In the meantime, we would be processing new appeals under the new legislation beginning in 2018.

Chairman ISAKSON. The determination you make is the determination of disability, is that correct, by percentage?

Mr. GIBSON. That is correct, yes, sir.

Chairman ISAKSON. Do we still—and I should know this—do we still have the concurrent receipt rule?

Mr. GIBSON. Somebody help me out.

Mr. MCLENACHEN. Yes, we do, Mr. Chairman. It has been amended several times over the past decade or so, but we still have that law.

Chairman ISAKSON. I am going on my memory, which is shaky at best at my age, but thinking back, we moved it to 50 percent disability or more, to exempt them from concurrent receipt, is that right?

Mr. MCLENACHEN. That is my recollection also, Mr. Chairman.

Chairman ISAKSON. So, if their estimate of disability is lower than 50 percent, then they have an offset on their Social Security benefit from the disability benefit or the retirement benefit from the disability benefit.

Mr. MCLENACHEN. This is one of the most complex things that we do in the compensation world. Since, as I said, the law has changed a couple times over the past few years, it continues to be a problem for us, yes.

Chairman ISAKSON. Well, the reason I brought the subject up is I think that is a contributing factor to the number of appeals you get. Am I right?

Mr. MCLENACHEN. I do not think I would go that far, Mr. Chairman. I think it is more as Deputy Secretary Gibson said. We are deciding more claims now. We know historically every year that 11 to 12 percent of veterans file appeals, not necessarily related to quality. They have a right to appeal. It is not necessarily related to any one particular factor, such as concurrent receipt. Veterans exercise that right about 11 or 12 percent of the time. So, as we decide more claims, we get more appeals, and once it gets into the process that we have now, it is kind of a never ending churn. That is the problem we are trying to deal with here, which we have worked very closely with the VSOs to fix.

Chairman ISAKSON. Well, I know it is a complicated issue and I appreciate the commitment you both have made to it. We will look forward to following it closely, as well as the CBO score and the final language when we get it.

Mr. MCLENACHEN. Yes, sir.

Chairman ISAKSON. Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Thank you all for being here today on legislation that is very important to our veterans. I take it, Mr. Gibson, that you have heard the remarks that were made this morning about Secretary McDonald's comments yesterday and that you will convey that message to him, which I think is felt unanimously on this Committee. You heard that we are expecting perhaps more from him in the way of an apology. I know from having spoken to him that he certainly is regretful about those comments which I would think, knowing him, he would be. As you have also heard here, there is a strong feeling that we all make mistakes and——

Mr. GIBSON. Yes, sir.

Senator BLUMENTHAL [continuing]. That often the best way to handle them is simply to make an apology and move on. As all of us know, actions in the end speak louder than words and his actions can speak louder than those words.

Mr. GIBSON. I am very grateful for the even-handed approach toward this particular issue. I made some comments where I said, "Bob and I." Bob McDonald is like a brother to me; has been a friend over 40 years. If he were sitting here, I know he would have said the same thing I just said, but that does not take the place of him saying it. I understand, sir.

Senator BLUMENTHAL. Let me talk about the appeals process reforms——

Mr. GIBSON. Yes, sir.

Senator BLUMENTHAL [continuing]. Which are desperately needed——

Mr. GIBSON. Yes, sir.

Senator BLUMENTHAL [continuing]. And I believe will actually save tons of dollars in the future. I wonder if you could elaborate on the long-term savings of this legislation and how reforming the appeals process will reflect timely results of appeals, and also dollar amounts that may be saved and why that will be so, just so the public understands as well as us.

Mr. GIBSON. Yes, sir. I would like to ask Dave to answer that question.

Mr. MCLENACHEN. Senator, I guess the bottom line is it would be a tragedy if we do not take this opportunity at this time, where we have worked in collaboration with the VSOs and other stakeholders, to do exactly what you said, which is solve this problem for all veterans in the future.

Just to talk you through a couple of those points, as the Deputy Secretary said, if we look out 10 years, we are looking at an average 10-year wait time on an appeal. Currently, VBA is deciding initial claims in 125 days. Now, the average is down to around 90 or 95 days. It simply is unacceptable to decide a claim in that amount of time and then have a veteran wait, on average, 10 years for a decision. That will only get worse after those 10 years if we just let the current process go.

We estimate that in about 10 years, we would have 1.2 million appeals pending as opposed to the 455,000 that we have right now. The bigger tragedy would be that veterans would be deprived of all the great features of the new design that we have come up with. I am sure you will have a lot of opportunities today to hear about

some of those features, which were also listed in the statements that were offered for this Committee hearing.

Let me just hit a couple of them real quickly. Early resolution of appeals—Veterans would have an opportunity when they get a decision from VBA to have veteran notice about what options are available to them, and based on that notice—the features of which we have included in the statutory language—they would be able to decide which is the best option for them. Do they get a second look at it in VBA by a higher level authority? Do they select submitting additional evidence in VBA? Or do they go to the Board, straight to the Board for a Board decision? In all respect, effective dates would be protected, something that is not available now; they have to go into the appeal process.

There would also be quality feedback loops for VBA, something that we cannot have now because the claim is constantly evolving in the appeal process. The new design would have two feedback loops for VBA. One would be in the higher level review within VBA and the other would be from the Board, because the Board and the higher level reviewer would be looking at the same evidence that was before the original adjudicator—a quality feedback loop that we have never had in VBA. That is critical. That was some of the feedback from VSOs and other stakeholders, that that was critical.

Transparency. Today, veterans do not know whether their appeal is in VBA or whether it is at the Board or whether it is bouncing back and forth between those two agencies. The design would answer that question. They would know that their claim decision is being reviewed in VBA or it is at the Board and it would be done in a timely fashion, within 125 days or within a year at the Board.

Taxpayers—you know, the alternative is, taxpayers for the next 10 years and far into the future are pouring money into a broken process. I think that is something that we all agree on, that this process is broken and it is just simply unjustifiable that taxpayers would continue to dump money into a process that does not work.

I think when you look at all those options that are available to us that we all agree upon, to include our partners at the VSOs and other stakeholders, there is simply no option that is available here.

Senator BLUMENTHAL. My time is expired. I may have some additional questions that I want to submit for the record, but in deference to my colleagues, I will yield.

Chairman ISAKSON. Senator Moran.

STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you and Senator Blumenthal.

Deputy Secretary Gibson, thank you for your presence today.

Secretary Michaud, nice to see you again. I remember positively our work on the House Veterans' Affairs Committee and wish you well in the position you now occupy.

Let me first begin with a compliment to a couple of folks at the VA, one of them in the room. Dr. Yehia, thank you very much for your help along with one of your Congressional Affairs colleagues, Jeremy Dillard. Mr. Secretary, in one of our hearings which you were in attendance last December, you offered if I would give you

some examples of people who were struggling with the Choice Act that you would see that those issues were addressed. One of them we just resolved last week, that was in large part due to those two individuals who took this veteran's case and saw the justice, in my view, finding the right solution.

This was an instance in which a veteran had been told by a VA physician's assistant that he qualified for the Choice Act, sent him to another provider, but there was no paperwork completed by the veteran. Then the VA in Kansas determined he was not eligible and was responsible for his own bills, despite being told by the VA physicians assistant that he needed to do what he did. So, thank you for those efforts.

I know the goal is to get this to the point in which it is not one veteran at a time, but for now, we will take them one at a time and try to solve them as we get the system to work better, so thank you very much.

Mr. Secretary, I want to talk to you about ARCH, which is a conversation that our offices have had over a period of time. When I was a House member with Secretary Michaud, I represented a Congressional district larger than the State of Illinois that has no VA hospital. In fact, at that time it almost had no VA facility at all. We pushed for outpatient clinics and were successful with the VA in providing those. But, it is still long distances to an outpatient clinic and that is in part the efforts that we have had for a long time to establish something now called the Choice Act that gives veterans more options at home.

Mr. GIBSON. Yes, sir.

Senator MORAN. I continue to be supportive of that effort, but as a pathway to something like Choice, we created ARCH. I introduced the legislation in the House, it became law, and it was a pilot program to determine how this might work. I assume it is who the providers would be, how we would pay the bills, what the computer connections would be, those kind of things.

One of those pilot programs—I think there were six in the country—one of those is in Kansas, so we have cared a lot about this. The goal here today is to make certain that those veterans who are participating in ARCH as we move to Choice do not lose their care with the provider that they currently are seeing.

Mr. Secretary, for the VA, you have made decisions that I applaud and appreciate which is the special provider agreements where you are going to allow ARCH veterans, those who are participating in an ARCH program, to continue their current care with their ARCH provider, and you are doing so under a proviso that allows you to do that because of excess burden.

So, Mr. Secretary, I want to thank you for those efforts to take care of those who might otherwise qualify for Choice, but in the process of qualifying for Choice would lose the provider they have today with the VA, and this keeps that patient contact in place for the future. So, thank you for that.

I also have introduced legislation, which is one of the items that is for consideration in the Committee hearing today. It is my understanding, Mr. Secretary, that you, the VA, supports the codification of your decision and that we have worked closely with you and your staff. In fact, you have made some technical suggestions that

would improve the bill which we have agreed to. I just want to make certain that my colleagues, the Chairman, the Ranking Member, and my colleagues on the Committee, understand that this legislation has the Department of Veterans Affairs support. It is also my understanding it has the support of both the minority and the majority in this Committee.

So, Secretary or Doctor, if you would tell us your thoughts about this option for ARCH veterans to continue under the program.

Mr. GIBSON. I would be glad to, and I will defer to Baligh if I do not get this exactly right. Yes, we are very much in favor of the legislation. I appreciate the kind remarks and the feedback that you have given. Quite frankly, this is the right thing for veterans and the right thing for taxpayers, which makes that the high ground and we are proud to stand on that high ground with you.

Dr. YEHIA. Yes, we are very supportive of that language. We appreciate the comments and also the close collaboration we have had with your office and others to achieve that. In all honesty, ARCH is what we—a lot of the features of ARCH is what we want in our consolidated plan as community care moves forward. So, we really think of it as a model of how we progress forward.

You touched on a couple key points that we want to maintain, which is that care coordination, that direct relationship between a patient and a doctor. Those are critically important, some of those that have been missing in Choice today, which we hope to fix with partnership with Congress. So, thank you for that.

Senator MORAN. Doctor, Mr. Secretary, thank you very much.

Chairman ISAKSON. I want to thank Senator Moran for bringing that subject up, because your work with the Committee on provider agreements and what we are trying to attempt in the omnibus is making all this possible. The VA has been very much reaching out, and your leadership in passing ARCH to begin with and now memorializing that program in provider agreements and equalizing reimbursement across programs so everybody is the same was a tremendous move forward, which is another reason why we have got to get the Veterans First bill out of the Senate and over to the House as soon as we can.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman, and thank you all for being here today. I appreciate your testimony and your support.

Back in the day when Choice was created, I supported it because I thought it was going to expedite care in the community when the VA could not provide that care. The bill also provided critical investments in VA's capacity, both in workforce and in infrastructure, to address the long-term needs of the VA.

However, some supported the creation of the Choice program as a first step toward privatizing the VA or simply outsourcing as much care as we possibly could to the private sector where the VA could not financially stay in business or there was not a financial justification for it.

I have read through most of the VSOs' testimonies and I can say that almost every VSO, if not every VSO, has said that they do not want the VA privatized. They also say the Choice program needs adjustment, and I think that is where the Veterans First Act comes

in; and that, by the way, will not be the last time we adjust the Choice program.

So, Sloan, I just would ask you if from your experience in the private sector and the experience that you have had in the VA, would it not make more sense to fix the Choice program first before we made it permanent?

Mr. GIBSON. I think the challenge that we are wrestling with right now is the rationalization of seven different programs for care in a community. So, in many respects, we do continue to try to fix the airplane while we are flying the airplane and that presents some challenges. I would tell you, if I had it to do over again, the biggest mistake I made in the last 2 years at VA was not asking for more time to implement Choice. I should have done that, and that is on me. I own that decision.

I think the work that we are doing around the consolidation of care, we are heading clearly and precisely in that direction, and whether or not Choice by that name becomes permanent or temporary is less relevant to affecting the changes to and the consolidation and streamlining of the various programs for care in the community.

Senator TESTER. Well, I would just—this is not a question, this is a statement. I just think it is incumbent upon this Committee, and I think it is one of the reasons I am so proud of the Chairman and Ranking Member for getting the Veterans First Act up, because I think it is a step in the right direction.

I do think that as we look to try to make Choice all it needs to be to meet the needs of the veterans, it may come to a point where we just say, hey, there is a better system out there, too, and that is the only reason I bring that up.

Baligh, it is good to see you. Thanks for coming to Montana.

Dr. YEHIA. Thank you, Senator.

Senator TESTER. It sounds like you did good work in Kansas. You have done good work in Montana. We need to probably keep you around.

Tell me what the major take-aways in the deliverables were from your trip to Montana, or your trips around the country, quite frankly, to make Choice work better, particularly as it applies to rural areas.

Dr. YEHIA. Well, thank you so much for those comments. Montana—and I was recently in Maine and Alaska—and what rang true was the different experience that rural veterans have compared to those that live in urban areas. When we think about how we consolidate community care, we need to make sue that no one is left behind, that the program is able to take into account every single sub-segment of the population, wherever they live.

What does that really mean? That means we need flexibility in reimbursement rates, because we know in some areas we might have to pay a little bit more to get doctors to see our patients. We need to make sure that the 30 days and the 40 miles are just a floor. If a veteran is seeing a provider and that provider decides that seeing someone in the community is what is best for them, we need to make sure that we empower them to do that.

So, those trips really kind of solidified for me what those unique features are of rural veterans and how we need to make sure we

do not have a cookie cutter approach to community care, but we tailor it to different geographies and populations.

Senator TESTER. Because I have visited with veterans in Montana and their experiences with Choice almost every time, if not every time, a third-party provider by the name of Health Net has come up; I am probably not Health Net's favorite Senator at this point in time, but that really does not matter. My question is, has Health Net delivered on the promises that they have made when they got the contract?

Dr. YEHIA. You know, I have a meeting every week with the Health Net executive and the TriWest executive because we need to do better for this program. They have been leaning forward more in recent months than before. We have set up joint groups of VA and our contracting partners. Now, when I go across the country to talk to veterans and providers, I make sure they come with us, because they need to hear directly from veterans and the doctors——

Senator TESTER. Right on.

Dr. YEHIA [continuing]. About how they can improve.

I will say, things are getting better. We are definitely not where we need to be, but on both the VA side of the house and the contractor side of the house, there has been improvement since the start of the program.

Senator TESTER. In closing, I would just say that veterans see Health Net as the VA, and that is not particularly healthy for the VA, because you guys are, at least in Montana, held in pretty high regard once the folks get through the door. So, they really need to start flying right which is why I am such a strong supporter of the Veterans First Act.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator.

Senator Tillis.

STATEMENT OF HON. THOM TILLIS,
U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair.

Thank you all for being here. It is good to see you and I want to thank you again for your continued investment and time with my office, and Senator Tester talking about the breakthrough priorities and the transformation effort you all are under.

I want to just speak briefly on—I have been here since January 2006, about seven dog years, and I have to say, in the length of time that I have been here, I really want to dispel the notion, at least on the Senate side—I cannot speak for the House—I do not know of anyone here who has had a serious discussion about privatization of the VA. I have said this before in committee. All you have to do is go out to the health care centers, you go out to the VA hospitals, and you understand the unique environment that they create that is uniquely therapeutic to a large base of veterans who need that facility.

So, I do not know—I seriously do not think that there is any effort to do that, and the fact of the matter is, a good portion of the VA has been privatized for some time through the non-VA care and now through Choice. It is a matter of getting the right balance.

It is also a matter of making sure that we do not go forward too quickly. I was, or am, a cosponsor of Senator McCain's Care Veterans Deserve Act, but within about 24 or 48 hours of us announcing that bill, I reached out to the VA to say, let us discuss the people, process, technology, and time implications of the bill. Let us reconcile it against transformation authorities, determine to what extent this may be a different suggested means to an end that you already have in mind. We have to continue to keep that dialog going. When we do that, I think that the difference in outcomes are not significant and that is a way we can get to a productive place to then determine additional authorizations and then appropriations that may be necessary if we are going to complete the picture.

I think it is critically important that the Department articulate in a very focused way how a well-intentioned idea is potentially disruptive to a number of other good ideas that are already stacked up that we intend to bring online. So, we have to keep that discussion going.

I do not think anyone at the end of the day has a concern with what Senator McCain and the team have crafted. It is more a matter of how it could potentially be disruptive and problematic to other things that we have to get done.

Now, moving on to other bills, one, I thank the senior Senator, Senator Burr, for his past work on the toxic substances exposure challenges that we have down in Camp Lejeune. I am glad to see that we generally have good support for that, and Mr. Chair, I hope we are able to move through with that fairly quickly.

I also want to thank Senator Klobuchar for the work that we are doing on the burn pits legislation. Again, I do not think it is controversial. We have an opportunity here to get at the head of the curve and not have the burn pit exposures be our Middle Eastern war's Agent Orange. I think we need to be productive, establish a Center of Excellence, and get that going. I do not think that that is necessarily destructive. In fact, I think it could be very helpful to future VA claims if we utilize science, get the practices right now to make that a better practice at the time that the soldiers or the veterans may need their help.

Then, on the Newborn Care Improvement Act, I get that you like it as long as we pay for it. What we are here to talk about now, and I think that can be said, you all probably have a rubber stamp somewhere. I think here, what we are talking about is authorizing programs, and we have to have a separate discussion about appropriations, how we have to pay for it. So, I appreciate the position, I think with the limited or no qualifications on those bills.

So, Mr. Secretary, I think that what we need to continue to do, though, is get very quickly to where we can get this framework in place. We are working with the VA on it, so that we can in a very constructive way communicate back to the members how the time and the technology and the people and process implications of well-intentioned initiatives affect your overall transformation strategy. If we do that, in some cases, we may find out that there is a fork in the road that we should take because we have discovered something that may be more promising or have more value. We need to really have that evaluation.

I know it is sometimes difficult for the Department to communicate that back because it becomes adversarial. We need to start getting some muscle memory into that just being a better way for us to engage so that we keep you all on what I think is a fundamentally sound overall transformation strategy.

Mr. GIBSON. I agree. As we discussed, I think there is an opportunity for that kind of informal exchange of information early in the process, particularly on legislation that we believe has the momentum associated with it and would see it through to potentially a floor vote or at least a vote out of Committee.

Senator TILLIS. Thank you. Also, just a closing comment, I know the Chair and the Ranking Member have talked about Secretary McDonald's publicized comments. I agree with them, that I can understand maybe what he was trying to communicate, though probably not the best way to communicate. What he is trying to do is provide excellent service as an organization. Get that past us fairly quickly so that we can focus on what I think is a productive working relationship. You have got a lot of work to do. Much of the swamp was there before you all came in to start draining it, but we have got to make sure that we just keep on working on positive messaging and do the best we can for the veterans.

Mr. GIBSON. Thank you for your very even-handed remarks.

Senator TILLIS. Thank you.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Manchin.

STATEMENT OF HON. JOE MANCHIN III,
U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman.

Thank you all for your appearance today and for the hard work that is being done. This is one Committee that you are going to see is mostly bipartisan because we are here for one purpose. We all have VAs and we would not be sitting here without them and you would not be sitting there without them. So, we are all committed and dedicated. No one is throwing stones at all. Secretary McDonald has proven he is as human as we are. Welcome to our world. We understand that and we just hope that he continues to do the good work that he is doing. All of your actions and his actions—picking you all has spoken volumes about caring for our veterans and why that comes first.

You know, and I am just going to call you Dr. Y. [Laughter.]

So, Dr. Y——

Dr. YEHIA. It works for me.

Senator MANCHIN. Huh?

Dr. YEHIA. I said, works for me. [Laughter.]

Senator MANCHIN. You know, this whole thing about Choice and how we could—when it all was unveiled about how long the waiting time and the horrible situations that our veterans were in for the purpose of some unscrupulous people within the system, I think that has been cleared up. I think we are moving forward and past that.

Then it came to light about Nuka, what Alaska was doing, and how they were doing it better, cheaper, quicker, and faster. So, we are going to say, well, if it works there, why does it not work every-

where? When you start talking to the veterans—you know, the veterans love their VAs. They love their hospitals. They love their CBOCs, because they know that people understand them. We are just trying to find that perfect blend, you know. I think that is it, the options. I know that Senators Tester, Tillis, and others are pushing the envelope now. How do we make it better? So, I do not think anyone is casting stones at you all but we are saying, can we make it better?

Dr. YEHIA. Yeah.

Senator MANCHIN. Can we make sure that each veteran knows that they come first? We see it has worked in Alaska. We do not have a hospital in Alaska, do we?

Dr. YEHIA. We do not have a full-fledged hospital.

Senator MANCHIN. No full-blown hospital, OK. And most of the—they are going to the Native American clinics, right——

Dr. YEHIA. That is right, and the DOD.

Senator MANCHIN. They get priority billing on that. Which is, I think, what we tried to do, model that, a little bit after that, to get the same flow in some of our rural areas.

You know, when Choice came out and the 40-mile rule, well—40 miles as the crow flies is like 85 miles by the way we drive in West Virginia. If you have never been to West Virginia, it is so beautiful, and we give you the roads so you can enjoy the beauty. [Laughter.]

With that being said, you all made those adjustments. We appreciate that. Tell me how we go to the next step. How can we give these options? I know that you are afraid we are going to throw the baby out with the bathwater, the cost is going to be exorbitant, boom, boom, boom, but we did not see that in Alaska. We did not see that in places where it works.

Dr. YEHIA. Yeah. You know, your point about the special role that VA plays is true. I was in clinic 2 weeks ago when I was seeing patients. I saw one of my patients in the waiting room. I thought, I did not see you on my calendar today. I did not know we were meeting. Oh, no. He says, I am just here kind of catching up with my buddies. You do not do that in other hospital systems.

Senator MANCHIN. Sure.

Dr. YEHIA. It is a very different place. I think we have to recognize that, as you did. At the end of the day, what we are looking to do is to get the best of both worlds. How do we play off the strengths of the VA and then play off the strength of the private sector?

In some areas, in Alaska, we probably are going to purchase more care than make. In other areas, we might be making more care than buying. It is really getting us to an integrated health care network and that is what we put forward in our plan to consolidate community care. We talk about how, by allowing flexibility for the doctor, for the patient, and for the system, we can achieve the right balance in different markets.

So, I think we have a good plan going forward. We just need the partnership, continued partnership with Congress to move some of that stuff past the finish line.

Senator MANCHIN. I want to say one thing on the opiates. You know, I was at our VA hospital in Clarksburg, WV, which has been there for quite some time and it is a beautiful operation for our vet-

erans. I spoke to one of your doctors who ran the CBOCs, and she is very direct. The reason I am saying this is the feedback I received from that gave us the impetus to move on legislation that would not keep ratings, because she said if these guys cannot call you guys, meaning the legislature, which is the Congress, and tell them that we did not do good by them because they were not given the pills they wanted, then we could do our job a little bit better. Very direct dialog.

We came back and formed legislation now that, basically, any time opiates are dispensed in the hospitals in any type of a setting, it cannot be used in a rating system, because an addict is not going to give you a good rating if they do not get what they want. It made such sense. That came from you all, the feedback. So, I want to thank you for that.

We are trying, we truly are, Mr. Gibson, to find that balance, and the biggest thing we have is people that need special care. Sometimes, we do not offer that or we do not have that expertise. How quickly can we get there, and what is the correlation between the private sector doctors responding back to you all, you know, and that correlation between someone outside the VA and the VA itself.

Mr. GIBSON. Well, that is the integrated network that Baligh is referring to——

Senator MANCHIN. Right.

Mr. GIBSON [continuing]. That we are working to build and create, and——

Senator MANCHIN. That is the biggest challenge you have right now, getting that——

Mr. GIBSON. I think it really is.

Senator MANCHIN. Yeah.

Mr. GIBSON. We want this to be seamless for the veteran. It ought to be about what is the right thing for veterans and taxpayers. Every time we are looking at this question, it is that dynamic. Can we make it with better value than we can buy it? Then we ought to be making it in a particular location. If we get better value by going—better care quality and better value for taxpayers by going in the community, that is where we need to go to provide that care for the veteran. And in rural communities, which Alaska is a great example, we are probably going to buy more care than we make.

Senator MANCHIN. We are fine with that, and I think that is where Thom, where you are coming from, too, right?

Senator TILLIS. [Nodding in agreement.]

Thank you. I really do appreciate it, and tell the Secretary, do not let the SOBs get him down.

Mr. GIBSON. I will do that, sir. He hears that from me regularly, so I will repeat it. Thank you.

Senator MANCHIN. He will be fine.

Chairman ISAKSON. Thank you, Senator Manchin.

Senator Heller.

STATEMENT OF HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Thank you, Mr. Chairman.

I think I am one of those SOBs. [Laughter.]

Mr. GIBSON. No way.

Senator HELLER. I am grateful that the panel is here and I want to thank you for taking time. As the Chairman knows, I wrote a letter to the Secretary yesterday, disappointed in his choice of words, and I want you to know that I do not hold anybody here on this panel responsible for the poor choice of words that were made by the Secretary yesterday.

In fact, I was going to let it go until I got this note here from his office, from the Secretary himself prior to this hearing. Without reading all of it, if I may, Mr. Chairman, it said, "I would like, Senator Heller, to focus on substantive issues and not on what I said yesterday." Frankly, I think what he said yesterday and what he said about the VA claims backlog is a substantive issue, and I think most on the panel today would agree with that.

I would like to share something of a text that I received yesterday from a veteran in response to a letter that I sent. He says, "Give them hell, Dean. For the amount of money they are paid, they should get in line like the veterans and see how they like it." Now, this particular veteran served in the Korean War. He was a Marine, one of the chosen few. He also happened to be the State Treasurer of Nevada. His name is Mr. Ken Santor.

Secretary Gibson, I did not hear your comments—I apologize for being late—when I came in. But, would you tell me how the Secretary would respond to Mr. Santor if he were in the room today?

Mr. GIBSON. Anyone that knows Bob McDonald knows that he would not for an instant entertain any kind of a notion of diminished importance for timely access to care for veterans. Bob was trying to make a point about service quality. I think the analogy was not a good analogy, not a good point of comparison.

As I read to this Committee before you arrived, sir, a verbatim quote of mine when I was the Acting Secretary in July 2014, where I noted the fact that having a single wait time standard for care in the largest integrated health care organization in America really did not make a whole lot of sense and that I fully expected, over time, what we would be doing is very much like private sector health care, migrating toward much more of a focus on patient satisfaction around access, which is precisely what we have been in the process of doing. That is not to the—with disregarding wait times. Where we are intensely more focused on wait times has to do around the urgent care needs of our veterans.

You know, we could say every single veteran gets an appointment within 30 days and still we would fail every single veteran that needed to be seen urgently today or tomorrow. That is—it is that kind of a single wait time standard, a single number of days is not meaningful, and that is why you do not see private sector health care organizations managing access to care in that way. They look principally at the satisfaction of their patients.

What we are trying to do is to focus very intensively on access. Wait times are very important where we are trying to ensure that timely access to urgent care services are required. You can look at the laundry list. The number 1 priority of the entire Department right now is improving access to care. We are committed to making primary care services available on a same-day basis at every single medical center across the country. We are doing that today in 34

different medical centers. We have committed to mental health evaluations on a same-day basis. We have committed to seamless care for veterans who may be traveling or who are seeking care or prescription refill at a facility that is not their regularly registered facility. We are training 25,000 schedulers across the organization. We are rolling out new scheduling software.

We are completely changing the health care enrollment process. By July, a veteran either by telephone or online will be able to complete the entire enrollment process and in most instances be able to get an answer almost immediately. Since the beginning of this fiscal year, every newly enrolled veteran—there have been about 200,000 so far this year—received a phone call from VA welcoming them to VA, asking if they want to get an appointment scheduled, helping them identify the nearest medical facility where the care they need is offered, and introducing them to their other benefits. Veterans are rating that experience almost perfectly, 4.9 out of five.

This is the kind of—this is the way we are approaching this, trying to look at everything we do from the perspective of the veteran to give the veteran the very best care experience we can give.

The point Bob was trying to make had to do with all of that is about a lot more than wait times. Wait times are still important and we have still got a lot of work to do about improving access to care.

Senator HELLER. Mr. Gibson, I appreciate your comments. You have got to understand that I am a little sensitive on this particular topic. I come from a State that had the worst wait times when it came to benefits. We were at—our regional office was one of the worst in the country just a few years ago and good improvements have been made. But, we have 300,000 veterans in the State of Nevada and you can imagine the sensitivity of comments similar to that.

Mr. GIBSON. In the month of April, 3,143 veterans completed appointments that were over 30 days. That is too long.

Senator HELLER. Yes.

Mr. GIBSON. Now, there were 68,000 completed appointments that were under 30 days. But, again, the 30-day standard, for a lot of those veterans that got in quicker than 30 days, we still might have let them down because they may have needed to be seen sooner, which is the goal that we are after. It has got to be from the veteran's perspective. We cannot do this from the inside out. We have got to do it from the outside in, and that is what we are trying to put in place.

Senator HELLER. Thank you very much.

And former Congressman Michaud, I welcome you also. I remember fondly our time together in the House, so thank you for being here today.

Thank you for the answers to my questions.

Mr. GIBSON. Yes, sir.

Senator MANCHIN. Mr. Chairman, I want the record to be very clear that I did not refer to my good friend from Nevada as an SOB. [Laughter.]

Or any of my colleagues who I think the world of. I am thinking of—the people I am referring to are those who do not know the job

that has been done. They are quick to criticize without knowing the hard work that goes behind it.

Senator HELLER. Thank you, sir.

Senator MANCHIN. My good friend from Nevada, thank you.

Chairman ISAKSON. Well, thanks to our first panel. We thank you all for your attendance and your input. We will welcome our second panel to come forward. [Pause.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The agenda for the hearing included a draft bill containing the proposal from the Department of Veterans Affairs (VA) for reforming the disability claims appeals process. In connection with that proposal, VA provided the Committee with data reflecting projected total and individual productivity levels under the current appeals process compared to what VA expects under the proposed new appeals process. That data reflects that currently the Veterans Benefits Administration averages 79 case resolutions or transfers per full-time equivalent (FTE) and the Board of Veterans' Appeals averages 47 resolutions or transfers per FTE. Under the new appeals process, VA projects productivity levels of 128 decisions per FTE in the supplemental claim lane at the Veterans Benefits Administration; 309 decisions per FTE in the higher-level review lane at the Veterans Benefits Administration; 180 decisions per FTE in the no-hearing lane at the Board of Veterans' Appeals; and 130 decisions per FTE in the hearing lane at the Board of Veterans' Appeals.

A. Please provide an explanation of what factors are expected to allow for each of those increases in individual productivity, including any statistics, trends, studies, or other relevant information used in generating those projections.

Response 1A. VA based its productivity estimates on the work rate standards (WRS) as published in the Veterans Benefits Administration's (VBA) Management Operations Manual M21–4, Appendix B. VA used the estimated fully-loaded labor hours required to complete end products associated with common disability rating claim work products. Fully-loaded labor hours include direct employee time spent adjudicating the claim, while indirect time is time spent by supervisory, managerial, and administrative staff who support the direct-labor workforce. Additionally, VA used a standard annual availability rate of 1,576 hours per Full Time Employee (FTE). Although the Office of Personnel Management uses 2,087 hours when computing basic rates of pay, VA depreciates the number of available hours by approximately 25 percent to account for leave, training, meetings and other time spent in pay status but not directly contributing to the completion of a disability rating claim.

For the supplemental claim lane, VA's estimated level of effort is based on approximately 8.45 labor hours to complete a supplemental disability rating claim. For these claims, an employee would complete approximately 187 claims per year. However, VA considered increased claims complexity since 2006 when the WRS were last reviewed and determined that the calculation should be adjusted. Over the past 5 years, VA's data shows that the number of disabilities decided per claim has increased by approximately 45 percent; thus, VA increased the number of labor hours necessary to complete supplemental claims commensurately to account for the additional processing time required to decide claims with higher numbers of claimed disabilities. This dropped the number of supplemental claims decided yearly per FTE from 187 to 128.

For the higher level review lane, VA's estimated level of effort is based on approximately 3.42 labor hours to complete a rating review action for a service-connected disability rating claim where the Veteran's disability requires an additional examination to review the current evaluation. However, claims considered in the higher level review lane will require employees to review prior actions on the claim to ensure compliance with VA's duty to assist, and will often require employees to review multiple issues. As such, VA has determined that the estimated labor hours for this lane should be adjusted up by approximately 49 percent—from 3.42 to 5.09 labor hours per rating review—to account for the anticipated complexity of claims considered under this higher level review. This dropped the number of reviews completed yearly per FTE from 461 to 309.

Regarding individual productivity at the Board of Veterans' Appeals (Board), the question above states that data provided by VA to the Committee reflects that, currently, the Board averages 47 resolutions or transfers per FTE. VA interprets "transfers" as referring to cases that are remanded by the Board to the Agency of

Original Jurisdiction (AOJ). To clarify, this number should be updated to reflect 86 decisions (resolutions and remands) per Board FTE. In Fiscal Year (FY) 2015, the Board completed a total of 55,713 decisions, with an average of 86.3 decisions/dispositions per FTE. The 86.3 dispositions per FTE include both decisions and remands. Of the 55,713 decisions/dispositions completed by the Board in FY 2015, 46.4 percent were remands to the AOJ. As previously reported, the average 47 resolutions per FTE reflected final decisions, not remands, completed by the Board.

As stated in the FY 2017 budget request, which has received support in both the House and Senate, sweeping legislative reform is needed to ensure that Veterans receive timely and quality appeals decisions. The FY 2017 budget proposed a Simplified Appeals Process—legislation and resources (i.e., people, process, and technology) that would provide Veterans with a simple, fair, and streamlined appeals process in which the vast majority would receive a final decision on their appeals within one year from filing the appeal. Specifically, the FY 2017 budget request included three legislative proposals which outlined changes to the VA appeals process to create a Simplified Appeals Process: one proposal to close the evidentiary record, with very limited exceptions, at the time that a claimant is provided notice of the AOJ's decision; a second proposal to transfer jurisdiction over an appeal to the Board at the time of receipt of a Notice of Disagreement (NOD); and a third proposal to eliminate optional Board hearings. Under the Simplified Appeals Process outlined in the FY 2017 budget request, VA projected that the Board would complete an average of 180 decisions per FTE. The Simplified Appeals Process outlined in the FY 2017 budget request started a conversation about appeals reform and led to a wide spectrum of stakeholder groups meeting with VA to reconfigure the VA appeals process into something that provides a simple, timely, transparent, and fair resolution of appeals for Veterans and makes sense for Veterans, their advocates, stakeholders, VA, and taxpayers. The result of those stakeholder meetings was the new appeals framework, as outlined in the draft bill considered during the hearing. While the new appeals framework has changed from the Simplified Appeals Process outlined in the FY 2017 budget request, we still expect increased productivity in the new framework and, because of similarities with the Simplified Appeals Process, we expect the same level of Board productivity in the non-hearing option lane.

In the non-hearing option lane, the evidentiary record before the Board would be limited to the evidence of record at the time of the AOJ decision on appeal, which is very similar to the Simplified Appeals Process, in which the evidentiary record closed at the time the claimant was provided notice of the AOJ's decision, with an exception for additional evidence added as a result of a remand to correct a duty to notify or duty to assist error that occurred prior to the initial AOJ decision. Also, in the new appeals framework, as in the Simplified Appeals Process, jurisdiction over an appeal would be transferred to the Board by filing an NOD. The non-hearing option lane in the new appeals framework is also similar to the Simplified Appeals Process in that there would be no Board hearings. In light of these similarities between the Simplified Appeals Process and the new appeals framework, the Board would expect the same productivity level as that contemplated in the Simplified Appeals Process included in the FY 2017 budget request.

The FY 2017 budget projected 180 Board decisions per FTE based on technology, legislative change, the fact that the Board's reasons and bases in its decisions would be simplified, and the fact that, with very limited exceptions, the Board would review only the evidence before the AOJ at the time of the rating decision. We continue to believe that the Board would achieve the same level of productivity in the non-hearing option lane in the new appeals framework, as the evidentiary record before the Board would be limited to the evidence of record at the time of the AOJ decision on appeal. Therefore, in FY 2018 we project 108 resolutions and 72 remands per Board FTE, for a total of 180 decisions per Board FTE. We note that the projection of 180 Board decisions per FTE in the FY 2017 budget was a projection based on a legal framework that we do not have experience administering. We will continually reevaluate Board productivity.

Estimated productivity in the Board hearing option lane is projected to be less than in the non-hearing option lane because Veterans will have the option to submit additional evidence during or within 90 days following a Board hearing or, if a hearing is not requested, with the notice of disagreement (NOD) or within 90 days following receipt of the NOD. Therefore, we expect productivity of 130 dispositions per FTE in the hearing option lane. We project, in FY 2018, 78 resolutions per FTE and 52 remands per FTE, for a total of 130 dispositions per FTE.

B. Do the projections for individual productivity levels at the Veterans Benefits Administration reflect any expected decrease in individual productivity as a result of the enhanced notice requirements in the draft legislation (revisions to 38 U.S.C. 5104(b))? If so, please outline how that was factored into the projections.

Response 1B. The projections for individual productivity levels at VBA do not reflect any expected decrease in individual productivity based on the enhanced notice requirements. While the new letters may require more effort to generate, VA expects they will contribute to a lower appeal rate, which would offset the effort to create the letter. VA will perform further analysis on the impact of the letters once acceptable letter templates have been prototyped and tested with the employees who will be responsible for creating the letters.

C. Do the projections for individual productivity levels take into account any lag time for hiring and training new employees and for newly hired employees to become fully productive? If so, please outline how that was factored into the projections.

Response 1C. While authority for new employee hiring would be contingent on subsequent budget cycles, VA has taken into account hiring and training of employees into its projections. Since the proposed legislation would have an 18-month effective date, VA would have the time needed to draft training materials and guidance documents as well as hire and train any new employees.

Regarding productivity, as the Board has a six-month period during which new attorneys receive training and develop the necessary skills to effectively produce quality decisions in a timely manner, we would expect any new Board FTE production in the first year to be 74 percent of regular production. VA does not expect reduced production from any new VBA employees, as new employees would be placed into the disability compensation claim processing teams and seasoned claims processors would be transitioned into new roles in the new framework's higher-level review and supplemental claim lanes. These seasoned claims processors may experience a slight learning curve productivity drop; however, we would not expect any significant decline in productivity and believe any impact would be negligible because of the increased efficiency of the new system.

D. If the projected levels of increased productivity turn out to be unreachable, what steps could VA take to avoid a backlog developing under the new appeals system?

Response 1D. VA will continue to develop and implement new systems to reduce error, optimize automation, and increase productivity of its employees to serve more Veterans and their families. The Board has already begun an Appeals Modernization initiative to overhaul its legacy IT system and create new tools to support accurate, timely decisions. The U.S. Digital Services Team is leading the effort and is working to replace the Department's appeals tracking system, the Veterans Appeals Control and Locator System (VACOLS), which was created decades ago, with a modern tool that seamlessly integrates with and leverages data from VBA's Veterans Benefits Management System (VBMS). Additionally, VBA has been working to streamline the claims process for the past few years, which will continue for original claims and the supplemental claim and higher level review lanes under the new framework. Finally, as VBA continues to modernize the claims distribution process through the National Work Queue, supplemental claims and requests for a higher level review at VBA under the new framework will be routed to available capacity nationwide to improve overall efficiency and timeliness.

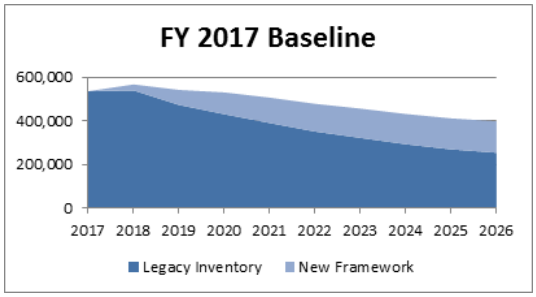
Question 2. Regarding VA's proposal to reform the appeals process, the Committee has received testimony and other communications from Disabled American Veterans, Veterans of Foreign Wars, The American Legion, AMVETS, Iraq and Afghanistan Veterans of America, Military Order of the Purple Heart, the National Organization of Veterans' Advocates, and Paralyzed Veterans of America all indicating that a critical element of appeals reform is for VA to put forth a comprehensive plan to address the large existing inventory of appeals (approximately 450,000). Although VA has provided the Committee with cost estimates for various staffing models that could be used to address the existing inventory of appeals, the information provided does not include a detailed plan for how and when the existing appeals will be resolved.

A. Please provide the Committee with a detailed plan for addressing the existing appeals (including any appeals that would be received before a new appeals process becomes effective), including information addressing personnel matters (for example, the extent to which VA would use all-hands-on-deck initiatives, overtime, contractors, new temporary employees, new permanent employees, etc.), any logistical challenges involved in handling a large volume of appeals in the near term, any proposed special appeals processing initiatives, any legislative changes that would be of assistance in handling legacy appeals in a timely manner, and key goals and milestones for processing existing appeals and related remands.

Response 2A. VA's current inventory is approximately 460,000 appeals, with approximately 78 percent pending with VBA. Legislative reform will help VA address

appeals filed from decisions issued on or after the effective date of the law. Moreover, the legislative reform package does not change the mandatory cost requirements and is more efficient to administer compared to the current framework. In fact, over time, the new framework will result in cost savings over the current baseline. However, the sizable inventory of appeals stemming from decisions issued prior to the effective date of the new law would be completed under legacy procedures. VA would require additional resources to meet the timely service expectations of both Veterans and Congress in processing these appeals.

VA is aware that any increase in resources above the FY 2017 baseline will be contingent on annual budget appropriations and resource requirements will be validated on a yearly basis through the annual budget process. As such, to demonstrate potential outcomes for Veterans awaiting final decisions on their appeals, VA has projected five scenarios that highlight possible outcomes depending on the level of funding appropriated by Congress. The graphs below visually display each scenario.

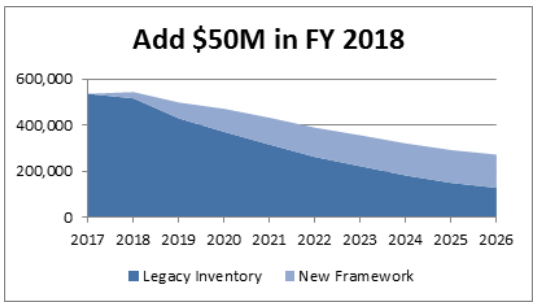


	Resources and FTE		Outcome
	FY 2017	FY 2018	FY26 Legacy Inventory
FY 2017 Baseline	$348,083	$358,589	214,837
Total FTE	2,417	2,417	
Legacy Inventory	535,726	529,706	

*The FY 2018 funding level in this model includes a 3 percent inflationary increase

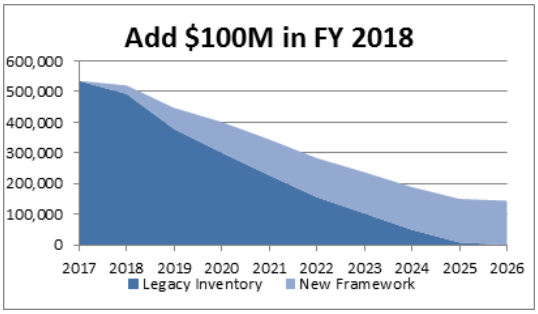
The first scenario above, titled "FY 2017 Baseline," assumes only legislative change without any new funding beyond FY 2017. Baseline funding is at the same level as FY 2016, with the exception of the addition of 242 FTE for the Board in the FY 2017 President's Budget. Under this model at least 214,837 appeals will take longer than 9 years to be resolved. Moreover, under this level of funding, some of these legacy appeals will take 28 years to be resolved.

In the rest of the scenarios presented below, VA has assumed funding above the FY 2017 baseline to accelerate resolution of the legacy appeals workload.



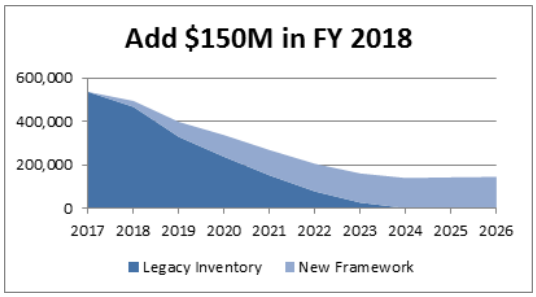
	Resources and FTE		Costs		Outcome
	FY17	FY18	FY17-FY21 Costs Above FY17 Baseline (5 year)	FY17-FY26 Costs Above FY17 Baseline (10 year)	FY26 Legacy Inventory
Add 50M in FY18	$348,083	$397,895	$164,917	$392,382	127,505
Total FTE	2,417	2,661			
Legacy Inventory	535,726	515,717			

The second scenario, titled "Add $50M in FY 2018," reflects the projected outcome if Congress funded VA appeals by an additional $50M above the FY 2017 baseline. Under this model, VA projects 127,505 appeals will take longer than 9 years to be resolved.



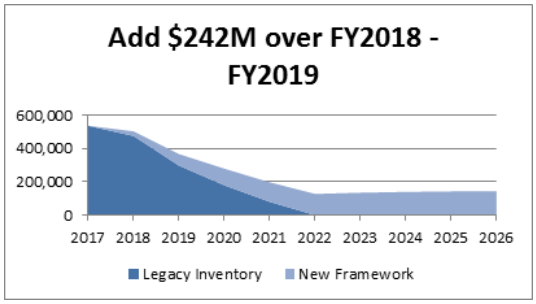
	Resources and FTE		Costs		Savings	Outcome
	FY17	FY18	FY17-FY21 Costs Above FY17 Baseline (5 year)	FY17-FY26 Costs Above FY17 Baseline (10 year)	FY17-FY26 Savings Over 10 Years	FY26 Legacy Inventory
Add 100M in FY18	$348,083	$448,005	$374,371	$731,203	$(62,123)	Complete by end of FY2026
Total FTE	2,417	3,001				
Legacy Inventory	535,726	492,749				

The third scenario, titled "Add $100M in FY 2018," reflects the projected outcome if Congress funded VA appeals by an additional $100M above the FY 2017 baseline. VA projects that under this model, it would be able to eliminate most of the legacy inventory by the end of FY 2026. Due to the open record and duty to assist in the current appeal process, VA will likely have a small, declining inventory of legacy appeals for several years after FY 2026.



	Resources and FTE		Costs		Savings	Outcome
	FY17	FY18	FY17-FY21 Costs Above FY17 Baseline (5 year)	FY17-FY26 Costs Above FY17 Baseline (10 year)	FY17-FY26 Savings Over 10 Years	FY26 Legacy Inventory
Add 150M in FY18	$348,083	$497,890	$572,735	$482,879	$(288,811)	Complete by end of FY2024
Total FTE	2,417	3,360				
Legacy Inventory	535,726	466,245				

The fourth scenario, titled "Add $150M in FY 2018," reflects the projected outcome if Congress funded VA appeals by an additional $150M above the FY 2017 baseline. Under this model, VA projects it would be able to eliminate most of the legacy appeals inventory by the end of FY 2024. Due to the open record and duty to assist in the current appeal process, VA will likely have a small, declining inventory of legacy appeals for several years after FY 2024.



	Resources and FTE			Costs		Savings	Outcome
	FY 2017	FY 2018	FY 2019	FY17-FY21 Costs Above FY17 Baseline (5 year)	FY17-FY26 Costs Above FY17 Baseline (10 year)	FY17-FY26 Savings Over 10 Years	FY26 Legacy Inventory
Add in FY 2018 & FY 2019	$348,083	$478,824	$590,330	$725,715	$323,307	$(518,938)	Complete by end of FY22
Total FTE	2,417	3,234	3,875				
Legacy Inventory	535,726	474,387	296,676				

In the last scenario, titled "Add $242M over FY 2018–FY2019," VA assumed a budget and hiring authority sufficient to functionally eliminate the legacy appeals inventory by FY 2022. VA projects that under this aggressive model, it would be able to reduce the inventory of legacy appeals from a high in FY 2018 of almost 536,000 appeals to approximately 80,000 appeals by the start of FY 2022—an 85-percent reduction in 4 years; with legacy inventory essentially eliminated by the end of FY 2022. Due to the open record and duty to assist in the current appeal process, VA will likely have a small, declining inventory of legacy appeals for several years after FY 2022. Under this model VA would need budget authorization for 242 million, receiving 130 million in FY 2018, and 112 million in FY 2019.

VA is grateful to Congress for the additional FTE in recent years, including an additional 107 for the Board in FY 2014 and an additional 300 for VBA, who were hired in 2015 to assist with the disability compensation claims rating backlog and shifted to work appeals in 2016. The 2017 President's Budget currently under consideration by Congress includes a request for an additional 242 FTE for the Board.

VA is also reviewing existing processes to improve the efficiency of the FTE working appeals in the legacy system. VBA's centralized mail and scanning is now han-

dling documentation from the Board in order to accelerate the transition of appeals to the digital environment. Currently, approximately 90 percent of all appeals are paperless. VBA and the Board are also working to resolve pending requests for Board hearings. The Board has made more hearing slots available through Video Teleconferencing, and VBA is working with VSOs and Veterans to ensure utilization of the hearing slots.

Another element of the plan to improve efficiency of the appeals process and resolve the legacy inventory is to improve the technology supporting appeals processing. VBA has outlined enhancements for VBMS to improve appeals processing. As stated above, the U.S. Digital Services Team is leading the effort to replace the outdated legacy appeals tracking system (VACOLS) and to further improve the processing of appeals at the Board with additional capabilities such as work queues, tools to optimize efficiency in eFolder review and decision writing and automation, among others.

B. To the extent the plan for addressing the existing inventory of appeals includes a near-term surge of employees (the New Framework + FTE Surge model submitted by VA), please include an explanation of how long it would take for VA to fully prepare for and implement the surge of employees, how long the surge would be expected to last, what level of productivity VA would expect to achieve as a result of the surge, and how VA would downsize its labor force once the need for the surge of employees has ended. For example, please include information about how long it would take to hire the additional employees at the Veterans Benefits Administration and the Board of Veterans' Appeals; how long it would take to train those employees; what additional capacity, if any, the Veterans Benefits Administration and Board of Veterans' Appeals would need in order to train the new employees; how much additional office space, if any, VA would require to accommodate the new employees and how long it would take to acquire that space; how long it would take to acquire any necessary computers, office supplies, or other necessary equipment for the surge of employees; what other logistical challenges VA would face with a large influx of employees; and what legal authorities would be used both to hire new employees and to downsize the labor force once the need for a surge has ended.

Response 2B. The question references the New Framework + FTE Surge model submitted by VA. As reflected above, there are various modeling outcomes regarding addressing the existing inventory of appeals depending on funding levels. The answers below would be generally applicable to any new budgetary appropriations that would involve additional FTE.

VA believes that the proposed 18-month lag between the passage of the appeals reform bill and the effective date for implementation is sufficient to execute the surge hiring strategy to address the legacy appeals inventory. VBA believes it can meet the FTE hiring surge within 6 months of the authority to hire. Training will follow VBA's normal protocol, which includes 3 weeks of centralized training followed by 6 months in trainee status at each Regional Office. VBA will deploy newly hired employees to work simpler, rating-related claims. This will allow more experienced employees to work on more complex claims under the new framework. In this model VBA has also accounted for resource requirements for training, space, and computer workstations.

The Board believes it can also hire and train additional FTE during the 18-month period between enactment of the legislation and its effective date. The Board is in the process of refreshing its attorney training curriculum to refocus on preparing decisions in a virtual environment and to shift from live training to more recorded modules that can be used on demand as needed both for initial training and refreshers. The new framework for appeals processing would be incorporated into this training. New judges will also undergo rigorous initial training, which will include training addressing the new framework, with follow-up mentoring and continuing education. Board administrative staff will also undergo new employee training specific to their business line.

The challenges faced by the Board would include human resources support, information technology (IT) support, training support, and office space. These challenges would be handled by having a strong recruitment plan in place, with a tiger team of dedicated personnel to handle the recruitment and on-boarding. The IT needs would also be identified in advance with a streamlined plan to have the necessary equipment in place in a timely fashion as new hires were on-boarded. The Board is already putting plans in place and is working with the Office of Human Resources & Administration and the Office of Information & Technology to ensure that it is ready for a surge of employees. The training needs would be handled by having a strong training plan in place, using lessons learned from the large training in 2013, when the Board successfully hired and on-boarded 125 new FTE (including 114 new attorneys) during two quarters of FY 2013, and subsequent trainings. Finally, the

office space requirements would be handled by a combination of repurposing existing space for storing paper claims files, and increasing telework for eligible employees.

VBA's historical attrition rate is approximately 7 percent; the Board's historical attrition rate is approximately 8.7 percent. As the legacy appeals inventory is resolved, VBA can divert its legacy appeals workforce to rating-related disability compensation work and/or conducting higher level reviews under the new framework. The Board expects that it will be able to primarily rely on attrition alone to meet the decrease in staffing requirements following the hiring surge in FY 2018 and 19.

Question 3. If the proposed legislation on appeals reform is passed, please outline the steps VA would need to take in order to fully prepare for and implement the new process, including any actions needed regarding logistics, training, information technology, and outreach.

Response. VA has proposed an 18-month delayed effective date for the legislation. This delay would provide VA with the time needed to prepare for implementation, including the drafting of regulations, updating forms and notice letters, developing guidance documents, updating information technology (IT) systems, implementing an outreach and communications plan, and hiring/training staff.

To implement the appeals reform legislation, VA must amend its existing regulations, to include its adjudication and appeal regulations in parts 3, 19, and 20 of title 38, Code of Federal Regulations. Due to the sweeping nature of these reforms, any regulatory changes will require public notice and comment. Such rulemakings can take up to eighteen months to finalize, so drafting will begin immediately upon enactment of the legislation. Concurrent with preparing these regulatory changes, VA will update its procedural guidance documents, to include VBA's M21–1 Adjudication Procedures Manual, as well as any letters and forms impacted by the legislation. As implementation draws nearer, VA will develop and implement appropriate training for all employees. VA does not anticipate any difficulty training employees, nor do we foresee a significant impact on current levels of productivity because the new framework would be more efficient to administer.

Regarding necessary IT upgrades, VA will continue its multi-phase process of enhancing appeals functionality in the paperless environment while simultaneously initiating any new development and/or upgrades necessary to implement the new framework.

VA will also use the 18-month period to develop and deploy a robust outreach plan to ensure that Veterans and their families, as well as other stakeholders fully comprehend the new framework. VA will leverage its existing tools, partnerships, social media platforms, and forums, to include *MyVA* Communities and Town Halls, to disseminate information about the upcoming changes and the impact on current and future appeals. Engaging with Veterans and stakeholders early and often will ensure that any issues may be addressed prior to final implementation. Furthermore, VA will apply best practices and lessons learned from its claims process transformation.

As discussed in response 2(B), VBA is prepared for budgetary approval for new resources, and VBA believes it will be able to hire FTE within 6 months of any authority to hire. Training would follow normal protocol, which includes 3 weeks of centralized training followed by 6 months in trainee status at each Regional Office. VBA would deploy newly hired employees to work simpler, rating-related claims, allowing for existing, experienced employees to work on more complex work under the new framework. In order to hire/train Board staff, the Board will have a strong recruitment plan in place, with a tiger team of dedicated personnel to handle the recruitment and on-boarding. The IT needs for these new employees would also be identified in advance with a streamlined plan to have the necessary equipment in place in a timely fashion as new hires are on-boarded. The training needs would be handled by having a strong training plan in place, using lessons learned from the large training in 2013, when the Board successfully hired and on-boarded 125 new FTE (including 114 new attorneys) during two quarters of FY 2013, and subsequent trainings. Finally, the office space requirements would be handled by a combination of repurposing existing space for storing paper claims files, and increasing telework for eligible employees.

Question 4. The agenda for the hearing included a legislative proposal that was in the fiscal year 2017 budget request for VA, which would modify the evidentiary threshold needed to trigger VA's obligation to provide a compensation and pension examination for a veteran seeking disability compensation. Generally, it would require objective evidence that the veteran experienced an event, injury, or disease during military service, in addition to existing evidentiary requirements.

A. Please provide any relevant data on how many compensation and pension examinations VA provides each year; how many veterans receiving those examinations have their disability claims granted; and how many veterans receiving those examinations have their claims denied.

Response 4A. In fiscal year (FY) 2015, VA conducted compensation and pension examinations for 284,207 original compensation claims containing 1,706,550 separate issues. VA is providing this information at the issue level rather than the claim level because a claim may contain multiple issues, each with their own reason for denial. Based on the results of these examinations, VA granted service-connection for 877,906 (51.4 percent) issues and denied service-connection for 828,644 (48.6 percent) issues.

B. Please provide any relevant data on how many examinations per year would not be conducted if this change were enacted.

Response 4B. For FY 2015, VA estimated that 113,080 original claims received a VA examination for an issue that was subsequently denied because the claimed condition was not incurred in nor caused by military service. Approximately 84,812 exams (75 percent) were considered unnecessary as they do not result in a grant of service-connection and may be avoided each year if this legislation was enacted.

C. Please provide any relevant data on how frequently disability claims are denied for lack of in-service incurrence after VA has provided an examination.

Response 4C. The chart below shows the number of claimed issues where examinations were conducted but the issue was denied during FY 2015. As shown below, the rate at which VA denies service-connection because the condition was not incurred in nor caused by service (NINC) increases significantly for claims filed a number of years after separation from service.

Proximity of Claim to Veteran's Separation from Military Service	Number of Denied Issues	Number of Denied NINC Issues	% of Denials that are NINC	% of Denials Based on "No Diagnosis"
<1 Year	322,257	127,995	40%	48%
1–10 Years	152,328	87,809	58%	28%
10–20 Years	60,801	37,905	62%	22%
20–50 Years	248,252	156,305	63%	17%
Over 50 Years	29,571	20,398	69%	17%

D. Please provide any relevant information regarding the nature of the claims that are being denied for lack of in-service incurrence after an examination has been provided, including the types of injuries or diseases most frequently involved and the length of time that has elapsed since leaving the military.

Response 4D. The chart below shows the top five disabilities for FY 2015 that were denied service-connection, after a VA examination was conducted, because the claimed condition was NINC. The disabilities are categorized by the number of years after discharge from military service and reflect conditions that were claimed as part of original claims for service connection.

Proximity of Claim to Veteran's Separation from Military Service	Number of Denied NINC Issues	% of Denials that are NINC	Top 5 Disabilities Denied based on NINC
<1 Year	127,995	40%	1. Low Back 2. Knee, Loss of Motion (LOM) 3. Ankle, LOM 4. Shoulder, LOM 5. Tinnitus
1–10 Years	87,809	58%	1. Low Back 2. Knee, LOM 3. Tinnitus 4. Shoulder, LOM 5. Knee, Instability

Proximity of Claim to Veteran's Separation from Military Service	Number of Denied NINC Issues	% of Denials that are NINC	Top 5 Disabilities Denied based on NINC
10–20 Years	37,905	62%	1. Low Back 2. Knee, LOM 3. Tinnitus 4. Knee, Instability 5. Shoulder, LOM
20–50 Years	156,305	63%	1. Hearing Loss 2. Tinnitus 3. Low Back 4. Knee, LOM 5. Hypertension
Over 50 Years	20,398	69%	1. Hearing Loss 2. Tinnitus 3. Low Back 4. Knee, LOM 5. Heart

E. Please explain what impact this change would have on veterans seeking disability compensation based on toxic exposures during service.

Response 4E. This legislative proposal would have little to no impact on Veterans seeking disability compensation based on toxic exposures during service. The purpose of this proposal is to reduce the number of examinations VA must provide when there is no objective evidence of an in-service injury, event, or disease. For Veterans seeking disability compensation based on toxic exposure during service, generally, VA does not order a disability compensation examination without evidence of in-service toxic exposure. In other words, when an examination is ordered for such claimants, the only remaining issue for consideration is typically whether there is a medical nexus between a current disease and the in-service exposure.

Furthermore, in cases where VA has established a presumption based on exposure to certain toxins (i.e., herbicide agents, ionizing radiation, mustard gas), a disability compensation examination is often not necessary to establish service-connection because VA has already determined there is sufficient scientific evidence to establish a medical nexus between a particular disease and toxic exposure during service.

Response to Posthearing Questions Submitted by Hon. Mazie K. Hirono to Hon. Sloan Gibson, Deputy Secretary, U.S. Department of Veterans Affairs

FEMALE VETERANS SUICIDE

Question 5. A. Deputy Secretary Gibson, I know that the VA, and all Members of the Committee, are extremely concerned with the rates that our veterans, particularly female veterans, are committing suicide which is why I support Sen. Boxer's bill S. 2487 the Female Veteran Suicide Prevention Act. VA figures note for women ages 18 to 29, veterans kill themselves at nearly 12 times the rate of non-veterans. To what extent has the VA taken the actions as directed in S. 2487 to identify: (1) VA mental health care and suicide prevention programs that are most effective for women veterans, and (2) such programs with the highest satisfaction rates among women veterans?

Response 5A. VA shares your concern for women Veterans and is leading national efforts to understand suicide risk factors, develop evidence-based intervention strategies, and proactively identify and care for Veterans—men and women—who are in crisis or at risk for suicide. We note that S. 2487 was enacted as Public Law 114–188 in June 2016. Accordingly, VA will include in its annual evaluation of VA mental health care and suicide prevention programs under 38 U.S.C. § 1709B, metrics applicable to specifically to women, and identify the programs that are most effective for women Veterans and such programs with the highest satisfaction rates among women Veterans.

VA MENTAL HEALTH CARE AND SUICIDE PREVENTION PROGRAMS FOR WOMEN VETERANS

More than 430,000 women Veterans are currently utilizing the VA health care system. Of these, over 42% use VHA mental health services. For women Veterans in need of mental health care, VA provides a full continuum of mental health services to women Veterans, including general outpatient, specialty, inpatient and residential rehabilitation treatment options. Some specialty care programs that target problems such as PTSD, substance use, depression, and homelessness include women-only services (e.g., women-only groups). Many facilities provide this care through specialized women-only outpatient treatment teams. With regard to specialty outpatient treatment options for Post Traumatic Stress Disorder (PTSD), evidence-based therapies for PTSD, including prolonged exposure and cognitive processing therapy, have been shown to decrease suicidal ideation. These treatments are available nationally at every VA medical center.

For women Veterans in need of more intense treatment, VA has residential rehabilitation and inpatient programs that provide treatment to women only, or have separate tracks for men and women. These residential rehabilitation and inpatient programs are considered regional and/or national resources, not just a resource for the local VA facility. Mixed-gender options are also available.

VA has enacted universal screening programs for some of the most common mental health conditions and related experiences, including those faced by women and associated with increased risk for suicide, such as depression, PTSD, alcohol use, and military sexual trauma (MST). These screening programs provide an opportunity to identify those individuals in need of mental health care and refer them to appropriate mental health services. Screening rates for depression, PTSD, and alcohol use are very high (96%–99%), exceed private sector rates, and do not significantly differ by gender.

VA has numerous suicide prevention resources available, including a 24-hour per day crisis hotline (1–800–273–8255) and Veterans Crisis Online Chat (http://www.veteranscrisisline.net/ChatTermsOfService.aspx). Veterans and their loved ones also may access resources through VA's comprehensive suicide prevention website (http://www.mentalhealth.va.gov/suicide—prevention/). At least one full-time Suicide Prevention Coordinator (typically a nurse or social worker) is assigned to each VA medical center and large community-based outpatient clinic. This individual is responsible for tracking high-risk Veterans (all attempters, and patients with serious ideation or others clinically determined to be at high risk for suicide) and tracking appointments and coordinating enhanced care between Veterans and providers, among other duties.

Finally, VHA has strong clinical training initiatives in place to ensure that mental health providers have the knowledge and skills to meet the unique treatment needs of the growing population of women Veterans accessing VA mental health services. These include didactic teleconferences, expert case consultation and a web-based training curriculum on women's mental health needs across the reproductive lifespan (e.g., psychiatric disorders during and after pregnancy). In addition, the Women's Mental Health Section of VA Mental Health Services recently held a national Women's Mental Health Mini-Residency. This 3-day intensive training event was designed to provide VA mental health providers with the clinical knowledge and skills to provide gender-sensitive care to women Veterans. The 171 participants represented nearly every VA medical center nationally. These women's mental health providers will serve as local women's mental health champions. Each has developed an Action Plan to improve women's mental health delivery at their local facility.

WOMEN VETERANS' SATISFACTION WITH VA MENTAL HEALTH CARE AND SUICIDE PREVENTION PROGRAMS

Research findings indicate that women Veterans with mental health problems are very satisfied with VA health care. For example, one recent survey study of over 55,000 male and female Veterans diagnosed with a mental health condition showed that nearly all (91%) rated their health care provider positively (Burnett-Zeigler et al., 2011). There were no between-gender differences in ratings. Nearly all Veterans surveyed indicated their health care provider listened to them (96%), inspired confidence and trust (95.4%), and that they participated in their own healthcare decisions (91.9%).

Data from a national sample of 10,000 Veterans who received VA mental health services in fiscal year 2015 indicated that both male and female Veterans are very satisfied with their VA mental health care, and there were generally few differences between men and women on individual satisfaction questions. Areas of particularly high satisfaction, where national averages were at least 4 on a scale of 1 to 5, were Veterans reporting that their mental health care was helpful; that their clinicians

were accessible, engaged and responsive to their needs; that they had access to treatment when and how much they needed and wanted treatment; and that they were treated with respect and kindness. Composite measures reflecting access to care and patient-centered care also indicated high satisfaction, with women Veterans reporting slightly higher satisfaction with the patient centeredness of mental health care compared to male Veterans.

Finally, although women Veterans satisfaction with suicide prevention programs has not yet been directly assessed, available research suggests that these programs are making an important difference. For instance, by partnering with U.S. states to gather information about Veteran suicides from death certificates, VA researchers recently calculated, for the first time, preliminary estimates of suicide rates in the overall U.S. Veteran population, including those who do and do not use VA health services. Results showed significantly lower rates of suicide among women Veterans who use VA health services as compared to those who do not use VA health care. This finding suggests that VA's suicide prevention efforts are having a positive impact. In summer 2016, VA will release a Suicide Data Report that provides comprehensive information regarding suicide mortality among all Veterans, including women Veterans, for the years 2001–2014. This report will provide a deeper understanding of the problem of suicide among women Veterans and inform initiatives for preventing it.

References

Hoffmire, C.A., Kemp, J.E., Bossarte, R.M. (2015). Changes in suicide mortality for veterans and nonveterans by gender and history of VHA service use, 2000–2010. Psychiatric Services 66(9), 959–965.

B. VA estimates S. 2487 would cost $2.2 million in fiscal year (FY) 2017 and $6.6 million over 3 years. Could you break down that cost estimate? Are additional staff necessary?

Response 5B. In order to ensure that the amount of data on women Veterans utilizing mental health services is sufficient for a robust analysis that would support the requirements of S. 2487 (enacted as Public Law 114–188), a significant over sampling of women Veterans is required. The costs required to accomplish this oversample include: the costs within VA for managing a contract and collaborating with the outside independent evaluator on the provision and interpretation of women-specific data; incremental costs in order to increase the sample size; and the incremental costs for conducting the additional analyses required.

Specifically, acquiring data for a subsample of women Veterans that would be sufficient to allow parallel analyses and comparisons with the data on male Veterans will require doubling the overall sample size for the Veterans Outcomes Assessment (VOA), at a cost of $1.8 million per year. The VOA data will be the primary source of outcomes data that the external contractor will utilize to evaluate VA mental health services. Additionally, internal costs to VA include 1.0 FTE Program Analyst and a 0.25 FTE Program Manager to manage the larger contract, oversee and conduct extra data pulls and analyses for the external independent evaluator, and serve as a liaison to the external evaluator on women-specific data issues. Finally, VA's estimate includes the marginal costs for the additional analyses and reporting required of the external evaluator.

Chairman ISAKSON. Let me welcome our second panel. We appreciate your patience in waiting through the first panel, and we will move straight to your testimony and then questions. We are grateful you came to comment on the legislation before us.

We have Mr. Carlos Fuentes, Senior Legislative Advisor, Veterans of Foreign Wars; Lou Celli—welcome back, Lou—the National Director of Veterans Affairs and Rehabilitation, The American Legion; Adrian Atizado, Deputy National Legislative Director of Disabled American Veterans; Carl Blake, Associate Executive Director of Government Relations, Paralyzed Veterans of America; Diane Boyd Rauber, National Organization of Veterans' Advocates; and Jerome Ensminger, U.S. Marine Corps, Retired, Master Sergeant.

We welcome all of you. We will begin with Mr. Fuentes.

STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ADVISOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. FUENTES. Chairman Isakson and Members of the Committee, on behalf of the men and women of the VFW and our Auxiliaries, I would like to thank you for the opportunity to present our views on legislation pending before the Committee. I would limit my remarks to bills for which we have concerns we urge the Committee to address.

The VFW supports most aspects of the Care Veterans Deserve Act of 2016, but we have serious concerns with the bill's significant expansion of the Choice program. The VFW agrees that the VA health care system must leverage its community care partners in order to fulfill its obligation to our Nation's veterans. However, we firmly believe that community care must complement, not compete, with the high-quality veteran-centric and comprehensive care veterans receive from their VA health care system.

For that and other reasons, the VFW believes Choice program eligibility must be based on a veteran's inability to receive a VA appointment within a clinically indicated date or within the distance a veteran and his or her doctor agree is clinically necessary and reasonable.

The VFW strongly supports Section 4, which would authorize certain doctors to practice telemedicine across State lines. This provision would considerably expand access to care for veterans who do not live in the same State as their VA health care facility and veterans who require home-based health care services.

The VFW supports the intent of the Janey Ensminger Act of 2016, which would require periodic literature reviews to determine whether health care conditions prevalent among veterans and family members exposed to contaminated water at Camp Lejeune are associated with such toxic exposures. To ensure literature reviews are aligned with the realities of medical research, we urge the Committee to require that the Agency of Toxic Substances and Disease Registry use the Institute of Medicine's categories of association instead of attempting to meet the unattainable threshold of causation.

The VFW also supports the intent of the Helping Veterans Exposed to Burn Pits Act. However, the VFW recommends Congress expand VA's risk centers rather than establish a new Center of Excellence. I am glad to see that the VA in its written testimony indicated that it would expand its risk centers rather than establish a new center.

With regards to appeals reform, the VFW agrees VA's current appeals process takes too long. However, to say that the appeals process is broken is an overstatement. While the process takes too long, nearly one-third of all appellants are granted something they did not receive from a VA regional office. The process clearly works for them.

At the request of Secretary McDonald, the VFW has actively participated in a series of meetings in an attempt to identify opportunities to improve the current appeals process, but participation does not imply consent or approval of any process.

The proposed outline in the legislation under consideration today, even if approved with the recommendations detailed in my written testimony, is only one-third of the solution. There are two elements missing in this proposal: a comprehensive plan by VA to effectively address the current backlog of more than 450,000 pending appeals, and properly staff the new process; and an allocation of sufficient resources by Congress to allow VA to execute this plan effectively. The VFW will not endorse any changes to the current appeals process until all three elements are in place.

The VFW opposes the discussion draft to modify requirements under which VA is required to provide compensation and pension examinations to veterans seeking disability benefits which would relieve VA of its obligation to order medical exams for certain veterans. The VFW firmly believes that raising the standard for VA's duty to assist would have a negative impact on veterans. Under this proposal, veterans who are unable to locate their service records or have a disability that cannot be observed by others, such as fatigue, pain, or tinnitus, may be denied the compensation and pension examinations needed to prove their injuries are a result of their military service.

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

[The prepared statement of Mr. Fuentes follows:]

PREPARED STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify on today's pending legislation.

S. 2896, CARE VETERANS DESERVE ACT OF 2016

This legislation would expand the Veterans Choice Program, authorize independent reviews of Department of Veterans Affairs (VA) medical facilities and expand access to VA health care. The VFW supports sections 3, 4, 5 and 6. The VFW has concerns with section 2.

While the Veterans Choice Program has made significant progress since it was implemented in November 2014, it has yet to achieve what Congress envisioned when it passed the Veterans Access, Choice, and Accountability Act of 2014. The purpose for this landmark program was to address the national access crisis that has plagued the VA health care system, where veterans wait too long or travel too far for the care they need. The VFW has made a concerted effort to ensure the program works as intended by evaluating what aspects of the program are working and identifying common sense solutions to aspects that are not working as intended. We have done this because we agree that VA must leverage its community care partners in order to fulfil its obligation to our Nation's veterans. However, we firmly believe that community care must complement, not supplant or compete with the high quality, comprehensive and veteran-centric care veterans receive from their health care system.

Section 1 would make any veteran enrolled in VA health care eligible for the Veterans Choice Program. The VFW is seriously concerned that such a significant expansion of eligibility would result in veterans receiving disparate and uncoordinated care. Medical research has determined that integrated and managed health care systems provide better health care outcomes than fee for service systems. That is why the majority of high performing health care systems, including VA, have implemented the patient-centered medical home model of delivering health care, which ensures patients receive the care they need when they need it.

Additionally, the VFW has continued to receive complaints from veterans who face delays receiving care through the Veterans Choice Program and continue to receive erroneous bills for care that VA is required to provide. The VFW believes the current program must be fixed before considering whether to dramatically expand eligibility. The VFW urges the Committee to amend this legislation by ensuring veterans who are unable to receive a VA appointment by a clinically indicated date, or within a distance an enrolled veteran and such veteran's health care provider agree is reasonable, are offered community care options.

The VFW supports Section 3, which would require VA to provide veterans access to private sector urgent care clinics across the country. Urgent care is designed to meet the gap between emergency room care and ambulatory care. Urgent care has also been proven to reduce reliance on more costly emergency room care for non-life threatening care and alleviate demand on primary care providers. The VFW is also glad to see this section would waive copayment requirements for veterans who seek care through community urgent care clinics. This would ensure veterans are not financially impacted for receiving the urgent care they need. However, the VFW urges the Committee to ensure VA has the resources and authority it needs to expand urgent care capacity at VA medical facilities.

The VFW strongly supports section 4, which would authorize certain providers to practice telemedicine across state lines. This provision would go a long way toward helping veterans who do not live in the same state as the facility in which they are enrolled and for veterans who require home-based health care services.

With geographic distance remaining a significant barrier to care for veterans, the use of telemedicine technology has emerged as a highly effective method of providing veterans timely and convenient care. Current law, however, restricts VA health professionals from practicing telemedicine across state lines unless both the provider and the veteran are located in federally owned facilities. Consequently, veterans are required to travel significant distances to Federal facilities just to access telehealth services. By allowing VA health care professionals to practice telemedicine across state borders, a veteran's physical location would no longer be a limiting factor in his or her ability to receive telehealth services.

Section 5 would extend operating hours for VA pharmacies and authorize VA to contract health care providers, including locum tenens to operate clinics on nights and weekends. The VFW fully supports extending operating hours for VA medical facilities. Veterans have continuously asked for VA medical facilities to increase operating hours. Doing so would ensure veterans who work during the day are not required to forgo wages to receive the health care they need. However, the VFW urges the Committee to amend this legislation to enable VA to use its health care providers during extended hours as well by removing the 80-hour biweekly restriction on VA employees. This would ensure veterans who receive care during extended hours can continue to receive their care from the VA medical professionals they know and trust.

S. 2888, JANEY ENSMINGER ACT OF 2016

This legislation would require the Agency for Toxic Substances and Disease Registry (ATSDR) to conduct periodic literature reviews of the existing research regarding the relationship between exposure to toxic water at Camp Lejeune and adverse health conditions. The VFW supports the intent of this legislation, but has a serious concern with the threshold it sets for medical research, which we hope the Committee will address before advancing this legislation.

The approximately 650,000 veterans and family members who served on Camp Lejeune between 1953 and 1987 deserve to know if their health care conditions are related to water they drank that was contaminated with trichloroethylene, tetrachloroethylene, vinyl chloride, and other toxins. That is why the VFW fully supports periodic literature reviews of the existing body of research on the relationship between contaminated water at Camp Lejeune and the health conditions prevalent among veterans and family members exposed to such toxic substances.

However, this legislation would require the ATSDR to evaluate whether a health condition is caused by exposure to contaminated Camp Lejeune water, which is an unreasonably high bar for determining a relationship between adverse health conditions and toxic exposure. This legislation would require the ATSDR to categorize related health care conditions into three categories: sufficient with reasonable confidence that the exposure is a cause of the illness or condition; modest supporting causation; or no more than limited supporting causation. This would mean that the majority of the health conditions the ATSDR considers to be associated with exposure to trichloroethylene, tetrachloroethylene, vinyl chloride in drinking water would fail to meet this threshold.

Research regarding toxic exposures has traditionally used the Institute of Medicine's (IOM) six categories of associations: sufficient evidence of a causal relationship; sufficient evidence of an association; limited/suggestive evidence of an association; insufficient evidence to determine whether an association exists; inadequate/insufficient evidence; and limited/suggestive evidence of no association. These six categories are aligned with the nature of epidemiological research and can be used to guide future research. The VFW strongly urges the Committee to reduce the threshold from causation to IOM's six categories of association.

S. 2883, APPROPRIATE CARE FOR DISABLED VETERANS ACT OF 2016

The VFW supports this legislation, which would reinstate the requirement for VA to provide an annual report to Congress that details its capacity in selected specialized health care services.

This capacity report would provide information on utilization rates, staffing, and facility bed censuses needed to ensure more accountability within VA and would help ensure VA is a good steward to finite taxpayer resources. The VFW believes this report would improve staffing levels at local VA medical facilities and overall access to VA's specialized systems of care.

S. 2679, HELPING VETERANS EXPOSED TO BURN PITS ACT

This legislation would create a center of excellence for veterans exposed to burn pits and other toxic substances. The VFW supports the intent of this legislation and has recommendations to improve it.

The use of open air burn pits in combat zones has caused invisible, but grave health complications for many servicemembers, past and present. Particulate matter, polycyclic aromatic hydrocarbons, volatile organic compounds and dioxins—the destructive compound found in Agent Orange—and other harmful materials are all present in burn pits, creating clouds of hazardous chemical compounds that are unavoidable to those in close proximity.

Unfortunately, the impact of exposure to such toxic substances on our Iraq and Afghanistan veterans is still not widely known or understood. What is clear, however, is that veterans exposed to burn pits continue to report debilitating pulmonary conditions which significantly affect their quality of life. That is why the VFW supports continued research on the impact of exposure to such burn pits on the health of Iraq and Afghanistan veterans. Furthermore, VA must ensure all its health care providers are aware of the symptoms experienced by exposed veterans and ensure these veterans receive appropriate medical treatments.

However, the VFW believes it would be more beneficial for veterans if the Committee were to expand VA's War Related Illness and Injury Study Centers (WRIISC) rather than establish a new center of excellence. The WRIISCs have been instrumental in conducting research on the health effects associated with exposure to burn pits, developing educational material for VA and community care providers, providing comprehensive exams for exposed veterans and providing high quality treatment specifically tailored to their needs. The VFW urges the Committee to increase funding for the WRIISCs and require VA to establish more centers throughout the country.

S. 2520, NEWBORN CARE IMPROVEMENT ACT

The VFW supports this legislation, which would expand VA's authority to provide health care to a newborn child, whose delivery is furnished by VA, from seven to 14 days post-birth.

According to the Centers for Disease Control and Prevention, newborn screenings are vital to diagnosing and preventing certain health conditions that can affect a child's livelihood and long-term health. The VFW understands the importance of high quality newborn health care and its long term impact on the lives of veterans and their families. VA must ensure newborn children receive the proper post-natal health care they need.

S. 2487, FEMALE VETERAN SUICIDE PREVENTION ACT

The VFW supports this legislation to improve VA mental health care and suicide prevention programs offered to women veterans.

As the population of female veterans continues to increase, it is important for VA and Congress to expand the availability of women-specific care at VA medical facilities. In a survey of 1,922 women veterans conducted by the VFW, 40 percent of respondents said they are either currently using mental health care services or they

have in the past. This indicates that female veterans are high users of VA mental health care services.

With medical research consistently pointing to gender differences in effective treatment of mental health and prevention of suicide, it is vital for VA to ensure it provides the high quality and gender-specific care our female veterans deserve. Given the increase in the number of suicides across the country, the VFW strongly believes this legislation would help prevent female veteran suicide.

S. 2049, A BILL TO ESTABLISH IN THE DEPARTMENT OF VETERANS AFFAIRS A CONTINUING MEDICAL EDUCATION PROGRAM FOR NON-DEPARTMENT MEDICAL PROFESSIONALS WHO TREAT VETERANS AND FAMILY MEMBERS OF VETERANS TO INCREASE KNOWLEDGE AND RECOGNITION OF MEDICAL CONDITIONS COMMON TO VETERANS AND FAMILY MEMBERS OF VETERANS.

The VFW supports this legislation, which would ensure community care providers who care for veterans and their families understand how to provide veteran-centric care. As the largest integrated health care system in the country and a worldwide leader in medical research, VA plays a significant role in training health care professionals. In fact, more than two thirds of all doctors in the country have received training in the VA health care system. This bill would rightfully ensure VA is able to train our current and future health care workforce.

Discussion draft to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs.

On January 22, 2015, the VFW testified before the Subcommittee on Disability Assistance and Memorial Affairs on the subject of the ever-growing appeals backlog [1]. We explored at length and in detail the reasons why the appeals backlog is the size it is today. We discussed the decades-long failure to request and receive appropriate levels of full time equivalent to deal with appeals. We pointed to deliberate choices made to ignore the growing problem by the Veterans Benefit Administration (VBA) managers at the local level as well as leaders in the Department of Veterans Affairs (VA) Central Office. Finally, we highlighted the fact that VBA leaders, with full knowledge of the consequences of their choices, decided to process disability claims, not for days, weeks or months, but for years, allowing appeals to wait.

Today, there are more than 450,000 appeals awaiting the years-long process to a final decision by the Board of Veterans' Appeals (BVA). Much of this backlog is due to the fact that eliminating the disability claims backlog was the focus of both VA and Congress. By focusing on disability claims, VA stopped relatively simple appeals tasks. If VBA directed some resources to the Notice of Disagreement (NOD) certification process, nearly half of all appeals would be removed. How? History shows that once an NOD is filed, only half of all veterans continue their appeals after they receive their Statement of the Case (SOC).

Now VA, feeling the pressure of another growing backlog, has begun describing the current appeals process as too complicated and confusing to veterans in a bid to get Congress to create a new process it describes with the adjectives "simple" and "fast." What is being overlooked is that, despite the fact that the current appeals process is long, it works in providing veterans relief. Under the current system, BVA granted benefits to veterans in 29.2 percent of the cases it finally decided. With such a high appeals grant rate, the VFW insists any reforms to the process must protect the rights veterans enjoy in the current appeals process. Simple and fast is not better for veterans if it means veterans lose rights and VA rushes to deny appeals.

Let us be clear, we are not advocates of the status quo. We are not the old guard standing in the way of improvements to a process that does not serve veterans in a timely manner. However, we are advocates for veterans, and we will not support any change simply for the sake of change, nor changes that make the process easier for VA at the expense of veterans.

In short, we will not support a new appeals process which reduces the rights and protections found in existing law and regulations.

At the request of Secretary McDonald, the VFW has actively participated in a series of meetings with other Veteran Service Organization (VSO) representatives and officials of VA in an attempt to identify opportunities for improvement to the current appeals process. However, participation does not imply consent or approval of

[1] VFW testimony before the Veterans Affairs Subcommittee on Disability Assistance and Memorial Affairs, January 22, 2015, http://www.vfw.org/VFW-in-DC/Congressional-Testimony/Veterans%E2%80%99-Dilemma---Navigating-the-Appeals-System-for-Veterans-Claims/

the any new process. We have worked with others to craft an alternative process which might provide speedier decisions without reducing rights and protections currently enjoyed by veterans.

The proposal outlined in the legislation under consideration today is, even if approved with the amendments we suggest, only one third of the solution. There are two elements missing from this proposal:

- A comprehensive plan by VA to competently and efficiently address the current backlog of pending appeals; and,
- An allocation of sufficient resources by Congress to allow VA to execute its plan.

The VFW will not endorse any change in the current appeals process until all three elements are in place.

CONCERN WITH THE PROPOSAL

While the VA's proposal is the combined work of a dozen VSO's and VA spanning hundreds of man hours of labor, much of it simply shifts work from an appeals lane, leaving it in a new center lane, labeling it a claim and not an appeal.

The proposal envisions several changes to current claims and appeals processing. Under the current claims process, a veteran submits a claim to a VA regional office. The claim goes through a stage of development and preparation for a decision. VA eventually decides the claim and notifies the claimant.

Under the current process, the claimant has the following options:

- Do nothing
- Submit new evidence within a year of the decision and ask for reconsideration
- Appeal

Under this proposal, the claimant has the following choices:

- Do nothing
- Submit new evidence (or new and relevant evidence) and receive a new decision
- Ask for a Difference of Opinion review and receive a new decision
- Appeal

As you can see, the proposed change to the appeals process shifts all of the regional office appeals processing, including the Decision Review Office (DRO) review, out of the current appeals lane and simply leaves it as another option available at the regional office,[2] never calling it an appeal.

All appeals functions currently within the purview of the regional office are taken out of the appeals process and are renamed. With only a few exceptions, this process is not fundamentally different from the current process. The only possible advantage to the claimant is that these issues no longer linger in the shadows of the appeals process and must be worked as a claim by VBA.

Once this fundamental fact is recognized, it is easier to see what the new process is and what it might do for claims and appeals processing.

STAFFING

The other fundamental fact which must be acknowledged is that despite substantial increases in VA staffing over the past decade, VA remains unable to adequately process all its work.

Allow us to explain by way of an illustration:

We are all familiar with the state of the Armed Forces. During the Cold War, it was a basic tenant of force structure that our military was large enough to deal with two major enemies at the same time. After the Cold War ended, Congress began reducing the size of the Armed Forces. In 2012, then Defense Secretary Leon Panetta acknowledged that the United States could no longer fight two sustained ground wars simultaneously.[3] If Congress wanted the Armed Forces to have the ability to fight two ground wars at the same time it would have to approve additional personnel and equipment to do so.

So too it is with VA. VA has received funding to perform only some of the functions assigned to it. If Congress expects VA to fulfill all of its tasks in a timely manner, it must provide the personnel to do so. Without appropriate levels of staffing, VA will continue to fail and veterans will continue to wait for decisions on their claims.

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[2] Under VA's proposal, the Decision Review Officer (DRO) position is eliminated. In its place, VA proposes to designate VBA employees to conduct Difference of Opinion reviews as an adjunct duty. The VFW opposes eliminating the highly skilled and experienced cadre of DRO's. It is our belief that the elimination of DRO's will result in a diminution of grants using the Difference of Opinion review authority.

[3] http://www.thewire.com/global/2012/01/us-cant-fight-two-wars-same-time-anymore/46892/

Today, VA has sufficient personnel to process claims to completion in a reasonable time. It has sufficient staff to process appeals expeditiously. However, it does not have sufficient staff to do both functions simultaneously.

The resolution of this backlog requires Congress to adequately staff both VBA and BVA to process the work it has before it. Unfortunately, without a comprehensive plan from VA, Congress can only guess at the number of personnel required to maintain disability claims processing at current levels while processing and resolving the current appeals backlog.

VA must develop a comprehensive plan for maintaining its current claims workload while attacking the appeals backlog. This plan must include recommendations to Congress on what legislative changes are required and how many additional personnel are needed to eliminate the current appeals backlog in a reasonable period of time.

EXAMINING VA'S PROPOSAL

Different lanes

The proposed change to the claims and appeals process creates what VA refers to as three lanes:

1. Center (claims) lane (The starting point for all claims)

   Under this lane all claims are processed much as they are today. A claimant submits a claim. VA develops the claim to completion and refers it for decision. VBA makes a decision and notifies the claimant.

2. Difference of Opinion review lane

   Once a decision is made, a claimant may elect to receive a higher level review from VBA. Under VA's proposal, this is not done by a Decision Review Officer but by someone who is at least one grade higher than the previous decision-maker. VA apparently envisions this assignment as an adjunct duty and not a primary responsibility.

3. Appeals lane

   A claimant may elect to appeal once they receive a decision by VBA (either a center lane decision or a difference of opinion decision). Under this proposal, a claimant must then make a choice: submit no new evidence and receive an expedited decision (promised within 1 year of the appeal), or choose to submit new evidence and/or request a hearing. Under this scenario, a Veteran Law Judge will conduct a hearing at some undefined point in time and make a decision.

   If the veteran elects the expedited lane, the BVA would conduct a de novo review of the evidence in the record at the time VBA made its original decision. If a hearing is held or new evidence is submitted, the BVA will make a decision based on the evidence in the record at the time the VBA decision was made and whatever new evidence is submitted during the appeal.

   However, under this proposal remands are severely limited and are only allowed if it is determined that VBA did not fulfill its duty to assist a claimant as required by law prior to the VBA decision under appeal. What is not addressed is what action is required if evidence submitted during the appeal, either prior to the hearing or at a hearing, would trigger VA's duty to assist if it were submitted as a center lane claim. It appears that VA will not require the remand of the appeal for duty to assist development. This penalizes veterans who seek appellate review but later discover evidence. The only way they can obtain the assistance of VA is by withdrawing their appeal and submitting a supplemental claim in the center lane. This causes them to lose their place in the appeal process. Further, it may not even be a viable alternative since the one year period for submitting a supplemental claim may have lapsed while awaiting a hearing at the BVA.

   Once the BVA makes a decision, the claimant may appeal to the Court of Appeals for Veterans Claims (CAVC) or may submit additional evidence within 1 year to have the issue reconsidered by VBA.

The premise of these changes is to provide virtually unlimited opportunity for the claimant to prove his/her claim by going through the center or claims lane. The other premise is that VBA will be able to adjudicate, or readjudicate, these claims in an expeditious manner (there is vague talk of the 125 day standard).

The BVA becomes the winner in this process. With remands limited to duty to assist errors, remands should be significantly reduced. While this is helpful to the BVA and appeals processing, it becomes problematic for veterans who have their appeals remanded for other reasons today.

This proposal is designed to address the frustration of claimants by reducing the length of time it takes them to obtain a decision from VA. However, what they lose is the ability to submit evidence critical to the favorable resolution of their claims. Further, we are certain that the percent of claims granted by the BVA will fall because of these changes.

Concerns

A number of areas of concern are not adequately addressed in this proposal. Leaving many of these issues to VA to refine by regulation creates an opportunity to do mischief.

Duty to Assist

The duty to assist claimants is well established by both regulation and case law. If a claimant at any point in the process identifies new evidence which is not of record, VA is obligated to assist the claimant in obtaining it. While we all want to see all the evidence submitted at the start of a claim, we understand that is not always possible. Newly discovered service or medical records may point to other evidence which must be obtained. New medical evidence may point to the need for an additional examination.

We have two concerns about limiting the duty to assist at the BVA. First, it is unclear what, if any, action is required if a claimant submits new evidence during the appeal process, either in documentary form or during a hearing. It is likely that additional development may be required. However, this proposal does not address how that is to be accomplished. Should the BVA remand the appeal to the VBA for development? Should the appeal be dismissed so the evidence can be developed? Or will the BVA make a decision based on the evidence in front of it, assuming that if the appeal is denied the newly submitted evidence will revert to VBA for additional development and decision? This last alternative suggests a legal problem: if the BVA receives evidence which in the center lane would trigger the duty to assist, and if the BVA makes a decision on that evidence without ordering additional development, would the veteran be precluded from bringing the claim back to the center lane for development because the issue was decided on that evidence?

Second, we are concerned that with a limited duty to assist requirement at the BVA, appeals may not be remanded because the BVA decides that the failures are "harmless error" and would not affect the outcome of the appeal. While we agree that there is danger in overdeveloping a record, there is also truth in the old adage, "you don't know what you don't know."

Docket Flexibility

Currently the BVA is limited to only one docket. Under this proposal, BVA would have to maintain at least two dockets in order to have the flexibility to more efficiently work its cases. At the very least, the BVA would need a separate docket for the fast, no hearing/evidence lane so that those appeals are decided as rapidly as possible. In addition, BVA would need at least a second docket for those appeals requiring hearings. Finally, to achieve the greatest efficiencies, the BVA should have a separate docket for appeals wherein the claimant submitted additional evidence but did not request a hearing.

Therefore, we suggest a total of five dockets during transition. We believe the BVA needs the flexibility to use two dockets during the resolution of its current backlog: one docket for those wherein hearings are requested and a second docket for those appeals without hearings. It needs three additional dockets under this proposal: one docket for the fast appeals lane; one docket for the hearing lane and one docket where evidence is submitted but no hearing is requested.

Independent Medical Opinion/Independent Medical Expert

Under this proposal, VA would eliminate the ability of the BVA to ask for an Independent Medical Opinion (IMO). It argues that IMOs are available through the claims lane, so this authority is not necessary.

There are several reasons why the Independent Medical Opinion (IMO) authority should remain with the BVA. Under the current claims process, requesting and obtaining an IMO is difficult. While VA policy allows a veteran's representative to ask for an IMO, it must be approved by the regional office Veteran Service Center Manager (VSCM) before submission to the VA Compensation Service. Then it must be approved by the Compensation Service before the opinion is requested. This cumbersome procedure requires the approval of two individuals who may, or may not, have sufficient training and experience to understand the need for the IMO.

The BVA currently orders about 100 IMO's per year. A veteran's representative need only convince a Veterans Law Judge (VLJ) that an opinion is necessary. VLJ's

have the training and experience necessary to make these decisions——training and experience which may be lacking in VSCM's and Compensation Service personnel.

New Evidence

Under current law, a claimant must submit new and material evidence in order to reopen a claim after a final disallowance. We have long believed that this creates an unnecessary burden on both VA and veterans. In practical terms, VA is required to make a decision as to whether evidence is both new and material. A VLJ recently estimated that between 10–20 percent of the appeals he reviews each year are on the issue of whether evidence is new and material.

It is our belief that eliminating the new and material standard would reduce non-substantive appeals by allowing regional office staff to make a merits decision on the evidence of record. With merits decisions, veterans have a better understanding of why the evidence they submitted was not adequate, and any appeal is on the substance of the decision, not on whether the evidence was new or material.

During our discussions with VA on an improved appeals process, we have argued that while a new and relevant evidence standard is potentially lower than the current new and material evidence requirement, it still imposes a bar to merits decisions, creating unnecessary work for regional office staff and unnecessary appeals to the BVA.

The VFW proposes that the only requirement to obtain reconsideration of a claim should be the submission of new evidence.

Higher Level Review

Under 38 CFR 3.2600, claimants may elect a review by a Decision Review Officer. This individual has the authority to conduct a de novo review of the evidence, order additional development as needed, and make a decision. No deference is given to the prior decision.

Under this proposal, a difference of opinion review is provided. The reviewer need not be a DRO but can be anyone of a higher grade detailed to make the review. It is likely that this reviewer will not receive separate training and will have this assignment as an adjunct duty.

The VFW believes that while retention of a difference of opinion review is potentially beneficial to claimants, this change in authority will ensure that less well qualified individuals will conduct these reviews, decreasing quality and increasing the number of claimants denied.

Further, VA intends to make these reviews based solely on the evidence of record and preclude the authority to order additional development except for duty to assist errors. This presents the same problems for a claimant at a difference of opinion review as it does for evidence submitted at a BVA hearing described above. Any evidence submitted during a difference of opinion hearing would not be subject to the duty to assist. Once a decision is made, how might a claimant receive assistance by VA as required by the current duty to assist provisions of the law? This problem is not resolved by the language of this proposal. The VFW believes that the difference of opinion reviewers should be able to remand a claim for additional development based on evidence received during the difference of opinion review.

Claims in Different Lanes at the Same Time

One of the unresolved issues is whether claimants may have the same issue in more than one lane simultaneously. Under the proposed appeals process, it appears that the following scenario is not possible:

A veteran files an appeal in the BVA fast lane (no evidence, no hearing). Several months later, and before the BVA issues a decision, the veteran obtains new evidence which is pertinent to the claim. Since the veteran is precluded from submitting it to the BVA, he/she must submit it to the claims lane for consideration and adjudication. Depending on the nature of the evidence and the relative efficiency of the regional office staff, it is possible that the veteran could receive a favorable decision at the regional office prior to the issuance of the BVA decision.

It is for this reason that we urge Congress to address the permissibility of submitting evidence during the pendency of an appeal and to which entity it should be submitted. The VFW suggests that if the BVA cannot order a remand to properly develop evidence submitted during an appeal, than claimants should have the right to submit that evidence to the center lane while an appeal pends at the BVA.

REPORTS

The only way to know whether a process is working is by collecting and studying the data generated by it. Noticeably absent from the proposed legislation is any requirement that VA collect data, analyze it and report to Congress and the public.

At a minimum, Congress and the veteran community might want to know the following on a regular recurring basis:

- Current backlog
  - The total number of appeals pending
  - The subtotals of pending appeals at each stage of processing
  - The average days pending at each processing stage
  - What actions were taken during the reporting period to process and resolve pending appeals in each processing stage
  - The oldest pending appeals at each stage and what action VA has taken to process them.
- Similar questions could be asked of VA concerning the new claims and appeal process
  - How many claims are pending in each lane
  - Average timeliness for processing claims and supplemental claims, by regional office
  - Average timeliness for processing claims in the difference of opinion lane, by regional office
  - Average days pending of appeals in the fast lane at the BVA
  - Average days pending of appeals in the hearing lane at the BVA
  - Average days pending of appeals in the evidence only lane at the BVA
  - Total number of IMO requests made by the BVA
  - Total number of IMO requests approved by the Compensation Service
- And, of course,
  - Appeals granted, remanded and denied under the current appeals process
  - Appeals granted, remanded and denied under the proposed appeals process.

PLAN TO REDUCE CURRENT BACKLOG

VA must have a plan in place to process to completion the 440,000 pending appeals. It must be part of the proposed legislation for two reasons:

VA will need additional latitude to process its current backlog of appeals. Changes to claims and appeals processing which VA may wish to consider include:

a. Allow the BVA greater flexibility in managing its workload. Specifically, the BVA should be able to maintain a second docket to allow faster processing of non-hearing appeals.

b. There are many cases pending BVA review which have additional evidence submitted while the issue was on appeal but not considered by VBA. In order to facilitate efficiencies, VA should be allowed to screen and assign those appeals to regional office staff for the purpose of determining whether the benefit may be granted. We suggest that with the greater number of Rating Veterans Service Representatives available to review those appeals, many could be granted without further appellate review. In the case where a full grant of benefits is not possible, the case can be returned to the BVA for further consideration without loss of place in the docket.

c. In the alternative, VA could create a cadre of DRO's who are tasked with pre-screening and deciding cases on appeal. They would have the authority to grant any benefit allowed under the law. They could also identify deficiencies in the record and order a remand. This alternative would free up VLJ's and their staff attorneys to more efficiently process other appeals pending before the BVA.

COURT OF APPEALS FOR VETERANS CLAIMS

Veterans could be adversely effected by these changes because they will be discouraged from seeking review by the Court of Appeals for Veterans Claims (CAVC). As this proposal is currently written, the only finality to the process occurs when one of three things happens:

1. The veteran becomes satisfied with a decision and stops seeking additional benefits;
2. The veteran fails to submit new (or new and relevant) evidence within the one year period following a VA decision; or
3. The veteran seeks review by the CAVC and is denied.

Under this proposal, the only possible time a veteran might seek review by the CAVC of a decision is when he/she has completely exhausted every possible piece of new evidence and has absolutely nothing left to submit to VA. One could argue that this is good for veterans and the BVA since it ensures that only those claim-

ants who have no more evidence to submit go to the CAVC. Fewer appeals mean fewer remands.

It also means fewer precedent decisions instructing VA that their practices do not conform to regulations and their regulations do not conform to the law. The CAVC has provided a significant and useful function throughout its nearly 30 years of existence——it has told VA when it was doing things wrong.

This bill is intended to create a new claims and appeals process. VA must write regulations which fill in the gaps and provide additional guidance to both VA employees and veterans. Without judicial review, there exists no entity which can review VA's actions and determine whether they follow the law.

This proposal is designed to significantly reduce the impact of the CAVC on claims processing with VA by discouraging veterans from appealing to the Court. To ensure that veterans are not discouraged from appealing to the CAVC, we urge Congress to amend this proposal to allow claimants to submit new evidence within one year of a CAVC decision.

RECOMMENDATIONS:

Our recommendations for amending this proposal are summarized below:

1. Require VA to devise a detailed and comprehensive plan for processing its current work while also processing its current appeals workload. This plan should include an estimate of total staffing required and a projected completion date based on receipt of that additional staff.
2. Congress should provide the additional staffing as required. Failure to do so will ensure that appeals will continue to increase.
3. Congress should provide BVA with the flexibility to establish an additional docket to process its current workload.
4. Once a new claims and appeal process becomes effective, provide the BVA with the flexibility to establish up to three additional dockets to handle appeals.
5. Congress should allow VA twelve months or longer to publish and finalize regulations necessary to implement this proposal. If this proposal is passed in 2016, we suggest that the effective date of the changes be January 1, 2018.
6. Congress must resolve the issues surrounding the duty to assist. We believe that those conducting the difference of opinion review and the BVA should be required to remand to the center lane for additional development any evidence submitted during the difference of opinion or appeal process which triggers the duty to assist.
7. If Congress limits the duty to assist as shown in the current version of this bill, it should allow the submission of new evidence in the center claims lane while cases are pending in either the difference of opinion or appeals lane.
8. Congress should retain the BVA's current authority to request Independent Medical Expert Opinions under 38 U.S.C. 7109.
9. The DRO position should be retained.
10. Congress should eliminate the new and material evidence requirement found in 38 U.S.C. 5108 and require only new evidence in order to reopen a claim.
11. Evidence required to file a supplemental claim should be new evidence and not new and relevant evidence.
12. Congress should require VA to provide the reports outlined earlier in this testimony and any other reports it deems appropriate.
13. Considering the critical role of the CAVC in the oversight of VA's rules making and claims processing, we encourage Congress to provide claimants with the opportunity to submit new evidence within one year of a CAVC decision.

DISCUSSION DRAFT REGARDING VETERANS AFFAIRS CONSTRUCTION REFORM

This draft legislation provides four provisions to improve the construction process and provide greater transparency related to costs and funding. While the VFW continues to call on Congress to provide VA greater authority to enter into public-private partnerships, sharing agreements and leases, VA will continue to need to build medical facilities.

The VFW fully supports the provision that mandates a forensic audit on any medical facility project that is projected to cost more than 25 percent of the appropriated amount. These audits will shine a light on what causes cost overruns, and provide both VA and Congress the information they need to correct inefficient construction practices.

Currently, the Secretary must report to Congress where bid savings come from and where they are going to be used. However, the Secretary is not compelled to report in detail the amounts that have already been obligated, how much of the

project has already been completed and how bid savings has already been provided to that project. This provision will provide Congress with a clearer picture of construction projects that are susceptible to cost overruns. The VFW fully supports this provision.

The legislation also calls for quarterly reports on the budgetary and scheduling status of each project, as well as a comparison between the planned and actual costs and scheduling status. This provision will provide Congress updates throughout the project life cycle, allowing it to detect cost overruns and construction delays early so corrective actions can be taken. The VFW fully supports this provision.

Last, this legislation calls on VA to use industry standards when constructing medical facilities. While the VFW agrees that VA should adopt private sector best practices, there are no clear industry standards to follow. That is why the VFW suggests codifying and putting in regulation many of the best practices, some of which VA has recently adopted, that will build in efficiencies and reduce cost overruns and building scheduling delays. The VFW believes that VA must always include a medical equipment planner as part of the architectural and engineering team; improve communications through a project management plan; subject all projects plans to peer review; develop change-order processes that increase the timeliness of the changes; and when practical, use a design-build process to reduce the number of change orders.

DRAFT BILL TO EXPAND ELIGIBILITY AND MEDICAL SERVICES UNDER SECTION 101 OF THE VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014.

This legislation would expand eligibility for the Veterans Choice Program to include veterans who have received care through the Project Access Receive Closer to Home (ARCH). The VFW supports this legislation and has a recommendation to improve it.

Project ARCH has been a very successful community care program that ensures veterans are not required to travel too far for the care they need. Veterans who receive care through Project ARCH inform the VFW that they want to continue to see their doctors. Given that Project ARCH is set to expire soon, the VFW has urged VA to ensure Project ARCH veterans are able to continue to receive the care they need without having to transfer to new providers or have their process for receiving such care changed. This legislation would rightfully expand community care eligibly to these veterans to ensure that occurs.

However, this legislation would make any veteran who has used Project ARCH eligible for the Veterans Choice Program, even if such veteran is no longer eligible for Project ARCH. That is why the VFW urges the Committee to amend this legislation to expand eligibility only to veterans who would otherwise continue to be eligible for Project ARCH.

STATE OUTREACH FOR LOCAL VETERANS EMPLOYMENT (SOLVE) ACT OF 2016

The VFW supports this legislation, which would provide states with greater flexibility in how they use funds provided under the Jobs for Veterans State Grants (JVSG) provided by the Department of Labor's Veterans Employment and Training Services (DOL-VETS).

This bill would prohibit DOL-VETS from rejecting a state's JVSG proposal based solely on which state agency would execute the plan. It would further prohibit DOL-VETS from rejecting a state's plan in its entirety because a portion of the plan is unacceptable, without providing an explanation of why that portion was not approved. The VFW does not believe that DOL-VETS does either of these things now, so these provisions would simply codify current practice. We note that DOL-VETS would maintain full authority to reject all or part of a state's plan based upon its merits, and believe states should continue to be held to a high standard to ensure JVSG funds are being administered in a way that maximizes employment outcomes for veterans.

This bill would also allow states to identify additional significant barriers to employment (SBE) that would make veterans eligible for intensive services from Disabled Veterans Outreach Program (DVOP) specialists. Currently, only veterans with compensable disabilities are defined as having SBE. Under this legislation, states may include other veterans as SBE, such as homeless veterans, or those experiencing long term unemployment. While the VFW believes that DVOPs should provide services to disabled veterans first, they may have the ability to assist others as well. We believe states should be encouraged to develop innovative solutions to meet the unique needs of their unemployed and underemployed veterans.

DISCUSSION DRAFT OF VA'S PROPOSAL TO MODIFY REQUIREMENTS UNDER WHICH THE DEPARTMENT IS REQUIRED TO PROVIDE COMPENSATION AND PENSION EXAMINATIONS TO VETERANS SEEKING DISABILITY BENEFITS.

The VFW opposes this legislation, which would relieve VA of its obligation to order medical exams for certain veterans who file claims for disability compensation by requiring "objective evidence" that the disability was incurred or aggravated in service; became manifest during a presumptive period; or the event in service was capable of causing the injury. The language of the bill leaves it up to VA to define "objective evidence" by regulation. This would raise the standard for duty to assist, which currently states that VA "will provide" an examination or opinion if necessary to decide the claim.

If this bill were to become law, it would have an indisputably negative impact on certain veterans. One category would be veterans who have disabilities that cannot be observed by others, such as fatigue, pain, or tinnitus. Another would be those whose service records may have been destroyed, damaged, or missing, including in the 1973 fire at the National Personnel Records Center.

To take one example, if a veteran's service records were not available, and attempts to locate them were unsuccessful, VA could just deny the claim. In certain circumstances, just receiving an exam will enable the veteran to show that the type of injury claimed would have onset during military service, given the severity and length of time between the injury and the exam.

Additionally, the word "objective" is not defined. It is unclear whether certified buddy statements, affidavits, and credible lay testimony would be considered "objective evidence" if the veteran did not fall into one of the "presumptions" where VA allows this evidence to be considered. VA currently accepts credible lay testimony from veterans in certain cases to prove an in-service event, even if it is a circumstance not controlled by 38 U.S.C. 501(a). Given these concerns, the VFW must oppose this bill.

DISCUSSION DRAFT, VETERANS MOBILITY SAFETY ACT OF 2016

The VFW supports this legislation, which would establish minimum safety standards for the Automobile Adaptive Equipment Program.

The Automobile Adaptive Equipment Program was established to enable severely disabled veterans to drive without the assistance of others by making modifications to their exiting vehicles or purchasing a new vehicle with the specific accommodations they need. Because the VA automobile grant is a one-time benefit, it is important that modifications made to vehicles are safe and function properly the first time.

Currently, VA prosthetic representatives are required to assist veterans in locating an approved vendor and inspecting the workmanship of vehicle modification. VA encourages veterans to verify that a vendor is registered with the National Highway Traffic Safety Administration (NHTSA), who is responsible for developing motor vehicle safety standards. However, NHTSA does not conduct thorough compliance evaluations to ensure registered adaptive equipment installers comply with the established standards. The VFW supports establishing a comprehensive policy regarding quality standards for providers. However, VA must also ensure that requiring certification of providers does not delay a veteran's ability to have his or her vehicle modified.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Committee Members may have.

Chairman ISAKSON. Thank you very much.

Lou Celli of The American Legion. Welcome back, Lou.

STATEMENT OF LOUIS J. CELLI, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. CELLI. Thank you very much.

Additional medical training for non-VA providers, VA coverage for newborns and their mothers, suicide prevention measures for our women veterans, ensuring veterans are properly treated and compensated for adverse exposure to burn pits, ensuring we understand VA's capacity to treat our severely injured veterans, construction management assistance, addressing the poisoning of our

Camp Lejeune military community, and while we are at it, we should probably address Fort McClellan, too, ensuring States are able to make the best possible use of the Federal funding they receive to help veterans reintegrate and find gainful employment, and finally, appeals modernization. All great legislative initiatives.

Chairman Isakson, Ranking Member Blumenthal, and Members of this Committee, on behalf of National Commander Dale Barnett and the over two million members that make up The American Legion, we welcome this opportunity to comment on bills that discuss these important issues as well as the future of VA health care.

The American Legion is proud to have worked on a number of these important issues with this Committee and would like to thank the Committee and your dedicated professional staff for all the work they did on the SOLVE Act. And while our position on all of these bills can be found in our submitted written testimony, I would like to spend the balance of my time today to talk about two measures before this Committee, appeals modernization and access to non-VA health care.

Dollar for dollar, VA provides the most access and best health care in the United States when care is provided onsite at a VA campus. They consistently score several points above their civilian counterparts in satisfaction surveys and have won awards from J.D. Power and Associates year after year.

When The American Legion worked with this Committee several years back to draft the legislation that would ultimately become the Choice Act, we did so as an emergency measure to ensure that veterans hidden away on secret wait lists were immediately provided the care that they had earned. We stated at the time and state here again today that we never supported Choice becoming a permanent program. The reason is because we know that VA already has every authority granted to it without Choice when it comes to providing contracted care to our Nation's veterans.

Current community contract authority, Project ARCH, and other contracting vehicles already in statute allow VA to send a veteran into the local community whether the veteran lives across the street from the nearest VA facility or is 20, 40, or even a hundred miles away. Further, once VA has established a provider relationship with area offices, agreements are put in place to ensure that VA gets the medical records back from these doctors and clinics so that they can incorporate them into the veteran's history.

This is an issue that The American Legion was very concerned about and the reason that the provision was in the original Act to require Choice contracted doctors to turn over the medical records before getting paid. But we all know how that worked out and we were back here a couple of months ago to repeal that provision because doctors simply refused to send the medical records to VA, resulting in VA being accused of slow paying and causing doctors to wrongly bill veterans and ultimately refusing to see any more VA patients until they got paid. Since it was more important to ensure veterans had the access to health care that they needed, and in an attempt to protect their credit, we all acquiesced and agreed to let the doctors get paid whether they have turned the records over or not.

This is not the system we support. Best as we can tell, the only positive thing to come out of Choice was the emergency funding that came with it.

The other major reform bills we are here to talk about today is the Appeals Modernization Act. VA came to Congress and said, we have a problem. The appeals process needs to be updated so that veterans will be served better. Congress said to VA, go make it so. VA gathered all of the stakeholders who work with veterans and do this work every day and said, how do we redesign the mouse trap?

So, for the past several months, VA, The American Legion, my colleagues here at this witness table today, and several of our partner stakeholders worked together to produce a process that preserves the rights of veterans, gives claimants more options, helps VA organize and track appeals more effectively, and improves the quality of the decisions and notifications that claimants receive. This new proposed process requires Congressional approval and will ultimately save money. We have done our part and now it is your turn.

I thank you and I look forward to any questions that this Committee may have.

[The prepared statement of Mr. Celli follows:]

PREPARED STATEMENT OF LOUIS J. CELLI, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify regarding The American Legion's position on the pending and draft legislation.

S. 2049:

To establish in the Department of Veterans Affairs a continuing medical education program for non-Department medical professionals who treat veterans and family members of veterans to increase knowledge and recognition of medical conditions common to veterans and family members of veterans, and for other purposes.

S. 2049, would require the Secretary to establish in the Department of Veterans Affairs (VA) a Continuing Medical Education (CME) program for non-Department medical professionals who treat veterans and family members of veterans to increase knowledge and recognition of medical conditions common to veterans and family members of veterans, and for other purposes. This bill also will ensure effective treatment for veterans who seek their health care outside the VA health care system.

This bill defines the term "non-Department medical professional" to mean any of the following individuals, a doctor; a nurse; a physician assistant; a psychologist; a psychiatrist; or such other individuals as the Secretary considers appropriate. They must be licensed by an appropriate medical authority in the United States and in good standing and is not an employee of the Department of Veterans Affairs that provides care to veterans or family members of veterans under the laws administered by the Secretary of Veterans Affairs.

This bill would provide education training for Non-VA medical professionals by giving them specialized training and resources to better serve veterans and their families. The program would also enhance Non-VA medical professional's knowledge of the medical, mental and physical conditions veterans experience based on their military service, which can represent a unique spectrum when compared to non-veterans.

The American Legion urges Congress and VA to enact legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to

quality VA health care; timely decisions on claims and receipt of earned benefits; and final resting places in national shrines and with lasting tributes that commemorates their service.[1]

The American Legion supports S. 2049.

S. 2520: NEWBORN CARE IMPROVEMENT ACT

To improve the care provided by the Secretary of Veterans Affairs to newborn children

Currently, VA covers newborn care for the first seven days after birth in a non-department facility for eligible women veterans who are receiving VA maternity care. Newborn care includes routine post-delivery care and all other medically necessary services according to generally accepted standards of medical practice. VA does not provide child delivery care in VA health care facilities, but rather refers women veterans outside the VA through contracted care. Under current law, VA only provides care for the first 7 days after birth, even if birth complications require continued care beyond that period.[2] Beyond 7 days, the cost of care is the responsibility of the veteran and not VA. If this bill is enacted into law, it would extend the timeframe VA would be responsible to 14 days.

In 2011, The American Legion conducted a Women Veterans Survey with 3,012 women veterans in order to better understand their healthcare needs through VA. The survey found while there were improvements in the delivery of VA healthcare to women veterans, challenges still existed, including access to appropriate care at VA facilities.

In 2012–2013, The American Legion's System Worth Saving Task Force report focused on women veterans' health care. The objectives of the report were to:

- Understand what perceptions and barriers prevent women veterans from enrolling in VA,
- Determine what quality-of-care challenges women veterans face with their VA health care, and to
- Provide recommendations and steps VA can take to improve these access barriers and quality-of-care challenges.

While maternity and newborn care is primarily purchased outside VA, the Task Force found several medical centers had challenges finding hospitals in the area that would accept fee-basis for maternity care services due to VA's required use of the Medicare reimbursement rate. At other medical centers, fee-basis expenditures on women veterans' gender-specific services were not even available. There must be better information on what is needed if VA is to improve services.

The American Legion recommends that the Business Office managers be required to track women veterans' gender-specific fee-basis expenditures.[3] Furthermore, these expenditures should be rolled up by VA Central Office (VACO) and disseminated to stakeholders and for future needs within VA. All stakeholders must be able to assess weak spots in order to improve services.

Currently, there is at least anecdotal evidence of problems meeting the full spectrum of neonatal care. If women veterans are to receive care during and following their pregnancies, it needs to be a full spectrum of care, and they should not be short changed in terms of necessary services.

With this legislation, the amount of care female veterans can receive post-pregnancy would be improved and this is a needed fix.

The American Legion is committed to working with VA in order to ensure that the needs of the current and future women veterans' population are met and the VA should provide full comprehensive health services for women veterans department wide.[4]

The American Legion supports S. 2520.

S. 2487: FEMALE VETERAN SUICIDE PREVENTION ACT

To direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans as part of the evaluation of such programs by the Secretary

This bill would improve female veteran suicide prevention programs within VA by amending Title 38 of the United States Code to direct the Secretary of Veterans Af-

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[1] American Legion resolution No. 23 (May 2016): *Support for Veterans Quality of Life*
[2] VA Women's Health Care FAQ
[3] The American Legion System Worth Saving Report: *Women Veterans Health Care*–2013
[4] American Legion Resolution No. 45: (Oct 2012): *Women Veterans*

fairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans.

This bill also strives to improve suicide prevention programs for female veterans enrolled in the VA healthcare system. According to figures in a 2015 study, suicide rates among women veterans rose 40 percent during the decade from 2000–2010, compared to a more modest increase of 13 percent among the equivalent civilian cohort of women. [5] Women veterans are nearly 6 times more likely than civilian women to commit suicide. This legislation seeks to address this imbalance.

The American Legion continues to urge the President and Congress to expand and improve the care provided to veterans and servicemembers who have mental health issues or are at risk of suicide.[6] This legislation to help women veterans who struggle with suicide is critical, as is in all legislation designed to help veterans struggling with mental health issues and suicide, be they male or female.

The American Legion supports S. 2487.

S. 2679: HELPING VETERANS EXPOSED TO BURN PITS ACT

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to establish within the Department of Veterans Affairs a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of health conditions relating to exposure to burn pits.

Military personnel currently serving and those who have served in Iraq and Afghanistan have been exposed to a variety of potentially harmful and hazardous substances to include smoke from the burning waste on military installations. Items such as plastics, aerosols, electronic equipment, human waste, metal containers, tires, batteries are thrown into open pits doused with jet fuel and set ablaze resulting in hazardous smoke drifting into bases and living quarters. As a result, The American Legion has long been at the forefront of advocacy for veterans who have been exposed to environmental hazards as a result of their service to their country.

The Helping Veterans Exposed to Burn Pits Act would create a Department of Veterans Affairs (VA) center for excellence for the prevention, diagnosis, mitigation, treatment, and rehabilitation of veteran's health-related conditions that have been associated with burn pits and environmental exposures.

The American Legion supports legislation requiring VA to establish a national center for the research on the diagnosis and treatment of health conditions of the descendants of individuals exposed to toxic substances during service in the Armed Forces and establish an advisory board, responsible for advising the national center, determining health conditions that result from toxic exposure and to study and evaluate cases of exposure.[7]

The American Legion supports S. 2679.

S. 2883: APPROPRIATE CARE FOR DISABLED VETERANS ACT OF 2016

To amend title 38, United States Code, to extend the requirement of the Secretary of Veterans Affairs to submit a report on the capacity of the Department of Veterans Affairs to provide for the specialized treatment and rehabilitative needs of disabled veterans.

This bill would ensure that severely disabled veterans receive quality health care from the VA. From 1996 through 2008, VA was required to report on the number of beds and employees who were treating severely injured veterans at VA healthcare facilities nationwide. The Appropriate Care for Disabled Veterans Act of 2016, would amend Title 38, United States Code (U.S.C.) 38 § 1706—*Management of health care: other requirements* by reinstating the reporting requirement. This would provide Congressional oversight that is needed to ensure VA has the resources needed to meet the demand. S. 2883 would preserve benefits and ensure veterans with specialized needs to include spinal cord injuries or disorders, blindness, amputations, and mental disorders receive inpatient care at a Department of Veterans Affairs Health Care facility.

The American Legion urges Congress and the Department of Veterans Affairs (VA) to enact legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions

[5] Changes in Suicide Mortality for Veterans and Non-Veterans by Gender and History of VHA Service Use, 2000–2010, *Psychiatric Services May 1, 2015*

[6] American Legion Resolution No. 196: (Aug 2014): *Suicide Prevention for American Veterans*

[7] American Legion Resolution No. 125: (Aug 2014): *Environmental Exposures*

on claims and receipt of earned benefits, and final resting places in national shrines and with lasting tributes that commemorates their service.[8]

The American Legion supports S. 2883.

S. 2888: JANEY ENSMINGER ACT OF 2016

To amend the Public Health Service Act with respect to the Agency for Toxic Substances and Disease Registry's review and publication of illness and conditions relating to veterans stationed at Camp Lejeune, North Carolina, and their families.

The American Legion has long been at the forefront of advocacy for veterans exposed to environmental hazards. In the last several years new concerns have been raised regarding contamination of stateside and international military installations such as groundwater contamination at Camp Lejeune, North Carolina. Toxic Groundwater at Camp Lejeune existed for decades, and veterans who served at that site from 1953 through 1987 were found to be a higher risk for 15 medical conditions.

In 2012, President Obama signed into the law The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, which requires VA to provide health care to veterans and families who have certain illnesses as a result of exposure to well water contaminated by human carcinogens. The Janey Ensminger Act of 2016, requires the VA to provide medical care for all diseases that can be scientifically associated to exposure to toxic chemicals found at Camp Lejeune. The bill also requires that the Agency for Toxic Substances and Disease Registry (ATSDR), an agency within the Centers for Disease Control and Prevention, review all significant scientific literature every three years to determine if links have been found between toxic exposures found at Camp Lejeune and added diseases and conditions.

The American Legion supports legislation requiring VA to establish a national center for the research on the diagnosis and treatment of health conditions of the descendants of individuals exposed to toxic substances during service in the Armed Forces and establish an advisory board, responsible for advising the national center, determining health conditions that result from toxic exposure and to study and evaluate cases of exposure.[9]

The American Legion supports S. 2888.

S. 2896: CARE VETERANS DESERVE ACT OF 2016

To eliminate the sunset date for the Veterans Choice Program of the Department of Veterans Affairs, to expand eligibility for such program, and to extend certain operating hours for pharmacies and medical facilities of the Department.

The American Legion appreciates Senator McCain's efforts to improve the provision of health care for America's veterans. However, one of the central, core elements of the bill expands care in the community in a way that is concerning. While The American Legion appreciates certain provisions of the bill such as:

- Providing enrolled veterans in the VA healthcare system access to walk-in-clinics either inside the VA or outside the VA through contracted health care clinics;
- Expanding VA operating hours to nights, weekends, and holidays to accommodate veterans schedules;
- Opening VA hospitals to community providers who volunteer their time for the purpose of treating veterans;
- Implementing best-practice peer-reviews by encouraging VA to partner with some of the best hospital networks in the Nation such as the Cleveland Clinic and the Mayo Clinic by having VA prioritize a review of VA hospitals with the worst wait-times or health outcomes and;
- Expand telemedicine services at the VA by allowing VA health care professionals that are licensed, registered or certified in a state to use telemedicine to provide health care treatments and therapies to veterans residing in other states.

The concerns with the unrestricted expansion of the Choice program remains a critical concern.

While many veterans initially clamored for "more Choice" as a solution to scheduling problems within the VA healthcare system, once this program was implemented, most have not found it to be a solution, indeed, they have found it to create as many problems as it solves. The American Legion operates the System Worth Saving Task Force, which has annually traveled the country examining up close the delivery of healthcare to veterans for over a decade. What we have found, inter-

[8] American Legion Resolution No. 23: (May 2016): *Support for Veteran Quality of Life*
[9] American Legion Resolution No. 125: (Aug 2014): *Environmental Exposures*

acting with veterans, is that many of the problems veterans encountered with scheduling appointments in VA are mirrored in the civilian community outside VA. The solutions in many areas may not be out in the private sector, and opening unfettered access to that civilian healthcare system may create more problems than it solves. Recent reporting, such as the National Public Radio story last week noted "thousands of veterans referred to the Choice program are returning to VA for care—sometimes because the program couldn't find a doctor for them" or "because the private doctor they were told to see was too far away."[10]

The American Legion strongly believes in a robust VA healthcare system that treats the unique needs of veterans who have served their country. Veterans should be provided with the option of receiving care in the community as a supplement to VA health care and not to supplant VA care. The American Legion supported the Choice program, and continues to support the ability to supplement VA care with care in the community where necessary as a means to augment the VA care, but wholesale opening of the program to include use of Choice without restriction means pursuing a "solution" we have already seen is not addressing the problems accessing care.

As predicted by The American Legion, sending patients off VA campuses to community providers absent well-crafted contracts such as those used for Project ARCH and PC3 has led to inadequate compliance by local physicians to return treatment records to VA following care provided by Choice.

When the Choice legislation was being developed, The American Legion insisted that any doctor treating a referred veteran have access to the veterans medical records so that doctors would have a complete history of the veteran's medical history and be able to provide a diagnosis based on a holistic understanding of the patients medical profile. This is important for a litany of reasons, not the least of which includes the risk of harmful drug interaction, possible overmedication, and a better understanding of the patients previous military history—all important factors in wellness.

Also, The American Legion was adamant that any treating physician contracted through Choice had a responsibility to return treatment records to be included in the patients VA medical file so that VA could maintain a complete and up-to-date medical record on their patients. We believed that safeguarding of the veterans medical records was so important, that we helped craft a provision be included in the language that prevented VA from paying physicians until they turned over the treatment records to VA. Sadly, a few months back, The American Legion was forced to acquiesce our position in favor of paying doctors whether they turned over the medical records or not, because doctors just weren't sending the records—it just wasn't that important to them, and when VA refused to pay, they pointed the finger at VA and blamed VA for not paying them, ultimately billing the veterans and refusing to see any more VA-referred patients until they got paid. Since it was more important that veterans had access to sufficient medical care and not have their credit damaged, The American Legion supported repealing the current provision.

This, among other reasons including unsustainable cost, is why Choice is not the answer. The equation is simple; a dramatic increase in cost is guaranteed to result in an increased financial burden to veterans using VA care which will include higher co-pays, premiums, deductions, and other out-of-pocket expenses currently suffered by non-VA healthcare programs.

The American Legion opposes S. 2896.

S. 2919: STATE OUTREACH FOR LOCAL VETERANS EMPLOYMENT (SOLVE) ACT OF 2016

To provide greater deference to States in carrying out the Disabled Veterans' Outreach Program and employing local veterans' employment representatives.

This legislation would empower states with additional flexibility and autonomy to better utilize existing Federal Department of Labor (DOL) veteran's employment grants. While every state will have to continue to submit their Jobs for Veterans State Grants (JVSG) plans to DOL for review and approval, this legislation would ease the plan approval process for states while allowing each respective Governor to decide which state agency or department should administer the grants. The idea is to allow the Governors to place the JVSG funds in their state veteran's commission, which is typically led by veterans who are more likely to care about veterans and certainly understand the struggles and issues facing our Nation's heroes and their families.

Further, it allows Governors to tailor and individualize what constitutes a "significant barrier to employment" (SBE) within their state. Understanding that SBE's are

[10] NPR—May 17, 2016

sometimes geographic, allowing or affording each Governor the ability to recognize and authorize an SBE for their respective state goes a long way to assist veterans seeking employment in a unique job market. Knowing how to effectively work in the fishing industry may be a very important skill set to possess in Alaska, Hawaii or Louisiana but not necessarily important to the job market in Montana, Ohio or Nevada; making sense to give states the ability and authority to create or add an additional SBE solely for their unique and specific job market.

This legislation is encouraging states to coordinate and co-locate with other state programs to efficiently use Federal and state veteran's resources together to benefit our servicemen and women. The SOLVE Act is a no-cost, common sense bill which encourages efficiency and good governance in the pursuit of increased employment for our Nation's veterans.

The American Legion supports the Department of Labor's Assistant Secretary for Veterans' Employment and Training Service being required to review all Department of Labor employment and training programs in order to ensure that all programs provide priority services to veterans.[11]

The American Legion supports S. 2919.

DISCUSSION DRAFT:

To reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs.

More than 1.4 million claims for veterans' disability were processed last year, and the Veterans Benefits Administration (VBA) is on track to surpass even that number this year. At a ten to twelve percentage rate of appeal, the workload at the Board of Veterans Appeals (BVA) will likely never disappear.

With an appeals inventory at roughly half a million pending claims, the VA asked stakeholders to gather in several high intensity day-long working meetings to help come up with a system that would recommend solutions to help VBA and the Court of Appeals for Veterans Claims (CAVC) better process and manage this existing workload.

The American Legion currently holds power of attorney on about three quarters of a million veteran claimants. We spend more than two million dollars a year on veteran claims and appeals processing and assistance. Our success rate at the BVA hovers at around 80 percent, either outright grants of benefits or remands to properly process a claim that VA had failed to properly process at the lower level of the Regional Office.

When VA invited stakeholders to the table to discuss appeals modernization, The American Legion knew that appeals modernization was not about appeals alone, that the recommendations required to streamline appeals needed to take place much earlier in the process, at the point of the initial adjudication. With that, one of the first things the group looked at was the VBA decision notice. Refining the initial decision notice is not as easy as it sounds and several of the Veterans Service Organizations (VSOs) worked with VA for months in 2014 to try and improve these letters, with frustrations over lack of clarity still remaining. Getting VBA to agree to improve the quality of the letter was a landmark accomplishment that got the process off to a good start.

After the initial VA commitment to improve the decision letter, the stakeholders listened to what they perceived as barriers to improved appeals processing, which supported another of the primary American Legion concerns, the lack of a centralized training process. The BVA has complained that the appeal case file that is finally presented to a veterans law judge looks nothing like the claim that was adjudicated at the Regional Office (RO) level in almost all cases, due to the allowance of additional evidence during the appeals process. Therefore VBA claims they have no way to determine how, or if ROs are misinterpreting the law or making mistakes.

BVA further argued that if there were a process within the appeals system that allowed law judges to review disputed decisions that were adjudicated at the regional offices, based only on the same information that the regional office had at the time the claim was originally decided, then BVA would be able to provide a "feedback loop" they could use to help train and educate ROs, and additionally help identify regional offices where the decisions uniformly fail to address specific legal issues.

It was with these two foundational underpinnings that the big six VSOs, in addition to state and county service officers, veteran advocate attorneys, and other inter-

[11] American Legion Resolution No. 336: (Aug 2014): *Support the Restoration of the Duties and Responsibilities of the DVOP and LVER*

ested groups worked with senior VA officials from VBA and BVA to design the framework of the legislation being discussed here today.

The guiding principle leading all of our discussion was ensuring that we preserved all of the veteran's due process rights while ensuring that they did not lose any of the claim's effective date, which we were able to do successfully.

When we started the design process, we had to suspend dealing with the current caseload of appeals while we designed the new model and treated the two sets of cases as independent of each other. Now that we have designed a more streamlined and effective model for future claims, all stakeholders will still need to determine how to deal with the existing inventory of appealed claims.

The design of the proposed appeals process allows for multiple options for claimants, as well as options for additional claim development, the option to have the decision reviewed by another adjudicator (difference of opinion) and the chance to take your case straight to the board to have a law judge review the decision and make a ruling on your claim.

The proposed bill provides veterans additional options while maintaining the effective dates of original claims. Veterans can elect to have an original decision reviewed at the ROs through a Difference of Opinion Review (DOOR) which is similar to the function of what the Decision Review Officers (DROs) do now. A DOOR provides an opportunity for a claimant to discuss concerns regarding the original adjudication of a particular issue, or the entire claim, prior to appealing to BVA. Additionally, the administrative actions remove the need for a Notice of Disagreement (NOD), a process that currently takes 403.6 days, according to the April 25, 2016, Monday Morning Workload Report.

Beyond improvements in administrative functions, the proposed bill will enable claimants to select a process other than the standard multi-year backlog if they want to have an appeal addressed more expediently, and if they believe they have already provided all relevant and supporting evidence. Similar to the Fully Developed Claims (FDC) program, veterans will be able to elect to have their appeals reviewed more expeditiously by attesting that all information is included within the claim, VA records, or submitted with VA Form 9 indicating the intent to have their claims immediately forwarded to BVA for review.

Veterans indicating that they may need additional evidence or time, could elect to have their claim reviewed in the current BVA format allowing additional evidence to be entered into the record. For veterans requiring additional evidence, such as lay statements from friends and families or a private medical examination rebutting VA medical examinations, this is a viable alternative to allow the time and opportunity to provide further development necessary to substantiate the claim for benefits.

Throughout this entire process, veterans will be able to maintain their effective date of the original claim. Recognizing that an increased burden is being placed upon veterans, VA will permit veterans to maintain their effective dates, even if BVA denies the claim. If an appeal is denied by BVA, the veteran can submit new and minimally relevant evidence to reopen the claim at the RO while holding that effective date that may have been established long before the second filing for benefit.

Just as we did when we worked in partnership with VA to roll out the Fully Developed Claims process, The American Legion is willing to put in the necessary work to ensure this program is successful. We recognize the increased burden it can place on veterans; we also recognize that our approximately 3,000 accredited representatives have the tools to ensure success for the veterans and claimants we represent. Throughout the year, we will continue to work with our representatives, our members, and most importantly, our veterans to understand the changes in law, and how they will be able to succeed with these changes.

Reforming a process as complex as the disability claims system is not simple, and not every aspect of appeals reform is able to be legislated, some parts are more nuanced and require the attention of all stakeholders. The American Legion is committed to providing constant feedback as we move forward with appeals modernization. We believe that the architects of this proposal have acted in good faith, and we support their efforts to modernize the appeals process for the good of veterans.

The American Legion supports the discussion draft.

DISCUSSION DRAFT: CONSTRUCTION REFORM ACT OF 2016

To make certain improvements in the administration of Department medical facility construction projects.

The Construction Reform Act of 2016 proposes a new subsection to 38 U.S.C. § 8103 by requiring the Secretary to enter into an agreement with an appropriate

non-Department entity for the purpose of providing full project management services for any super construction project. Super construction projects are defined as "a project for the construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $100 million." Under the provisions of this section, the Secretary may not obligate or expend funds for advance planning or design for any super construction project, until the date that is 60 days after the date on which the Secretary submits to the Committees on Veterans' Affairs and the Committees on Appropriations of the Senate and House of Representatives notice of such obligation or expenditure.

The American Legion is a strong supporter of legislation and oversight to improve future VA construction programs. The American Legion also urges VA to consider all available options, both within the agency and externally, including options such as the Army Corps of Engineers, to ensure major construction programs are completed on time and within budget.[12]

The American Legion supports the discussion draft.

DISCUSSION DRAFT:

To modify requirements under which the Department is required to provide compensation and pension examinations to veterans seeking disability benefits.

The current disability compensation program has proven to be a fair and equitable manner in which to indemnify veterans suffering disabilities that have been incurred or aggravated from their military service. The American Legion is totally supportive of every benefit that is currently provided to veterans for their contributions to their country.

This proposal seeks to amend 38 U.S.C. § 5103A(d) to clarify the evidentiary threshold for which VA, under its duty to assist obligation, is required to request a medical examination for compensation claims. This amendment would clarify section 5103A(d)(2) to require, prior to providing a medical examination, the existence of objective evidence establishing that the veteran experienced an event, injury, or disease during military service. VA would still consider lay evidence as sufficient to show a current disability or persistent symptoms of a disability. However, except in special circumstances, objective evidence such as medical records, service records, accident reports, could also be of record to trigger a medical examination. The American Legion believes a veteran should be afforded a compensation and pension (C&P) examination whenever new evidence is submitted.

This discussion draft will result in making it more difficult for a claimant to receive a VA examination. The American Legion opposes any administrative or legislative proposal to dilute or eliminate any provision of the disability compensation program.[13]

The American Legion opposes the discussion draft.

DISCUSSION DRAFT: VETERANS MOBILITY SAFETY ACT OF 2016:

A bill to amend title 38, United States Code, to make certain improvements in the provision of automobiles and adaptive equipment by the Department of Veterans Affairs.

This discussion draft requires a vendor of automotive adaptive equipment to be certified by a qualified organization or the manufacturer of the adaptive equipment. Through the VA Automotive Adaptive Equipment (AAE) program, VA provides physically challenged persons the necessary equipment to safely operate their vehicle on the country's roadways. Through the Department of Rehabilitation and Prosthetic Services VA provides the necessary equipment such as: platform wheelchair lifts, under vehicle lifts; power door openers; lowered floors/raised roofs; raised doors; hand controls; left foot gas pedals; reduced effort and zero effort steering and braking; and digital driving systems.

Based on our research, The American Legion has not found any issues with veterans obtaining automobile adaptive equipment or automobile grants and does not feel that there is a need at this time for additional policy. The American Legion is continuing to research this issue and should information change would consider working to develop a resolution with our membership to provide specific policy guidance if there was need for improvement.

The American Legion does not have a position on the discussion draft at this time.

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[12] American Legion Resolution No. 24: (May 2015): *Department of Veterans Affairs Construction Programs*

[13] American Legion Resolution No. 18: (Aug 2014): *Department of Veterans Affairs Disability Compensation*

DISCUSSION DRAFT

To expand eligibility for hospital care and medical services under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 to include veterans in receipt of health services under the pilot program of the Department of Veterans Affairs for rural veterans.

One in every three veterans treated by the VA lives in rural communities. Rural and highly rural veterans have been underserved due to a lack of access to health care which can be attributed to several factors to include lack of health care insurance, little awareness of VA benefits and services, greater travel distances, and an inadequate number of primary and specialty health care providers that work in rural communities.

This discussion draft would grandfather eligible veterans into the Project Access Received Closer to Home (Project ARCH) program by setting up special provider agreements with current Project ARCH providers to guarantee continuity of care for veterans who live in rural communities.

The American Legion agrees that veterans should be grandfathered into the Project ARCH Program however, the bill as written, would not only grandfather current and past users of Project ARCH, but also includes veterans who have relocated out of the Project ARCH pilot program catchment area and into regions of the country that are not rural or highly rural. In order to cure the unintended consequences of the bill as written. The American Legion asks that the language of Section 1(a)(3)(E) be amended to read "has received health services under the pilot program under section 403 of the Veterans' Mental Health and Other Care Improvements Act of 2008 (Public Law 110–387; 38 U.S.C. 1703 note) and resides in a location described in section (b)(2) of such section.

The American Legion urges Congress and the VA to enact legislation and programs within VA that will enhance, promote, restore, or preserve benefits for veterans and their dependents, to include timely access to quality VA health care.[14]

The American Legion would support this discussion draft if amended according to our remarks above.

CONCLUSION

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division.

Chairman ISAKSON. Thank you, Mr. Celli.

Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, I want to thank you for inviting DAV to testify at this hearing to present our views on behalf of our 1.3 million wartime service-disabled veterans.

You know, DAV supports many of the bills on today's agenda, which follow our organization's single purpose, which is to empower veterans to lead high-quality lives with respect and dignity. So, for example, DAV supports S. 2520, the Newborn Care Improvement Act, and S. 2487, the Female Veteran Suicide Prevention Act. Both these bills address key recommendations in DAV's 2014 report on women veterans called "The Long Journey Home."

Gender-specific care is an issue that will remain at the forefront of DAV in our advocacy work, and we applaud Senators Klobuchar, Tillis, Boxer, Blumenthal, as well as this Committee and other supporters of these bills for their strong commitment to hard work to meet the needs of women veterans.

[14] American Legion Resolution No. 23: (May 2016): *Support for Veteran Quality of Life*

DAV also supports S. 2888, a bill that would expand the list of conditions for which veterans may be suffering from due to their exposure to contaminated waters at Camp Lejeune. We do issue a concern on this bill, Mr. Chairman. Our concern is that the burden of care for affected non-veterans rests with VA, the family members. The costs of care in other cases of significant environmental exposures are the assigned responsibility of the Administrator of the Agency of Toxic Substances and Disease Registry under the Comprehensive Environment Response and Compensation Liability Act of 1980, also known as the Superfund Act. We do ask this Committee consider supplementing VA's appropriations and funding for this program by requiring the Administrator and possibly the Navy or the Marine Corps to reimburse VA for medical services funds expended for this program.

DAV also supports Sections 4, 5, and 6 of S. 2896, the Care Veterans Deserve Act of 2016. Section 4 would expand veterans' access to care while preserving the quality of such care through telemedicine, which we believe is currently and unnecessarily constrained for VA.

Section 5 would expand the operating hours of VA pharmacies. We believe it should be commensurate with extended operating hours of outpatient clinics.

Section 6 would reduce the variability of the available best practices across the VA health care system. I know this is near and dear to Deputy Gibson's heart as well as Secretary McDonald and Under Secretary Shulkin.

DAV is, however, unable to support Section 2, which would make permanent the authority underlying the Choice program. As this Committee is aware and as my colleagues have spoken about, there are numerous issues regarding the Choice program that is inextricably intertwined with existing policy that this measure would not address.

Regarding Section 3, we urge the Committee to clarify the term "walk-in clinics," as there are considerable cost and quality of care implications at play.

I would like to now turn to the VA Appeals Modernization Act of 2016. Mr. Chairman, the draft appeals modernization legislation before the Committee is the result of a truly collaborative relationship among the Veterans Benefits Administration, or VBA, the Board of Veterans Appeals, and 11 major stakeholder organizations, including DAV. Under the proposed new appeals framework, veterans who disagree with their claims decision would have a new set of options at VBA and the Board to seek more favorable outcomes. If they remain unsatisfied with the outcomes from one option, they could continue to pursue one of the other options while still preserving their earliest effective date for benefits.

Overall, we support the draft bill, which could improve the appeals process while protecting due process rights of veterans, although there are still some important issues to be addressed. For example, clarity is needed on how the Board will handle new evidence introduced outside the limited opportunities under this bill. Will the Board consider such evidence? Will they ignore it? Or will they remand it back to VBA for readjudication?

We are also concerned about how the Board and VBA will address the current appeals backlog and whether adequate resources will be requested and provided to meet new staffing, infrastructure, and IT requirements to make the new system effective.

Finally, Mr. Chairman, on the topic of claims process, DAV strongly opposes the draft bill that would raise the evidentiary threshold for VA to provide compensation and pension examinations. The policy espoused in this draft runs counter to the uniquely pro-claimant nature of VA's adjudicatory system exemplified by VA's statutory duty to assist.

This concludes my statement, Mr. Chairman. I would be happy to work with you, with this Committee, on those legislation that we support and to resolve any issues that we have raised in our testimony. Thank you.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN M. ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DAV

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee: Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing, and to present our views on the bills under consideration. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

S. 2049—TO ESTABLISH IN THE DEPARTMENT OF VETERANS AFFAIRS A CONTINUING MEDICAL EDUCATION PROGRAM FOR NON-DEPARTMENT MEDICAL PROFESSIONALS WHO TREAT VETERANS AND FAMILY MEMBERS OF VETERANS TO INCREASE KNOWLEDGE AND RECOGNITION OF MEDICAL CONDITIONS COMMON TO VETERANS AND FAMILY MEMBERS OF VETERANS

This bill if enacted would establish a web-based Department of Veterans Affairs (VA) Continuing Medical Education Program for non-VA medical professionals. This program would be intended to provide certain private sector medical professionals who treat veterans continuing education credits to learn about and recognize conditions common in veterans and their family members, and would improve outreach to veterans and families.

Under the bill, training would consist of identifying and treating common mental and physical conditions of veterans and their family members. As determined by the VA Secretary, it would also convey educational information about programs and benefits and other matters considered appropriate, available to veterans through VA, the Department of Labor, and other Federal and non-Federal agencies. If enacted, the program would be authorized for five years, and would be effective on enactment.

The bill would require the Secretary to accredit the program in as many state licensing authorities as possible, and from such medical credentialing organizations as the Secretary considered appropriate. The curriculum and number of hours of credit would be determined by the Secretary. The program would be made available at no cost for those participating.

Under current law, the Committee should be aware that VA does not provide continuing education credits for its own professional workforce, but places the burden on the individuals involved to maintain their qualifications and licensure to practice in VA by obtaining their own continuing education requirements. Current law provides a discretionary authority for VA to reimburse VA physicians not more than $1,000 per year for obtaining continuing education credits, but does not do so for other professional disciplines, including those listed in this bill. VA professionals would be barred from participating in this program, which raises an equity and fairness question in policy. Also, if thousands or even tens of thousands of private practitioners decided to use the program proposed by this act, it could become the source of a significant shift in funding from the direct care provided to veterans within the VA, while placing substantial new pressure on VA's already overburdened information technology system. Finally, setting up this national program could be administratively burdensome and costly for VA, diverting human resources and academic

activities away from where they are needed now. We ask the Committee to address these issues with respect to this bill.

S. 2487, THE FEMALE VETERANS SUICIDE PREVENTION ACT

If enacted, this measure would amend currently required VA evaluations of its mental health and suicide prevention programs by adding a specific focus to include the needs of women veterans. Also, the bill would require an independent contractor to VA to include in its annual reports to VA the mental health and suicide prevention programs that are most effective and have the highest satisfaction rates among women veterans. This bill is in agreement with DAV Resolutions 039 and 040, which support program improvements and enhanced resources for VA mental health programs, and improvements in medical services for women veterans. The bill is also consistent with recommendations from DAV's 2014 Report, Women Veterans: The Long Journey Home. For these reasons DAV is pleased to support enactment of this bill.

S. 2520, THE NEWBORN CARE IMPROVEMENT ACT

This measure would authorize the Secretary to extend from 7 to 14 days of post-delivery care services, covering all care and services that a newborn child of an enrolled veteran would require. The bill also would require a report on the health services provided to newborns during the preceding fiscal year, including the number of newborns cared for during the period. DAV has received Resolution No. 104 from our membership, which calls for support of enhanced medical services and benefits for women veterans. Consequently DAV supports enactment of this measure.

As a technical matter, the bill's requirement of VA's submission to Congress of a new annual report about the care of newborns not later than 31 days after the end of each fiscal year would likely be administratively daunting; therefore, DAV recommends the Committee consider an amendment to the bill allowing for a more reasonable period to permit orderly data collection and internal review by VA.

S. 2679, THE HELPING VETERANS EXPOSED TO BURN PITS ACT

This bill would mandate VA to establish a center of excellence focused on diagnosis, prevention, treatment, rehabilitation, and research of health conditions related to veterans' prior exposures to burn pits and other environmental exposures while they served in Iraq and Afghanistan. The bill would provide criteria and standards for selection of this new center, and would specify a number of required qualifications, abilities, accomplishments and relationships of the VA facility selected to be so designated. The bill would authorize an appropriation of $30 million annually for the initial five years of operation of this center.

DAV members have approved Resolution No. 112, calling for improvements in care and benefits for veterans exposed to environmental hazards in deployment, and DAV Resolution 222, calling for Congressional support of a robust VA Medical and Prosthetic Research Program. Therefore, DAV supports the intent of this bill. Nevertheless, we recommend the Committee carefully consider the funding level proposed in light of the statutory limitations applied to startup funding of other Congressionally mandated VA specialized centers of excellence, such as its Geriatric Research, Education and Clinical Centers, and Mental Illness Research, Education and Clinical Centers. DAV would be deeply troubled should funds for this new center be taken from the Medical and Prosthetic Research appropriation. Finally, DAV recommends the Committee consider an amendment to the bill to provide a Congressional reporting requirement to evaluate the center's operations and effectiveness, given the level of funding this bill would make available to the center, and considering the importance of its mission to veterans who have experienced health consequences from exposure to environmental hazards while serving.

S. 2883, THE APPROPRIATE CARE FOR DISABLED VETERANS ACT OF 2016

This bipartisan measure would be intended to ensure VA maintains adequate capacity to deliver the best, comprehensive specialty care services to the most vulnerable veteran populations served by VA. It would reinstate a reporting requirement that expired in 2008 for the VA to report on its capacity to provide specialized services in areas such as blindness, burns, amputation, Traumatic Brain Injury, spinal cord injury and dysfunction, mental illness, and long-term services and supports.

Since 2008, there have been continuous reports of bed closures, staffing shortages, and delayed and denied access to these specialized care units. This bill would ensure that VA is held accountable for its mandated responsibility to care for veterans with the most severe disabilities, including catastrophic injuries and diseases.

DAV supports this legislation based on Resolution No. 126, which calls for the preservation of VA's mission and role as a provider of specialized services to veterans ill and injured due to military service.

S. 2888, THE JANEY ENSMINGER ACT OF 2016

This bill if enacted would require the Secretary, acting through the Administrator of the Agency for Toxic Substances and Disease Registry, under the Public Health Service, to periodically review the scientific literature relevant to the relationship between employment or residence of individuals at Camp Lejeune, North Carolina, for no fewer than 30 days during the period beginning on August 1, 1953 and ending on December 21, 1987, and to list the specific illnesses or conditions incurred by these individuals.

The bill would require the Administrator to determine each illness or condition for which evidence exists that exposure could be the cause of that illness or condition. If found, the Administrator would be required to categorize the connection of exposure to specific illness or condition as "sufficient," "modest," "limited," or "no more than limited." When completed, a listing of all such illnesses and conditions would be published in the *Federal Register*, accompanied by bibliographic citations, and posted on the Department of Health and Human Services' website. The bill would require the listing to be periodically updated as new conditions or illnesses were shown to be connected to exposure.

For individuals whose illness or condition was determined to be "sufficient or modest" in its connection to prior exposure to a toxic substance as documented by the listing mandated by this bill, VA would be required to provide the individual hospital care and medical services to treat the illness or condition.

The bill would also authorize continuation of care by VA to any veteran or other person under VA care at the time of enactment who lived, worked, or served at Camp Lejeune during the prescribed period, notwithstanding the absence of evidence the illness or condition being treated was connected to exposure under criteria otherwise required by this bill.

The bill would require a transfer of $4 million over a period of two fiscal years from VA's Medical Support and Compliance appropriation to the VA's Chief Business Office and Financial Services Center for the purpose of continuing their information technology work associated with the Camp Lejeune Family Member Program.

The delegates to our most recent National Convention adopted two resolutions related to this bill. Resolution No. 112 urges congressional oversight and Federal vigilance to provide for research, health care and improved surveillance of disabling conditions in veterans resulting from military toxic and environmental hazards exposure. Also, Resolution No. 114 calls for eliminating VA health care out-of-pocket costs for service-connected disabled veterans. Accordingly, we support the provision in this measure that expands the list of conditions for which veterans may be suffering from due to their exposure to contaminated waters at Camp Lejeune and that these veterans will not be charged a copayment for treatment associated.

However, we remain concerned that the burden of care for affected non-veterans rests with VA through its Chief Business Office Purchased Care as an expanded responsibility in contravention of the requirement that in other cases of significant environmental toxic exposures, the costs of care are the assigned responsibility of the Administrator of the Agency for Toxic Substances and Disease Registry, under the Comprehensive Environment Response, Compensation, and Liability Act of 1980, also known as the "Superfund Act." As the Committee considers this bill, we ask that it also consider requiring the Administrator, the Navy or the Marine Corps to reimburse VA's Medical Services appropriation the cost to carry out the bill's purposes in treating those who were harmed by this environmental exposure at Camp Lejeune.

S. 2896, THE CARE VETERANS DESERVE ACT OF 2016

Section 2 of this measure would make permanent the Veterans Choice Program, established by Section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113–146, and would make all veterans enrolled for VA health care eligible for the Veterans Choice Program.

When the Senate passed VACAA, DAV commended this Committee for quickly passing bipartisan legislation in response to the crisis in accessing VA health care. DAV committed itself to continue working with the Senate, House and VA to help fine tune, strengthen and coalesce around effective administrative, regulatory and legislative changes needed to address VA's capacity and access problems.

We believed then as we do now in strong care coordination provisions to ensure the best health outcomes for all veterans receiving care paid for by VA, regardless of the provider of that care. Equally important then as now, when expanding VA's mandate to provide care through non-VA providers, Congress must ensure that it appropriates all the additional funding needed without taking away funding from VA's medical centers and clinics that are already at or over capacity.

Our shared goal must be to ensure that VA programs that purchase care in the community function as seamlessly and efficiently together with a robust, safe, efficient, high-quality VA health system that provides the best health outcomes. To accomplish this goal, Congress must address the misalignment among resources, demand and authorities that allow VA to provide hospital care and medical services. Because Section 2 only addresses demand by expanding it into the private sector, we are unable to offer our support.

DAV Resolution No. 105 opposes any legislative proposal that would have the effect of privatizing VA health care and diminishing the VA health care system. In addition, DAV Resolution No. 107 calls on Congress to provide necessary authorities, sufficient resources and staff to reduce waiting times so ill and injured veterans can realize timely access to all medically necessary services from the VA health care system.

Section 3 would require VA to contract with a national chain of walk-in clinics to provide hospital care and medical services to veterans enrolled in VA health care. Information on the care and services provided would be automatically transmitted to VA by such clinics, and no copayment or prior authorization would be required for care veterans would receive.

Notably, the measure does not define a walk-in clinic. If a walk-in clinic were simply a health care provider that allows a patient without an appointment to be seen by a provider, this could be further defined as a retail clinic (such as MinuteClinics), an urgent care clinic, or even a freestanding or hospital emergency department (ED). When considering this measure, we recommend the Committee clarify the term due to considerable cost implications to taxpayers and quality of care implications for veterans who would seek these services.

A March 2016 study published in *Health Affairs* examined insurance claims data for three million patients from 2010 to 2012 who were treated for certain simple, acute medical problems. Despite the lower per-visit cost of a retail clinic instead of an ED or physician's office, the researchers found that overall spending for the retail clinic cohort increased.[1] The increased spending from higher use of services outweighed the savings that resulted when patients went to less expensive retail clinics instead of a physician's office or an ED.

Moreover, the RAND Corporation found in 2010 that retail clinics were less likely to be located in medically underserved areas, but were mostly quite urban. We recommend the Committee consider the appropriateness of the provision prohibiting VA from requiring the expansion of walk-in clinic locations, which would limit veterans' access to care.

In reviewing the merits of this bill, in addition to its cost, we urge the Committee consider the formal positions taken on retail clinics of the American Academy of Family Physicians,[2] American Academy of Pediatrics,[3] American College of Physicians, American Academy of Family Practitioners,[4] and the American Medical Association.[5] Three general concerns emerge: (1) quality and safety of care, (2) impact on coordination and continuity of care; and (3) scope, oversight, and interaction with traditional primary care providers.

However, if the walk-in clinics referred to by this measure are urgent care clinics, DAV supports the intent of the provision and urges the Committee make urgent care part of VA's medical benefits package. Urgent care fills the gap between emergency care and regular appointment-based outpatient care, by enabling immediate access. Developing a nationwide system of urgent care at existing VA clinics and affording veterans the opportunity to receive urgent care from smaller urgent care clinics around the country would alleviate much of the pressure on outpatient clinics.

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[1] "Retail Clinic Visits For Low-Acuity Conditions Increase Utilization And Spending," Ashwood, Gaynor, et al. March 24, 2016, Accessible at: http://content.healthaffairs.org/content/35/3/449

[2] http://www.aafp.org/about/policies/all/retail-clinics.html

[3] http://pediatrics.aappublications.org/content/133/3/e794

[4] https://www.acponline.org/acp-newsroom/retail-clinics-best-used-as-backup-to-a-patients-primary-care-physician

[5] https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/DIR/D-160.986.HTM

As mentioned above, we recommend the Committee consider the appropriateness of the provision explicitly prohibiting VA from requiring the expansion of urgent clinic locations, which would limit veterans' access to care. VA should be afforded the opportunity to tailor access to this type of care that best meets veterans' needs and enhancing the VA health care system.

DAV Resolution No. 114 calls for legislation to eliminate or reduce VA health care out-of-pocket costs for service-connected disabled veterans; thus we support the provision that would not require veterans to pay a copayment for services received under Section 3. However, DAV's primary concern with Section 3 is the proposed policy itself, which could ultimately lead to fragmentation of veterans' health care unless it is coordinated with VA primary care providers. Similar to our position on section 2 above, DAV cannot support this proposal.

Section 4 would enable a health care professional of the VA, including a contract provider, who is authorized to provide health care by or through VA, and who is licensed, registered, or certified in a state to practice his or her profession at any location in any state, regardless of where the professional or veteran is located, to treat a veteran through telemedicine. If enacted the bill would permit telemedicine treatment regardless of whether the professional or the patient were physically located in a federally owned facility.

This section would also require VA to report to Congress one year following its implementation on a variety of aspects of VA's telemedicine program, including patient and provider satisfaction, access, productivity, waiting times and other information related to appointments made and completed through telemedicine.

Delegates to our most recent DAV National Convention approved Resolution No. 126. Among other priorities, this resolution calls on VA and Congress to establish and sustain effective telemedicine programs as an aid to veterans' access to VA health care, particularly in the case of rural and remote populations. Our delegates also approved Resolution No. 226, fully supporting the right of rural veterans to be served by VA. Section 4 of this measure is consistent with these resolutions and DAV policy; therefore, DAV strongly supports this section and appreciates the sponsor's intention to promote the use of telemedicine in the care and treatment of veterans.

S. 2919, THE STATE OUTREACH FOR LOCAL VETERANS EMPLOYMENT (SOLVE) ACT OF 2016

This measure seeks to boost proficiency and controls in the pursuit of increasing appropriate and sustainable employment opportunities for our Nation's veterans. The bill would increase individual states' influence and flexibility to maximize existing Federal Department of Labor (DOL) veterans' employment grants to support the work of Disabled Veterans' Outreach Program Specialists (DVOPS) and Local Veterans' Employment Representatives (LVERS) to provide greater assistance to veterans seeking employment services.

Specifically, section 3 of the bill would allow state Governors to select the particular state agency, such as a state veterans' affairs agency, rather than a state's department of labor exclusively, to administer these programs. It encourages states to co-locate DVOPS and LVERS at one or more of the existing American Job Centers for efficient synchronization.

The bill encourages each state to tailor their annual plan to meet the employment and training needs of veterans in their state. As part of a State Governors annual plan, they would submit proposals for additional individual barriers to employment they view as significant enough for DVOP and LVER access. This would allow additional categories of veterans to receive services. For example, an individual barrier could be proposed in the case of veterans suffering from PTSD who have difficulty negotiating numerous bridges around their locality to obtain employment services, VA health care and job interviews. Administering employment and VA health care services to the increased number of geriatric veterans in Connecticut is a challenge.

The measure also directs DOL to only disapprove certain parts of state plans, rather than rejecting plans in their entirety. In the case where certain sections of a plan receive DOL approval, it directs DOL to submit an explanation to the state for the rejected section.

DAV has no resolution and no position on the specific issue this measure seeks to address. However, DAV Resolution No. 134 expresses a continuing concern our organization has regarding the diversion of DVOPS/LVERs from their prime mission to assist veterans with their employment and training needs. We are pleased the sponsor is working with us to ensure this measure would avoid or otherwise protect against such occurrences.

Moreover, we are aware DOL is executing a number of initiatives that may be adversely impacted by enactment of the bill as currently written. We urge the spon-

sor, this Committee and DOL to work together to ensure the final outcome will enhance state programs to better assist veterans with their employment and training needs.

Ensuring that our Nation's ill and injured wartime veterans receive proficient opportunities for substantial gainful employment is DAV's concern. Wartime veterans who have sacrificed as a result of their military service need competent guidance and services at all levels to achieve maximum employability

DRAFT BILL, TO REFORM THE RIGHTS AND PROCESSES RELATING TO APPEALS OF DECISIONS REGARDING CLAIMS FOR BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS

Mr. Chairman, this draft bill comes as a result of a collaborative effort among VBA, the Board and 11 major stakeholder organizations—including DAV—that assist veterans with their appeals. For the past three months, this workgroup has been meeting intensively with the goal of developing a new structure and system for appealing claims decisions. However, this recent effort actually builds on that of a very similar workgroup involving VSOs, VBA, and the Board that began meeting over two years ago. That workgroup spent over six months examining the cause of and possible solutions to the rising backlog of appeals. At that time, the claims backlog was finally beginning to drop after years of transformation efforts.

The signature achievement of that first VSO-VA workgroup was the development of and widespread support for the "fully developed appeals" (FDA) proposal. Under the FDA proposal, veterans could have their appeals routed directly to the Board by agreeing to eliminate several processing steps at the regional office level, forego hearings, and take greater responsibility for developing evidence necessary to properly consider their appeals. The FDA was modeled on a similar claims initiative—the "fully developed claims" (FDC) program—which has contributed to dramatic improvement in claims processing times at VBA.

As a result of that VSO-VA collaboration, legislation was drafted and introduced in both the House and Senate. Earlier this year, the House approved a broad benefits bill (H.R. 677) which included the FDA program. The Senate legislation introduced by Senators Sullivan, Casey, Heller and Tester (S. 2473) was approved by this Committee earlier this month as part of the Veterans First Act omnibus bill. We want to thank everyone involved for your efforts in advancing FDA legislation.

As you are aware, the FDA's premise of eliminating certain appeals processing steps at VBA while providing a quicker route for appeals to the Board has essentially been incorporated into this comprehensive appeals reform bill. Though not as far-reaching as this proposed legislation, the FDA pilot program could reduce the time some veterans wait for their appeals decisions by up to 1,000 days, while lowering the workload on both VBA and the Board.

Building on the work of the earlier VSO-VA workgroup, and particularly its FDA proposal, VA convened the latest workgroup in March of this year to examine whether agreement could be reached on more comprehensive and systemic change. Over a very compressed but intensive couple of months, that included a number of closed-door, all-day sessions, the workgroup was able to reach general consensus on principles, provisions and ultimately the draft legislation before us. DAV and most of the other stakeholders support moving forward with this draft appeals reform legislation, notwithstanding some remaining issues yet to be addressed.

We believe that if all stakeholders continue working together—in a good faith partnership with full transparency—we have a good chance of resolving the remaining issues and achieving an historic reform this year. However, as we have long said, the most important principle for reforming the claims process was getting the decision right the first time; we must also ensure that this appeals reform legislation is done right the first time. Further changes to any part of this draft legislation could affect our ultimate support for the bill; therefore, we urge this Committee and VA to continue working with DAV and other stakeholders in a transparent and collaborative manner.

With that in mind, while the latest workgroup was initially focused on ways to improve the Board's ability and capacity to process appeals, from the outset we realized that appeal reforms could not be fully successful unless we simultaneously looked at improving the front end of the process, beginning with claims' decisions. One of the issues that development of the FDA proposal exposed was the importance of strengthening decision notification letters provided by VBA in order to improve decisions about appeals options. A clear and complete explanation of why a claim was denied is key to veterans making sound choices about if and how to appeal an adverse decision. Therefore, a fundamental feature of the new appeals process must

also ensure that claims' decision notification letters are adequate to properly inform the veteran.

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

(1) A list of the issues adjudicated;
(2) A summary of the evidence considered;
(3) A summary of applicable laws and regulations;
(4) Identification of findings favorable to the claimant;
(5) Identification of elements that were not satisfied leading to the denial;
(6) An explanation of how to obtain or access evidence used in making the decision; and
(7) If applicable, identification of the criteria that must be satisfied to grant service connection or the next higher level of compensation for the benefit sought.

DAV recommends that in order to better inform veterans about this new notification provision and the redesigned claims and appeals process being proposed, the legislation should include a requirement that VA create an online tutorial and utilize other web or social media tools to enhance veterans' understanding of how claims decisions are made and how to choose the best options available in the redesigned appeals system.

THE CURRENT APPEALS SYSTEM

In order to evaluate the new appeals framework in the draft legislation, it must be compared to the existing system. Currently, if a veteran is not satisfied with their claims decision, they may appeal the decision by completing a Notice of Disagreement (NOD) form which provides them two options: a de novo review or a traditional appeal to the Board of Veterans Appeals. The de novo option takes place locally within the VARO, and is performed by a Decision Review Officer. The de novo process allows the introduction of new evidence and a hearing, requires VBA to fulfill its "duty to assist" throughout the process, and provides a full de novo review of the claim. If benefits are granted in the de novo process, the effective date for the award would be the date of the claim, if the facts found support entitlement from that effective date.

The second NOD option is to formally appeal to the Board. When a veteran chooses this option, the VARO must prepare a Statement of Case (SOC) for the veteran and then the veteran must complete the VA Form 9 specifying the issues they are appealing and the reasons supporting their appeal. If new evidence is submitted after the NOD requiring development, a Supplemental Statement of Case (SSOC) may also be issued. A veteran who elected a de novo review but who was not awarded the full benefits sought may also continue their appeal to the Board as described above. As part of the Board process, appellants have the opportunity to request a hearing and introduce new evidence at any time. Throughout its consideration of an appeal, the Board is required to comply with VA's "duty to assist" and performs a de novo review of all the evidence submitted, before and after the date of the NOD filing.

If the Board does not grant the full benefit sought, the veteran's primary recourse would then be to appeal to the Court of Appeals for Veterans Claims ("Court"), which can take many more years before final disposition. Alternatively, the veteran at any time could file a new claim with new evidence, which could be processed under the FDC program in less than 125 days, however the effective date for this claim would be the new filing date, potentially requiring the veteran to forfeit months or years of entitlement to earned benefits.

In many cases the Board will remand the claim back to VBA for either procedural errors (i.e. "duty to assist" errors) or for the development of new or existing evidence needed to make a final determination. More than half of all pending appeals will be remanded at least once under the current system, lengthening the time veterans wait for final resolution of their appeals and contributing to the growing backlog of pending appeals.

The current system allows veterans unlimited opportunities to submit new evidence to support their appeals, requires that VA fulfill its "duty to assist" to veterans by securing and developing all potential evidence but requires that the formal appeal be maintained in order to protect the effective date of the original claim. While these features help ensure that veterans rights are protected, they have

evolved into a system that incentivizes many veterans to file and maintain formal appeals because there is no other option available to protect their earliest effective dates, which could affect thousands of dollars in earned benefits.

A NEW FRAMEWORK FOR VETERANS' CLAIMS AND APPEALS

Understanding the benefits and weaknesses of the current system, the workgroup developed a new framework that could protect the due process rights of veterans while creating multiple options to receive favorable decisions more quickly. A critical factor was developing a system that would allow veterans to protect their earliest effective dates while allowing them opportunities to introduce new evidence, without having to be locked into the long and arduous formal appeals process at the Board.

In general, the framework embodied in the draft legislation would have three main options for veterans who disagree with their claims decision and want to challenge VBA's determination. Veterans must elect one of these three options within one year of the claims decision.

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

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

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

For the second option—the higher-level review—the veteran could choose to have the review done at the same local VARO that made the claim decision, or at another VARO, which would be facilitated by VBA's electronic claims files and the National Work Queue's ability to instantly distribute work to any VARO. The veteran would not have the option to introduce any new evidence nor have a hearing with the higher-level reviewer, although VBA has indicated it will allow veterans' representatives to have informal conferences with the reviewer in order for them to point out errors of fact or law. The review and decision would be de novo and a simple difference of opinion by the higher-level reviewer would be enough to overturn the original decision. If the veteran was not satisfied with the new decision, they could then elect one of the other two options to pursue resolution of their issue.

For this higher-level review, the duty to assist would not apply since it is limited to the evidence of record used to make the original claims decision. If a duty to assist error is discovered that occurred prior to the original decision, unless the claim can be granted in full, the claim would be sent back to the VARO to correct any errors and readjudicate the claim. If the veteran was not satisfied with that new decision, they would still have all three options to resolve their issue.

Mr. Chairman, one additional change that we have suggested and VA has agreed to include, but that is not in this Senate discussion draft, would be to add a new section to section 5104B, title 38, United States Code, to clarify that all higher-level reviews would be done as de novo reviews, without the veteran having to affirmatively elect a de novo review option. We would like to highlight for the Committee the companion bill introduced in the House, H.R. 5083, contains this revision and we strongly recommend this provision be maintained in any legislation moving forward.

These first two options take place inside VAROs and cover much of the work that is done in the current de novo process, although it would be separated into two different lanes: one with and one without new evidence and hearings. VA has also proposed eliminating the position of Decision Review Officers and reassigning these personnel to functions that are appropriate to their level of experience and expertise, such as higher-level reviewers.

For the third option—Board review—there would be two separate dockets for veterans to choose from: an "expedited review" that allows no hearings and no new evidence to be introduced; and a more traditional appeal that allows both new evidence and hearings. Both of these Board lanes would have no duty to assist obligation to develop any evidence submitted. For both of these dockets, the appeal would be routed directly to the Board and there would no longer be SOCs, SSOCs or Form 9s completed by VBA or the veteran.

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

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

If the Board discovers that a "duty to assist" error was made prior to the original claim decision, unless the claim can be granted in full, the Board would remand the case back to VBA for them to correct the errors and readjudicate the claim. Again, if the veteran was not satisfied with the new VBA claim decision, they could choose from one of the three options available to them, and as long as they properly make the election within one year of the decision, they would continue to preserve their earliest effective date.

One additional option becomes available after a Board decision: the appellant would also have the opportunity to file a Notice of Appeal to the Court of Appeals for Veterans Claims ("Court") within 120 days of the Board's decision, which is the current practice today. Decisions of the Court would be final.

The draft legislation would also amend existing statute to change the "new and material evidence" standard to a "new and relevant evidence" standard, as it relates to readjudication and supplemental claims. Under current law, a claim can only be reopened if "new" and "material" evidence is presented, which was designed to prevent unnecessary work reviewing immaterial evidence that would not affect the outcome of a claim. However, in practice this standard has often had the opposite effect, requiring VBA to make a "new and material" determination, which can then be appealed to the Board, often requiring a hearing, and adding years of delay before getting to the core issue of whether the evidence would actually change the claim decision.

The draft bill would replace the term "material" with the term "relevant," and add a definition of "relevant evidence" as "evidence that tends to prove or disprove a matter in issue." While we understand the intention of VBA in trying to deter submission of unrelated evidence, we believe that this revised standard would not be any more effective in preventing submission of truly unrelated and irrelevant evidence. Instead, creating a new and untested standard could result in additional appeals on procedure before the substance was adjudicated, and then it, too, could be appealed.

For this reason, DAV and others involved in the first appeals workgroup had discussed revising this standard by amending section 5108 of title 38, United States Code, to require VBA to review all evidence submitted in order to directly address the substance of the issue rather than be required to first clear a procedural hurdle. The workgroup considered changing section 5108 to read as follows:

> **§ 5108 Evidence presented for disallowed claims**
>
> If evidence is presented with respect to a claim which has been disallowed that adds to or changes the facts as previously found by the Secretary, the Secretary shall develop or adjudicate the claim as appropriate.

For truly unrelated evidence, the determination that such evidence does not "add to or change the facts" underlying the claim decision should not require any more

time than a determination of whether such evidence is new or material. Thus, we recommend the Committee consider incorporating this alternative approach as an amendment to this bill.

The draft bill also includes an amendment to section 5104A to require that any finding made during the claims or appeals process that is favorable to the claimant would be binding on all subsequent adjudicators within the Department, unless clear and convincing evidence is shown to the contrary to rebut such favorable finding. In the new structure in which appeals can move back and forth from the Board to VBA, veterans must be reassured that favorable findings cannot be easily overturned by a different adjudicator or reviewer during this process. Thus, we strongly support this section.

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

REMAINING ISSUES AND QUESTIONS RELATED TO THE DRAFT APPEALS REFORM LEGISLATION

Over the past several weeks, DAV and other VSO stakeholders have continued to work with the Board and VBA to resolve and clarify a number of issues, further improving the proposed new appeals structure. While we believe the current draft bill should be moved forward in the legislative process, there are still some critical issues that need to be further explored to ensure that there are no unintended negative consequences for veterans.

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

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

In addition, since there is no "duty to assist" requirement after the NOD filing, what if evidence properly submitted indicates that additional evidence exists which could affect the decision: will the Board ignore that evidence or inform the veteran that there was additional evidence that could have changed the decision but that it was not sought nor considered? Will or should the Board remand the appeal back to the VBA for readjudication to allow for full development of all evidence? In order to protect the veteran's due process rights, we would recommend that these uncertainties be resolved before final legislation is enacted into law, preferably through clear and unambiguous statutory language.

There are also two critical operational concerns that will effect whether the new appeals structure can be properly implemented as envisioned. First, the Board and VBA must develop and implement a realistic plan to address the almost 450,000 appeals currently pending, most of which are still within VBA's jurisdiction. Until these pending appeals are properly resolved, no new appeals structure or system can expect to be successful. While we have been in discussion with VBA and the Board about how best to address these legacy appeals, we have yet to agree on formal plans to deal with its current backlog of appeals. We need Congress to perform aggressive oversight of this process to ensure a proper outcome.

Furthermore, since appeals that are filed today can take years to be completed, some will last more than a decade, how will VBA and the Board operate two dif-

ferent appeals systems simultaneously, each with separate rules for treating evidence and the "duty to assist?" How will new employees be trained under both the old and new systems so that there is efficient administration of these two parallel appeals systems? How will the Court view the existence of two different standards for critical matters such as the "duty to assist" veterans? We would recommend that these questions be thoroughly considered by the Committee and discussed with VSOs to avoid future problems.

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

Mr. Chairman, the draft legislation being considered today represents a true collaboration between VA, VSOs and other key stakeholders in the appeals process. Building on the work first begun two years ago, tremendous progress has been made this year culminating in this draft appeals legislation. There are still a number of improvements and clarifications that must be made to the draft legislation but we remain committed to working with Congress, VA and other stakeholders to resolve them as soon as feasible. Working together, we are hopeful that the Senate and House will enact comprehensive appeals reform legislation before the end of this year to provide veterans with quicker favorable outcomes, while fully protecting their due process rights.

DRAFT BILL, THE VETERANS MOBILITY SAFETY ACT OF 2016

The Veterans Mobility Safety Act of 2016 would enhance the VA program providing automobiles and adaptive equipment assistance for service-disabled veterans.

Under current law, Congress authorizes financial grants for certain ill and injured veterans and active duty servicemembers to purchase a new or used automobile or other conveyances. This grant may also be paid if disabilities are a result of medical treatment, examination, vocational rehabilitation or compensated work therapy provided by VA. In addition to financial assistance toward the purchase of an automobile or other conveyance, financial assistance is provided for modifications that may be necessary to accommodate these covered service-connected disabilities resulting from an injury or disease incurred or aggravated during active military service.

Currently, grants are paid directly to the seller of the automobile for the total price up to $20,114.34. A veteran or servicemember may only receive the automobile grant once in his or her lifetime. Repairs and modifications to a vehicle may also be authorized throughout the veteran's lifetime, subject to predetermined limits.

This legislation would require the Secretary of VA to develop comprehensive quality standards for providers of vehicle modification services under the automobile adaptive equipment program. This new policy would be developed and overseen in consultation with veterans service organizations, the National Highway Transportation Administration, industry representatives, manufacturers of automobile adaptive equipment and other entities with expertise in installing, repairing, replacing, or manufacturing mobility equipment or developing mobility accreditation standards for automobile adaptive equipment.

Although DAV has no resolution from our members concerning this issue, we support the intent of this legislation to help injured and ill veterans lead high quality lives. The legislation would provide an added measure of quality assurance to protect these seriously ill and injured veterans from substandard craftsmanship that could potentially jeopardize their safety, the safety of their families and the general public.

We recommend the stakeholders identified within this proposal be involved throughout this entire process, to include rule and policy development and implementation. Furthermore, we recommend that all efforts be made to ensure that any policy that is created does not adversely impact a veteran's ability to receive vehicle modifications. If standards are not implemented carefully, some manufactures or installers may be unable, or unwilling, to comply with the new requirements. In this

scenario, a veteran's options could become increasingly limited when they seek out installation and repairs of their automobile adaptive equipment.

DRAFT BILL, TO EXPAND ELIGIBILITY FOR HOSPITAL CARE AND MEDICAL SERVICES UNDER SECTION 101 OF THE VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014 TO INCLUDE VETERANS IN RECEIPT OF HEALTH SERVICES UNDER THE PILOT PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS FOR RURAL VETERANS

Section 1 of this bill would make veterans who have received care under the Access Received Closer to Home (Project ARCH) pilot program eligible to participate in the Veterans Choice Program. Section 403 of the Veterans' Mental Health and Other Care Improvements Act of 2008 (Public Law 110–387; 38 U.S.C. 1703 note), provided VA with authority to conduct this pilot in five sites in Kansas, Montana, Virginia, Arizona and Maine.

Project ARCH sites became operational on August 29, 2011, and the three-year pilot program, which was set to expire on August 29, 2014, was extended to August 7, 2016 by section 104 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113–146. Moreover, the VA is required to ensure that medical appointments for those veterans eligible to participate in Project ARCH be scheduled not later than five days after the date on which the appointment is requested and occur no later than 30 days after such date.

DAV has supported the extension of Project ARCH beyond its initial authorization. This pilot project has shown promising results in achieving a more patient-centered, coordinated, cost-effective delivery model for fee-basis care. We believe this is primarily due to the dedicated VA Care Coordinator at each participating site who works closely with veterans and community providers to ensure continuity of care and that veterans no longer need to travel hundreds of miles to receive acute or tertiary care.

DAV has previously testified in support of provisions making veterans enrolled in Project ARCH eligible to receive care in the community as part of the overall effort to fix the misalignment of resources, demand and, in particular, existing authorities that hamper VA's ability to purchase or directly provide health care to ill and injured veterans.

While we welcome the intent of the bill to extend eligibility to participate in the Veterans Choice Program to veterans who have received care under Project ARCH, we are concerned veterans who are current participants in Project ARCH will experience disruptions in care as this transition occurs. We have already heard from VA Care Coordinators who have expressed concern for the veterans they care for under Project ARCH who experienced unwarranted disruptions in their care due to parallel VA programs that purchase care in local communities.

DISCUSSION DRAFT, INCLUDING PROVISIONS FROM THE CONSTRUCTION REFORM ACT OF 2016, A BILL TO MAKE CERTAIN IMPROVEMENTS IN THE ADMINISTRATION OF DEPARTMENT MEDICAL FACILITY CONSTRUCTION PROJECTS

This bill would build on a prior statutory reform of the management of VA major medical facility construction projects (including "super construction projects") by establishing a new, mandatory requirement that VA follow industry standards, standard designs, and best practices in constructing VA facilities. The bill also would require forensic audits by a qualified outside Federal auditor in cases in which the final cost of a major medical facility construction project exceeded its statutory appropriation by more than 25 percent.

This bill would amend VA's notice requirements to Congress with regard to accounting for bid savings on major projects, with specifications.

Finally, this bill would require a quarterly report to Congress on super construction projects, including progress being made, planning variances and budgetary matters.

Delegates to our most recent National Convention approved Resolution No. 100, urging the Administration and Congress to properly support VA's construction and infrastructure needs. This bill is consistent with the intent of our resolution; therefore, DAV supports this bill and urges its enactment.

DISCUSSION DRAFT, INCLUDING VA PROPOSAL TO MODIFY REQUIREMENTS UNDER WHICH THE DEPARTMENT IS REQUIRED TO PROVIDE COMPENSATION AND PENSION EXAMINATIONS TO VETERANS SEEKING DISABILITY BENEFITS

The proposed discussion draft bill would change the standards for determining when VA is required to provide a disability compensation examination or obtain medical opinions.

Currently, VA's "duty to assist" veterans with disability compensation claims includes requirements for providing disability compensation examinations or medical opinions in order for VA to reach a fully informed and proper entitlement determination. VA is required to provide these examinations or medical opinions when a veteran's record does not contain sufficient medical evidence for VA to make a decision and there is competent evidence of a current disability, or persistent or recurrent symptoms of a disability; or when the record suggests that a disability, or symptoms, may be associated with active military service.

The discussion draft bill adds a new requirement that the veteran's claim record contain "objective evidence" that an injury or disease was incurred, or aggravated while performing active military service; or that the injury, or disease became manifest during the applicable presumptive periods; or that the veteran experienced an event in service, capable of causing a particular injury or disease. The effect of this draft proposal would raise the evidentiary threshold for when VA would be required to provide a VA examination or medical opinion.

Enactment of such legislation would make it more difficult for veterans seeking to establish entitlement to benefits derived from injuries or illnesses acquired as a result of their active military service. Disability compensation examinations play a vital role in helping to develop the evidence necessary to support a veteran's claim. Creating more stringent requirements before VA has an obligation to order an examination or opinion would impose a significant new barrier for many veterans to overcome as they attempt to prove the validity of their claims.

Further, as VA denies more veterans the ability to have an examination or receive a medical opinion, there would likely be an increase in the number of appeals, forcing many veterans to endure a lengthy appeals process in order to have their claims properly developed.

DAV strongly opposes this draft legislation consistent with DAV Resolution No. 008, which opposes any proposals that would reduce, add limitations on, or eliminate benefits for service-connected disabled veterans or their families. Because the changes contemplated within this draft bill would make it more difficult for veterans to prove meritorious claims, we oppose the legislation.

Mr. Chairman, DAV appreciates the opportunity to provide testimony. I would be pleased to address any questions you, or Members of the Committee may have on the topics covered in this statement.

Chairman ISAKSON. Thank you very much for your testimony.

Mr. Blake.

STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Chairman Isakson, Members of the Committee, on behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

It has been our historical experience and that of our members who have extensive interaction with the VA health care system that veterans around the country prefer to receive their care from the VA health care system. This point as affirmed from a recent survey of our members gauging their experiences with VA health care.

As we consider legislation designed to reform the VA health care system, it is important to recognize that the VA's specialized services, particularly spinal cord injury and disease care, cannot be adequately duplicated in the private sector. Many advocates for greater access to care in the community often minimize or even ignore altogether this point without recognizing the potentially devastating impact that pushing more veterans into the community might actually have on the larger VA health care system and particularly specialized health services that rest on the bedrock of that system.

While we appreciate the intent of S. 2896, we believe it is based on the flawed assumption that the Choice program as currently implemented is the best way forward for VA health care. I would point out that the VA just last fall released its community care consolidation plan and we believe that sets a better benchmark for the path forward.

During the House Committee on Veterans' Affairs where this plan was first considered just last fall, that plan was roundly lauded by members on both sides of that committee, including all of the doctors in both parties. Yet, selective amnesia seems to have caused us to forget that that was actually praised by both parties on that committee when it was unveiled.

Additionally, PVA, along with our partners in the *Independent Budget*, the VFW and the DAV, presented to this Committee a framework for VA health care reform that builds on the VA's own plan. It includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of health care while laying out a long-term vision for sustainable high-quality and veteran-centric care.

Mr. Chairman, as the Committee considers moving forward with VA health care reform, I think we have to change our focus simply from Choice, Choice, Choice, to what is the right program to benefit veterans in the right way. I think Dr. Yehia has done an outstanding job trying to shepherd this process through. Sometimes I wonder if we are paying enough attention to what he is really doing, other than individual instances where he has made an impact on individual Senators' and Members of Congress' district.

PVA strongly supports the draft bill, the Veterans Mobility Safety Act of 2016. Adaptive automobile equipment is one of the most important issues for PVA members. We support the effort to ensure veterans with mobility impairment receive adaptive equipment and adaptations that meet industry standards and specifications and that are properly installed for use. Strangely, current law does not require VA to actually certify that those businesses installing adaptive equipment on vehicles for disabled veterans are qualified to do so.

We appreciate Senator Moran introducing this bill. It is a companion to H.R. 3471. We particularly appreciate the fact that before the Committee, they were willing to entertain the language changes that had been worked out as the House Committee on Veterans' Affairs moved that bill, and we look forward to seeing that bill pushed through until final passage.

Last, Mr. Chairman, I think there has been a lot of discussion about the appeals reform process. PVA was pleased to work with our colleagues here on this panel, with VBA, and with the representatives of the Board of Veterans Appeals to come up with a real solution to the appeals process. I think the numbers have been mentioned a number of times already here. More than 450,000 in the appeals backlog, potentially two million in the backlog if changes are not made within the next decade, claims or appeals that may end up dragging out for 6 to 10 years if those same reforms are not made. Those are clearly all unacceptable statistics.

We are encouraged by VA's ambitious efforts to achieve reform. VA has recognized that VSOs have specific concerns and they have

worked with us to find solutions to move us forward without diluting veterans' rights in the process. We appreciate the fact that they continue to work with us even today as this bill is being considered.

We support the general framework of the legislation as it has been proposed, but at a minimum, we would point you to our written statement for some additional considerations as the bill is moved forward for final passage.

I would also have to just—I would be remiss if I did not mention that as we move forward with appeals reform, we cannot forget, I think Mr. Chairman or one of the Senators mentioned about the existing backlog and how that gets addressed in the context of this appeals process, because it will do no good to stand up a new process with the weight of that still pressing down on the VA appeals system.

With that, Mr. Chairman, I would like to thank you for the opportunity to testify. I would be happy to answer any questions you or the members may have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee: Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on legislation pending before the Committee. The magnitude of the impact that veterans' health care reform will have on present and future generations of veterans cannot be overstated, and we are proud to be part of this important discussion.

THE "SOLVE ACT"

The Department of Labor (DOL) administers the Veterans Employment and Training Services Program which is responsible for distributing Jobs for Veterans State Grants (JVSG). Through these grants, states fund two types of positions that can be found in most American Job Centers. Disabled Veterans' Outreach Program (DVOP) specialists provide intensive services to veterans and eligible spouses, designed to facilitate participants' transition into meaningful civilian employment. Local Veterans' Employment Representatives (LVER) perform outreach to local businesses and employers to advocate for the hiring of veterans.

Currently, DOL reviews state applications for JVSG's, but when a provision within the state's proposal is rejected, the entire plan is rejected without explanation. This bill would allow DOL to approve or disapprove certain aspects of a state plan rather than a blanket rejection. It would also ensure that States receive a full explanation as to why the proposal was rejected. This legislation would also provide Governors more flexibility in deciding how best to utilize the grants. It recognizes that states are in a better position to determine what circumstances constitute significant barriers to employment for their local veterans instead of having DOL establish a few criteria meant to capture all barriers throughout the entire U.S. The bill also encourages states to better coordinate and co-locate with job centers ensuring that DVOPs and LVERs continue to focus on their core mission.

S. 2896, THE "CARE VETERANS DESERVE ACT OF 2016"

PVA's historical experience and extensive interaction with veterans around the country leads us to confidently conclude that veterans prefer to receive their care from the Department of Veterans Affairs (VA). We recognize, however, that while for most enrolled veterans VA remains the best and preferred option, VA cannot provide all services in all locations at all times. Care in the community must remain a viable option.

As we consider legislation designed to reform VA health care, it is important to recognize that VA's specialized services, particularly spinal cord injury care, cannot be adequately duplicated in the private sector. Many advocates for greater access to care in the community also minimize, or ignore altogether, the devastating impact that pushing more veterans into the community would have on the larger VA

health care system, and by extension the specialized health services that rely upon the larger system. Broad expansion of community care could lead to a significant decline in the critical mass of patients needed to keep all services viable. We cannot emphasize enough that all tertiary care services are critical to the broader specialized care programs provided to veterans. If these services decline, then specialized care is also diminished. The bottom line is that the SCI system of care, and the other specialized services in VA, do not operate in a vacuum. Veterans with catastrophic disabilities rely almost exclusively upon the VA's specialized services, as well as the wide array of tertiary care services provided at VA medical centers. Specialized services, such as spinal cord injury care, are part of the core mission and responsibility of the VA. As the VA continues the trend toward greater utilization of community care, Congress and the Administration must be cognizant of the impact those decisions will have on veterans who need the VA the most.

PVA, along with our Independent Budget (*IB*) partners, Disabled American Veterans (DAV) and Veterans of Foreign Wars (VFW), developed and previously presented to this Committee a framework for VA health care reform. It includes a comprehensive set of policy ideas that will make an immediate impact on the delivery of care, while laying out a long-term vision for a sustainable, high-quality, veteran-centered health care system. Our framework stands on four pillars: 1) restructuring the veterans health care system; 2) redesigning the systems and procedures that facilitate access to health care; 3) realigning the provision and allocation of VA's resources to reflect the mission; and 4) reforming VA's culture with workforce innovations and real accountability. We believe the proposal included in this legislation to make all veterans eligible for the Choice program is not the best avenue to accomplish the goals and principles laid out above, and we cannot offer our support.

While PVA cannot support the proposal to expand and make permanent the current Choice program, there are productive aspects of this legislation. As technology advances and opens access to health care for veterans using telemedicine, the legal parameters of that care need to expand alongside the technology. Permitting a licensed health care professional to treat veterans on behalf of the U.S. Government in any location benefits veterans in the form of greater access and the VA by increasing its pool of employees. This is already in practice with attorneys working for or on behalf of the U.S. Government.

PVA also supports the expansion of operating hours for pharmacies and VA medical facilities to hours comparable to those in the retail industry, and we are glad to see that in this legislation. In a recent survey of PVA members about their experiences with VA health care, one of the most common themes was the lack of access to pharmacy services, particularly beyond normally expected business hours. This provision would alleviate some of those concerns.

S. 2888, THE "JANEY ENSMINGER ACT OF 2016"

PVA understands and supports the intent of S. 2888, the "Janey Ensminger Act of 2016." This legislation would amend the Public Health Service Act with respect to the Agency for Toxic Substances and Disease Registry's (ATSDR) review and publication of illness and conditions relating to veterans stationed at Camp Lejeune, North Carolina, and their families. The bill would require the ATSDR Administrator to review the scientific data pertaining to the relationship between individuals at Camp Lejeune and the suspected resulting illness or condition. The ATSDR Administrator would be required to determine each condition that may be caused by toxic exposure, categorize the level of evidence for these conditions into three categories; sufficient with reasonable confidence that the exposure is a cause of the illness or condition, modest supporting causation, or no more than limited supporting causation. This information would then be published and continually updated on HHS' website. If these evidentiary categorizations are different from previous categorizations those veterans and their families currently receiving care under them would continue to receive that care. Newly registered veterans and family members would receive care based on the list provided by the ATSDR Administrator. Research regarding toxic exposures and the subsequent credibility of presumptive conditions has traditionally been the charge of the Institute of Medicine (IOM). The bill does not discuss the processes should the ATSDR conflict with the findings of the IOM.

S. 2883, THE "DISABLED VETERANS CARE ACT"

PVA strongly supports S. 2883, the "Disabled Veterans Care Act." This legislation would reinstate the requirement for the Department of Veterans Affairs (VA) to provide an annual report to Congress that details its capacity in selected specialized health care services, particularly spinal cord injury and disease (SCI/D). The report includes information such as utilization rates, staffing, and facility bed censuses.

Requiring VA to compile such data into the form of a report to share with Congress annually will lead to more accountability within VA, help ensure more efficient allocation of VA resources, particularly in the area of staffing, and improve veterans' access in VA's specialized systems of care.

Within VA's Spinal Cord Injury and Disease system of care, access to timely care is critical to the health and well-being of this population of veterans. Many of the VA's specialized services and rehabilitative programs have established policies on the staffing requirements and number of beds that must be available to maintain capacity and provide high quality care. The fact is VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans. Reductions in both inpatient beds and staff in VA's acute and extended care settings have been continuously reported throughout the system of care, particularly since the capacity reporting requirement expired in 2008.

When VA facilities do not adhere to these staffing policies and requirements, veterans suffer with prolonged wait times for medical appointments, or in the case of PVA members, have to limit their care to an SCI/D clinic, despite the need for more comprehensive care. There have been instances within VA's SCI/D system of care when staffing positions have gone vacant for long periods of time, and as a result, the facility's bed capacity is diminished, thus decreasing access. An annual capacity report, to be audited by the VA Office of Inspector General, will allow VA leadership and Congress to have an accurate depiction of VA's ability to provide quality care in its specialized systems of care.

This critically important legislation has been a top priority for PVA for years. We applaud Senators Brown, Toomey, Murray, Sanders, Casey and Coons for working to ensure VA is able to provide for the unique health care needs of catastrophically disabled veterans. While we certainly appreciate the fact that this issue is included in the recently passed "Military Construction and Veterans Affairs Appropriations Act for FY 2017," we believe this bill must be pursued until this issue is pushed through to final passage.

S. 2679, THE "HELPING VETERANS EXPOSED TO BURN PITS ACT"

PVA supports S. 2679, the "Helping Veterans Exposed to Burn Pits Act." This proposed legislation would establish within the Department of Veterans Affairs (VA) a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of health conditions relating to exposure to burn pits. The site selected would be equipped to study, diagnose, and treat the health conditions related to burn pits. Additional responsibilities would task VA to determine the best practices for treatment, and to provide guidance for the health systems of VA and DOD in determining the personnel required to enact those best practices. This bill would allow the center to access and use the data accumulated in the burn pit registry.

Across Iraq and Afghanistan, military sites commonly used burn pits for waste disposal. The materials burned were varied but can range from batteries to human waste. With limited means for disposing of trash, the burning of waste and the subsequent inhalation of those fumes are an unavoidable certainty. Not unlike the experience of veterans exposed to Agent Orange following the Vietnam War, veterans with conditions likely attributable to burn pits face difficulties proving exposure as well. The scientific linkages have yet to be made conclusive enough. As a result, veterans' access to health care and benefits is compromised. VA maintains that research thus far has failed to provide the link between exposure and long-term disease. Until such research is conducted, affected veterans continue to wait for answers, validation, and treatment. For veterans exposed to Agent Orange this wait lasted decades. This country has a responsibility to determine the cause of and treat the conditions that result from one's service.

S. 2520, THE "NEWBORN CARE IMPROVEMENT ACT"

PVA supports S. 2520, the "Newborn Care Improvement Act," a bill to amend Section 1786 of title 38, United States Code, to authorize hospital stays of up to 14 days for newborns under VA care. The current provision allows for a maximum stay of seven days. As the average hospital stay for a healthy newborn is two days, S. 2520 would provide enormous relief for families facing complications immediately after birth or severe infant illness.

S. 2487, THE "FEMALE VETERAN SUICIDE PREVENTION ACT"

PVA strongly supports S. 2487, the "Female Veteran Suicide Prevention Act." This bill would direct the Secretary of Veterans Affairs to identify mental health care and suicide prevention programs and metrics that are effective in treating women veterans. Newly published data by VA determined that female military vet-

erans commit suicide at nearly six times the rate of other women. For young women, ages 18–29, the suicides are twelve times as high. The rate among women veterans nearly reaches the rate of male veterans. Of the annual suicide deaths per 100,000 people, male veterans comprised 32.1, and non-veteran men 20.9. Among women veterans they comprised 28.7 compared to just 5.2 among non-veteran women. This is a particularly concerning statistic since men, on average, are far more likely than women to commit suicide. VA is woefully ill-equipped to address women veterans' mental health needs, particularly as relates to risk for suicide. S. 2487 would make a first and giant step in addressing these inadequacies.

S. 2049, to establish in the Department of Veterans Affairs a continuing medical education program for non-Department medical professionals who treat veterans and family members of veterans

PVA supports S. 2049, to establish in the Department of Veterans Affairs a continuing medical education program for non-Department medical professionals who treat veterans and family members of veterans. Veterans suffer from a wide range of medical issues that are not experienced by the majority of the American population. Continuing medical education that focuses on veterans' issues will better prepare these medical professionals to provide care for veterans.

DISCUSSION DRAFT—REVISION OF EVIDENTIARY THRESHOLD FOR MEDICAL EXAMINATIONS AND OPINIONS

PVA is opposed to the draft bill "Revision of Evidentiary Threshold for Medical Examinations and Opinions." This bill attempts to increase the burden on the claimant, specifically those who have not deployed in combat, to demonstrate evidence of service connection. "Objective" evidence is a high standard, and requiring a veteran to meet it undermines the very purpose of VA's statutory duty to assist. In fact, 38 U.S.C. 5103(a)(2) makes clear that the Secretary's duty to assist is not required only in circumstances where there is no "reasonable possibility" that such assistance would aid in substantiating the claim. If there is a reasonable possibility that an exam would aid a veteran in adequately presenting his or her claim, this provision would block that assistance unless the veteran first clears this new substantial hurdle of showing objectively that service-connection exists.

It is exceedingly rare for a claimant to have to argue the need for an exam under the current provisions in § 5103(d). This will certainly provoke numerous appeals, right at a time when the VA and VSO community are trying to tackle the appeals backlog. This provision is also somewhat redundant, if not confusing, if one attempts to reconcile it with subsection (2)(c). Veterans should have access to the tools necessary to adequately present their claims. This bill instead appears to be reminiscent of a time when veterans were required to submit "well-grounded" claims.

DISCUSSION DRAFT—VETERANS MOBILITY SAFETY ACT OF 2016

PVA strongly supports the draft bill "Veterans Mobility Safety Act of 2016" submitted for discussion by Senator Moran. The adaptive automobile equipment grant is an important issue for PVA members, as they are the highest users of this particular benefit. Those veterans with catastrophic disabilities have a critical need for mobility to help maintain a high quality of life and allow them to continue to be active members of their community despite their disability. PVA supports the effort to ensure veterans with mobility impairment receive adaptive equipment and adaptations that meet industry standards and specifications. As technology advances, new automotive adaptive devices continue to open the door to more drivers with disabilities. Each person with a mobility issue is unique and has individual requirements and specific features that will allow them to feel confident and comfortable while they drive.

The law as it is currently written requires that before providing an automobile under this section, the Secretary determine that the eligible person is able to operate the vehicle safely. In response to this provision, Veterans currently receive training from the VA Driver's Rehabilitation Program on how to safely operate their new vehicle or equipment before embarking out onto public roadways. VA also has a requirement to monitor the quality of the equipment being installed. But VA is not required to ensure that those installing adaptive equipment on vehicles for disabled veterans are qualified to do so. The bulk of the training and monitoring the quality of equipment being issued is rendered meaningless if the adaptive equipment itself fails. Requiring that vendors offering such services be certified is simply a matter of due diligence in line with the previously mentioned requirements. One can easily recognize the gravity of harm that can ensue upon not only the veteran, but other motorists, passengers and pedestrians when this type of equipment fails due to faulty installation or repairs.

It is also important that VA remain good stewards of tax payer dollars. When a veteran hires an unqualified installer, and the vehicle fails, either the veteran is stuck trying to mend the situation or the VA is stuck with an avoidable secondary bill.

The companion bill currently being considered by the House Committee on Veterans Affairs, H.R. 3471, originally produced inadvertent consequences, particularly with regard to promoting or creating certain conflicts of interest. The text in front of us today mirrors the substantial improvements reflected in the recently amended version of H.R. 3471 that PVA pushed for in the House to ensure that veterans remain the focus of this legislation, not private industry. It brings together industry stakeholders and the veteran community that stands to be directly impacted to construct a policy which establishes standards without inhibiting industry growth and technological advancement. It also ensures that choice/access remain viable for rural veterans without compromising safety.

Section (3)(e) is unnecessary and, at worst, might contradict the provision in Section (3)(b)(4), which permits the Secretary to designate organizations who meet or exceed the standards developed under this Section to certify providers. The importance of (3)(b)(4) is paramount, as it ensures that providers who already adhere to high quality standards are not penalized by this bill and forced to undergo another round of certification unnecessarily. It also facilitates the implementation of this legislation by having providers available and not awaiting certification. Ultimately the conflicts that arose in the original text in H.R. 3471 were addressed by changing the structure of the bill and removing the construction of standards from the grasp of private industry.

DISCUSSION DRAFT—TO EXPAND ELIGIBILITY FOR RURAL VETERANS

With the imminent sunset of Project ARCH in August 2016, this bill would expand eligibility under the current Choice program to any veteran who has at one time or another received health services under Project ARCH. There should be a caveat to this provision which contemplates the possibility of a veteran having moved or will move his or her residence in the future to a location where access to care in the community is unnecessary. As authorities are shifted in statute, the bill should also ensure the resources and ability to preserve existing contracts with the providers who currently serve veterans enrolled in ARCH are also addressed so that services are not disrupted.

DISCUSSION DRAFT—PROVISIONS FROM THE CONSTRUCTION REFORM ACT OF 2016

PVA supports the discussion draft including provisions from the Construction Reform Act of 2016, a bill to make certain improvements in the administration of Department medical facility construction projects. In light of the egregious construction management failures in places like Denver, Colorado, Orlando, Florida, and New Orleans, Louisiana, a serious discussion about VA's responsibility in the construction business has taken place. This bill serves to support steps that have already been taken to improve construction management at VA. We appreciate the Committee focusing on this important issue.

APPEALS REFORM

PVA has a highly trained force of over 70 service officers who spend two years in specialized training under supervision to develop veterans' claims for both our member and non-member clients. PVA maintains a national Appeals Office staffed by attorneys and legal interns who represent clients at the Board of Veterans' Appeals. We also have attorneys who practice before the Board and before the Court of Appeals for Veterans Claims which enables continuity of representation throughout subsequent appellate court review.

In March 2016, the Veterans Benefits Administration (VBA), the Board and major veterans service organizations (VSO's) partnered to form a working group with the goal of reforming the appeals process. The number of pending appeals has surpassed 440,000. If the process goes unaddressed, VA projects that the appeals inventory will climb to over two million over the course of the next decade. Experienced Veteran Law Judges (VLJ) who adjudicate appeals are a commodity and form a critical component of the system. This attribute limits VA's ability to scale its resources to the extent necessary to deal with such an inventory. Ten years from now, if the system remains unchanged, veterans will expect to wait six years for a decision. We believe reform is necessary, and we support this legislation moving forward.

PVA is encouraged by VA's ambitious efforts to achieve reform. The haste with which it desires to move, though, invites caution from those who recognize that overhauling such a complex process will produce unintended consequences. While

we have a responsibility to serve the veteran community and tackle problems, we also have the responsibility to ensure that in doing so we do not leave veterans worse off. VA has recognized that VSO's have specific concerns and has worked with us to find solutions that move us forward without diluting veterans' rights in the process.

It is important that as we approach this major issue that we do not lose sight of the fact that veterans have earned these benefits through the highest service to their country and have every right to pursue these earned benefits to the fullest. As we promote and seek public support for change, it is easy to use statements such as, "there are veterans who are currently rated at 100% who are still pursuing appeals," to illustrate the problems that pervade the system. PVA will be the first to point out, though, that a veteran rated at 100% under 38 U.S.C. § 1114(j) might also be incapacitated to the point that he or she requires 24 hour caregiver assistance. A 100% service-connected disability rating does not contemplate the cost of this care, and veterans may seek special monthly compensation (SMC) to the tune of thousands of dollars needed to address their individual needs. Few people would disagree that pursuing these added disability benefits are vital to a veteran's ability to survive and maintain some level of quality of life. Without clarification, such statements lead people to believe that veterans are the problem.

This is why PVA believes it is so important to ensure that VSO's remain as involved in the follow-on development process and implementation as they are now if this plan is to succeed. This is a procedural overhaul, and VSO's are the bulwark that prevents procedural change from diluting the substantive rights of veterans. Notwithstanding the strong collaboration between VA and the various stakeholders over the last few months, many important questions remain unanswered at this stage in the development process.

THE FRAMEWORK

There is no shortage of news articles and academic pieces that attempt to illustrate for readers the level of complexity and redundancy in the current appeals process. It is a unique system that has added layer after layer of substantive and procedural rights for veterans over the years. The most notable aspect differentiating it from other U.S. court systems is the ability for a claimant to inject new evidence at almost any phase. While this non-adversarial process offers veterans the unique ability to continuously supplement their claim with new evidence and seek a new decision, it prevents VA from accurately identifying faulty links in the process, whether it be individual raters or certain aspects of the process itself.

As the working group came together and began considering ways to address the appeals inventory, it became clear that a long-term fix would require looking beyond appeals and taking a holistic view of the entire claims process. The work product in front of us today proposes a system with three distinct lanes that a claimant may enter following an initial claims decision—the local higher-level review lane, the new evidence lane, and the Board review lane. The work horse in this system is the new evidence lane. The other two serve distinct purposes focused on correcting errors.

When a claimant receives a decision and determines that an obvious error or oversight has occurred, the local higher-level review lane, also known as the difference of opinion lane, offers a fast-track ability to have a more experienced rater review the alleged mistake. Review within this lane is limited to the evidence in the record at the time of the original decision. It is designed for speed and to allow veterans with simple resolutions to avoid languishing on appeal.

If a claimant learns that a specific piece of evidence is obtainable and would help him or her succeed on their claim, the new evidence lane offers the option to resubmit the claim with new evidence for consideration. VA indicates that its goal is a 125-day turn around on decisions within this lane. Another important aspect is that the statutory duty to assist applies only to activity within this lane.

The third lane offers an appeal to the Board. Within this lane there are two tracks with separate dockets. One track permits the addition of new evidence and option for a Board hearing. The other track permits a faster resolution by the Board for those not seeking to supplement the record. A claimant within this track will not be permitted to submit new evidence, but they will have an opportunity to provide a written argument to accompany the appeal.

If the claimant receives an unfavorable opinion at the Board, he or she may either revert to the new evidence lane within one year or file a notice of appeal with the Court of Appeals for Veterans Claims within 120 days. Unfavorable decisions at the Court would be final, and the claimant would no longer have the benefit of the original effective date associated with that claim.

One of the most beneficial aspects of this new plan is the protection of the effective date. Choosing one lane over the other does not limit the ability to later choose a different lane. The decision to enter any of the lanes must be made within one year of receiving the previous decision. Doing so preserves the effective date relating back to the date of the original claim. Another major issue with the claims process that is addressed in this plan is improved decision notices. A thorough understanding of why a claimant received an adverse decision leads to educated decisions with regard to subsequent lane choices or discontinuing the claim altogether.

PVA'S CONCERNS

PVA is concerned with the dissolution of the Board's authority to procure an independent medical examination or opinion (IME) under 38 U.S.C. § 7109. VA originally proposed to dissolve this authority in order to maintain consistent application of the concept of having all development of evidence take place at the Agency of Original Jurisdiction (AOJ) level in the New or Supplemental Evidence Lane. Throughout extended discussions and negotiations on this topic, PVA has worked with the Board to find an alternative authority supported by certain administrative commitments which would collectively preserve the function of § 7109. While we believe the outright removal of § 7109 is a choice of form over substance which disproportionately affects our members, we think if certain provisions are added to this bill they might preserve the core attributes of § 7109 to an acceptable level.

An IME is a tool used by the Board on a case-by-case basis when it "is warranted by the medical complexity or controversy involved in an appeal case." § 7109(a). The veteran may petition the Board to request an IME, but the decision to do so remains in the discretion of the Board. The Board sua sponte may also request an IME. VA's standard for granting such a request is quite stringent. 38 CFR 3.328(c) states, "approval shall be granted only upon a determination ... that the issue under consideration poses a medical problem of such obscurity or complexity, or has generated such controversy in the medical community at large, as to justify solicitation of an independent medical opinion." The number granted each year usually amounts to no more than 100 with approximately 50% being requested by the Board itself. Experienced Board personnel thoroughly consider the issues which provoke the need for an outside opinion. Complicating the process further, the Court of Appeals for Veterans Claims (CAVC) has carefully attempted to set parameters for the proposed questions to be answered by experts. A question presented to a medical expert may neither be too vague, nor too specific and leading. A question too vague renders the opinion faulty for failing to address the specific issue, while a question too specific tends to lead the fact finder to a predisposed result.

By simply striking § 7109 in its entirety, the current bill proposes to delegate the procurement of an IME to the AOJ under preexisting authority found in 38 U.S.C. § 5109. PVA recommends retaining the authority found in § 7109. By its nature, an IME tends to address the most complex medical scenarios. Removing this tool from the purview of the Board would undermine the reality that properly presenting questions to the participating expert is best left to the judge seeking to resolve the medical controversy or question. VA's recommendation implicitly suggests that AOJ staff members are equipped with the requisite level of experience to carry out this delicate exercise. Even more worrisome is that in the current claims processing system, IME's are almost exclusively requested at the Board level, despite the AOJ's existing authority to procure one. This begs the question of how many rating officers have the experience and expertise to even identify the need for an IME, let alone to draft a nuanced question that would comport with veterans law jurisprudence.

Dissolving § 7109 would have the additional effect of abolishing the centralized office of outside medical opinions. This small staff has played a vital role in facilitating IME's and maintaining their effectiveness by developing relationships with doctors who are experts on particular subjects and willing to do this tedious task for almost no money. This office not only expedites the receipt of opinions, but it also ensures a high level of quality. Now this concentrated effort conducted by a group of people thoroughly versed in the IME process will simply disintegrate in favor of IME's being requested, maybe, by a savvy rating officer who has the wherewithal to recognize the need. Even in such a fortuitous circumstance, the rating officer will be left to fend for itself in finding a qualified and willing expert to conduct the task—something this office would have done for them.

If the Committee intends to strike § 7109, we would ask to have included the mitigating language reflected in the House companion bill, H.R. 5083. PVA worked with VA to reduce the impact by supplementing § 5109 with a new subsection (d) and § 5103B(c)(2). This approach, however, still discards a properly functioning organ of the Board in favor of more bureaucracy. IME's generally have a fast turn-around

at the Board, and the weight of the opinion is often significant enough to bring finality to a claim. It is possible that VA could preserve the function of the office of outside medical opinions in some fashion, perhaps consolidating it under VBA's authority. The Board has considered our suggestions and alternative proposals in this regard. VA's senior leadership has committed to PVA that it will take the necessary steps to preserve the best practices and resources of this office. PVA highly recommends that if this Committee is entertaining striking § 7109, it should obligate VA to explain how it plans to mitigate against the loss of this office and the Committee should conduct oversight during implementation. Similarly, the decreased efficiency with having the process conducted at the AOJ level is concerning. Instead of the VLJ requesting an IME and receiving the opinion, now a second person must review the claim—the rating officer who received the file on remand. If a veteran wishes to appeal this re-adjudication, PVA has asked for and received VA's commitment to reroute the appeal by default, with exceptions, back to the same VLJ who remanded the case to avoid yet another person having to review a claim with enough medical complexity to warrant the IME.

Under the proposed plan the Board would limit remands to errors related to VBA's duty to assist under 38 U.S.C. § 5103A. There are, however, circumstances where the AOJ received two separate examinations and honored the duty to assist, but an IME is needed to resolve conflicting opinions. The current language in the draft bill does not provide the Board the ability to remand a case with an order to procure an IME to resolve the conflict in evidence. Of course, we would also note that such a situation could easily be resolved if VA would better adhere to its own reasonable doubt provision when adjudicating claims. We still see too many VA decisions where this veteran-friendly rule is not properly applied. More often it appears VA raters exercise arbitrary prerogative to avoid ruling in favor of the claimant, adding obstacles to a claimant's path without adequate justification. While due diligence in gathering evidence is absolutely necessary, too often it seems that VA is working to avoid a fair and legally acceptable ruling favorable for the veteran. Both the failure to accept and tendency to devalue non-VA medical evidence are symptoms of this attitude.

We also recommend an additional jurisdictional safeguard for the Board. In 38 U.S.C. § 7104, it would be helpful to include language that addresses situations where the Board finds that an appeal presents extraordinary circumstances. The Board, in its sole discretion, should be able to retain jurisdiction over a remand of that appeal.

A second concern that must be noted is the fact that the problem that brought us to the table in the first place is not addressed in this plan—the current bloated appeals inventory. It is extremely difficult to place an effective date on this legislation in the absence of a plan to address the inventory. This legislation is a way to prevent the inventory from growing, it is not the answer to reducing the current inventory. Blurring this distinction should be avoided. The question of how this plan should be implemented in light of the current situation deserves serious scrutiny that can only be applied by further collaboration between VA and the stakeholders involved in this process thus far. We have not considered the question of whether this system could be integrated immediately (taking into account the time needed to promulgate the necessary rules and regulations) or if steps to reduce the backlog are needed first.

The plan presented here today is predicated on an expectation that decisions in the middle lane will be adjudicated within an average time of one hundred and twenty-five days. As a result of the Fully Developed Claims process and other efforts that included a surge in resources and mandatory overtime, VBA is currently doing well in achieving this average wait time for initial claims. And while that is encouraging for the plan we are contemplating here, the present state of affairs could be misleading, and we have not had the opportunity to consider the impact on that wait time if the new system were implemented and suddenly altered the current workflow. Also left unaddressed is the resource requirement that might balloon if the plan runs parallel to the current system until all pending claims are phased out and resolved. Adequate resources will be essential to weather the growing pains as this new system is laid in. Leaving these kinds of questions unanswered and moving forward invites the possibility of trading one mangled system for another.

Some stakeholders have expressed concern over the replacement of the "new and material" evidence standard with "new and relevant." PVA believes this is an acceptable standard for veterans to meet. It is true that the number of appeals in the system currently disputing a decision that evidence submitted was not deemed "material" may be as high as 20 percent. The concern is that changing "material" to "relevant" will simply exchange one appealable issue for another. A clever idea was put forward to have VA simply deny the claim if it found that the new evidence

submitted was not relevant. This would prevent a veteran from appealing the relevance determination, and thereby significantly reduce the number of forthcoming appeals. However, this discounts two things. The first is that "relevant" is a significantly lower legal threshold than "material." Therefore, most determinations will actually lead to the admission of the evidence, and, therefore, fewer appeals. The second is that it might have the counter-intuitive effect of creating a bigger slow-down as raters are forced to issue full decision notices when they deny a claim instead of simply finding that the evidence was not relevant.

PVA was a supporter early on of judicial review, and we believe the availability of that review has improved the appeals process for veterans. We are concerned that this proposal could limit a veteran's access to court review, and would be happy to work with the Committee on creating assurances that this path remains an open and effective means to correct error in individual cases as well as to correct agency misinterpretations of the law.

We also have concerns about whether some language as drafted will reflect the promises made in those long meetings. For example, it is our understanding that reform will not impact the availability of the duty to assist but it will only be enforced on remand to the AOJ, yet as proposed, the language on this issue is confusing. We suggest a clearer approach, so that veterans have the assurance they are not losing any existing protections in this reform.

Finally, this is not simply a VA problem. As stated earlier, PVA has many service representatives and spends a great deal of time, funds, and effort on ensuring they accomplish their duties at a high level of effectiveness. However, it is important that veterans and their representatives also share responsibility when appeals arrive at the Board without merit. A disability claim that is denied by VBA should not automatically become an appeal simply based on the claimant's disagreement with the decision. When a claimant either files an appeal on his own behalf, or compels an accredited representative to do so with no legal basis for appealing, that appeal clogs the system and draws resources away from legitimate appeals. Since 2012, PVA has taken steps to reduce frivolous appeals by having claimants sign a "Notice Concerning Limits on PVA Representation Before the Board of Veterans' Appeals" at the time they execute the Form 21–22 Power of Attorney (POA) form. PVA clients are notified at the time we accept POA that we do not guarantee we will appeal every adverse decision and reserve the right to refuse to advance any frivolous appeal, in keeping with VA regulations.

PVA believes that substantial reform can be achieved, and the time is ripe to accomplish this task. Our organization represents clients with some of the most complex issues, and we cannot stress enough that moving forward should not be done at the expense of the most vulnerable veterans. We must remain vigilant and appreciate the benefits of bringing together the variety of stakeholders who are participating and bringing different perspectives and viewpoints—it is a healthy development process that ensures veterans remain the focus.

Thank you for this opportunity to present PVA's views on the pending legislation before the Committee and I would be happy to answer any questions you may have.

Chairman ISAKSON. Thank you, Mr. Blake.

Ms. Rauber.

STATEMENT OF DIANE BOYD RAUBER, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF VETERANS' ADVOCATES, INC.

Ms. RAUBER. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, the National Organization of Veterans' Advocates thanks you for the opportunity to offer testimony on pending legislation. We limit our testimony today to the draft appeals reform bill and the discussion draft on the evidentiary threshold for medical examinations and opinions.

NOVA supports improving the appeals process for veterans and endorses several features of the appeals reform bill as detailed in our written statement. Briefly, these provisions include the requirement that VA provide detailed notice of a decision, effective date relief after a BVA decision, the elimination of redundant procedural steps, a mandate requiring VA to be bound by favorable findings, and the veteran's continued right to engage an attorney.

While these provisions represent a step in the right direction, there remains areas of concern that require additional Congressional scrutiny. We have expanded on those in our written statement, so I will only highlight a few here today.

First, it is unfair to limit effective date relief solely to VA and BVA decisions without allowing for the same relief after a final CAVC decision. This limitation will discourage veterans from exercising their hard fought right of judicial review, because a conscientious advocate is unlikely to advise a veteran to appeal to court and risk losing the earlier effective date if there is any chance it could be preserved by submitting new and relevant evidence after the BVA decision. To prevent a chilling effect on judicial review, effective date protection should be extended to a year after a court decision. Extension of this protection would, in fact, affect a relatively small number of cases, because veterans lost less than half of the roughly 4,000 court appeals decided in 2015.

VA has also taken the position that a veteran could not simultaneously seek judicial review of a BVA denial and file a supplemental claim before VA to preserve the original effective date. Foreclosing the opportunity to pursue both avenues of relief is not only contrary to the veterans'-friendly scheme designed by Congress, it potentially prevents the court from correcting prejudicial legal errors. Congress should clarify that a veteran may pursue both avenues of relief simultaneously.

In addition, the framework does not clearly address how the existing 445,000 appeals will be resolved. There is a huge difference between the veteran who files her NOD today and the veteran whose 5-year-old appeal is now waiting at BVA for a decision. Based on recent discussions, VA appears reluctant to allow for any voluntary opt-in or to provide specifics about docket management. We cannot endorse any proposal that does not resolve these issues.

NOVA has several concerns regarding docket management. Multiple dockets could result in unjust treatment for separate classes of veterans. If multiple dockets are created, a formula needs to be developed for docket management.

Furthermore, VA should allow a veteran who chooses to submit evidence only to join the non-hearing docket. Because this evidence will not trigger any duty to assist obligation for BVA, there is no reason BVA cannot consider these appeals in the non-hearing lane.

In addition, VA should only require new evidence for supplemental claims. VA has replaced the material standard with relevant. Merely trading relevant for material will not significantly reduce the adjudication burden for VA. Removing relevant eliminates the need for a threshold determination and allows VA to adjudicate the merits.

The success of this reform hinges on VA's ability to consistently issue rating decisions in a 125-day window and decide appeals in a year. As demonstrated with the claims backlog and scheduling of medical appointments, VA often struggles to meet its own internal goals, to the detriment of veterans.

Furthermore, VA has demonstrated significant difficulty obtaining adequate medical examinations and opinions, which result in frequent remands. Without substantive reform to this process, to include consideration of a greater role for private and treating phy-

sician evidence, it is unlikely procedural reform can alone solve systemic problems.

This brings me to VA's proposal to require a veteran to provide objective evidence, such as medical records, service records, or accident reports, before requiring VA to provide an examination. NOVA opposes this provision. Such a heightened standard would effectively shut out many veterans who are not entitled to the relaxed standards of 38 U.S.C. Section 1154(b) as combat veterans. Many in-service symptoms or incidents may not be documented because a veteran does not consider them serious enough to require treatment, or in some instances, such as psychological symptoms, may choose not to report them for fear of demotion or separation.

Mr. Chairman, NOVA shares the concern that veterans wait too long for a decision on appeal. We welcome the opportunity to continue to work with this Committee and VA to achieve fair appeals reform.

We thank you again for allowing us to address these proposed bills and I would be pleased to take any questions.

[The prepared statement of Ms. Rauber follows:]

PREPARED STATEMENT OF DIANE BOYD RAUBER, ESQ., EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF VETERANS' ADVOCATES, INC.

On behalf of the National Organization of Veterans' Advocates (NOVA), I would like to thank Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee for the opportunity to offer our views on pending legislation. NOVA will limit its testimony to the draft bill addressing appeals reform and the discussion draft on the evidentiary threshold for medical examinations and opinions.

NOVA is a not-for-profit 501(c)(6) educational membership organization incorporated in the District of Columbia in 1993. NOVA represents more than 500 attorneys and agents assisting tens of thousands of our Nation's military veterans, their widows, and their families seeking to obtain their earned benefits from VA, and works to develop and encourage high standards of service and representation for all persons seeking VA benefits. NOVA members represent veterans before all levels of the VA's disability claims process. In 2000, the United States Court of Appeals for Veterans Claims recognized NOVA's work on behalf of veterans with the Hart T. Mankin Distinguished Service Award. NOVA operates a full-time office in Washington, DC.

DRAFT BILL TO REFORM THE RIGHTS AND PROCESSES RELATING TO APPEALS OF DECISIONS REGARDING CLAIMS FOR BENEFITS UNDER THE LAWS ADMINISTERED BY THE SECRETARY OF VETERANS AFFAIRS

Background

VA currently reports that there are over 455,000 appeals in the entire system, and estimates the number of appeals will rise to two million over the next decade without reform. In addition, there are more than 60,000 pending hearing requests. Since BVA currently only has the capacity to hold approximately 11,000 hearings per year, a veteran can wait several years to have a hearing.

To address this problem, VA proposed a "simplified appeals process" in its 2017 budget for BVA. The process proposed by VA included several concepts contrary to the veteran-friendly system created by Congress, such as closing the record and denying veterans the due process right to be heard before BVA. Department of Veterans Affairs, *Congressional Submission, FY 2017, Vol. III* at BVA 280–83 (February 9, 2017). VA presented this proposal as a "straw man" designed to draw stakeholders into discussions on reforming the appeals process.

As a result, numerous organizations, including NOVA, participated in a three-day summit with VA officials and continue to participate in ongoing meetings to discuss appeals reform. Deputy Secretary Sloan Gibson charged the group with developing an appeals process that is timely, fair, easy to understand, transparent, and preserves veterans' rights.

One issue raised by NOVA and other stakeholders is the need for all accredited representatives to have complete access to clients' electronic files. This issue has been a NOVA priority since the advent of the Veterans Benefits Management Sys-

tem (VBMS). On April 13, 2016, VA issued a memorandum instructing regional office personnel to process attorneys and agents for the background checks required for access. While we appreciate VA's response and look forward to implementation, NOVA maintains full access must be achieved for any reform to be successful and VA must commit to ongoing improvements to existing electronic systems that are critical to meaningful representation.

NOVA appreciates the opportunity to have a seat at this table and participate in the dialog. However, as set forth in more detail below, while NOVA supports the concept of improving the appeals process for veterans and endorses several features of the proposed reform, there remains areas of serious concern that require additional congressional scrutiny.

LEGISLATIVE PROVISIONS NOVA SUPPORTS

Requirements for detailed notice of the decision are included in the statute.

The declining quality of VA rating decisions and notice has been cited by stakeholders numerous times over the years as the primary problem in the claims process. Efforts by VA to improve notice have been unsuccessful. The participants in VA's appeals summit agreed that detailed notice of the rating decision is critical to making an informed decision regarding further review. Proper notice allows a veteran to understand the reasons for the underlying rating decision and enables an advocate to provide a veteran with the best possible advice on the evidence needed to prove a claim.

The proposed language to amend 38 U.S.C. § 5104 is an important first step in reform, but only if properly implemented by VA. VA's proposed process hinges heavily on a change VA has always had the authority to make, but has been unsuccessful to date in doing so. VA will need to commit to extensive training of its regional office employees to provide adequate notice and well-written decisions. Without it, the new process could result in another backlog at the local level.

Effective date protection is extended to BVA decisions.

The draft proposal removes many procedural and due process protections for veterans. To a degree, the removal of these protections is offset by the primary benefit conferred to veterans: the ability to preserve the effective date of a claim denied in a BVA decision by filing a "supplemental claim" within a year of that denial (with no limit to the number of times the veteran can avail himself of this option).

The legislation calls for the same process following a rating decision, but it does not meaningfully expand a veteran's rights beyond what is already permitted under 38 CFR § 3.156(b). NOVA supports this regulatory provision being included in the statute. Furthermore, NOVA recommends the provisions of 38 CFR § 3.156(c) also be codified in the statute as an important protection for the effective date of claims for veterans who find additional service records after the original claim.

Allowing a veteran to file a supplemental claim following a BVA denial is a positive development, and we believe it must remain part of any reform package considered. It is not without a downside however. As mentioned below, without expansion to denials by the United States Court of Appeals for Veterans Claims, this proposal as written would likely dilute the court's oversight function.

The proposed bill eliminates redundant procedural steps.

NOVA has historically supported the amendment of 38 U.S.C. § 7105 to eliminate the redundant requirements of a statement of the case (SOC) and substantive appeal. See, e.g., Veterans' Dilemma: Navigating the Appeals System for Veterans Claims: Hearing Before the Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs, 114th Cong., 1st Sess. 37, 112 (2015)(statement of Kenneth M. Carpenter, Esq., Founding Member, National Organization of Veterans' Advocates). NOVA maintains that, as a result of judicial review, the need for an SOC and affirming substantive appeal no longer exists.

As the number of claims has risen, in turn resulting in more appeals, these procedures have become the source of growing delays. For example, VA reported in 2015 an average of 405 days passed between filing of the notice of disagreement (NOD) and VA's issuance of the SOC. Furthermore, the average days from the time of the substantive appeal to BVA certification was 630 days. Department of Veterans Affairs (VA) Appeals Data Requested by House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs (January 2015). NOVA maintains that any minimal value in these procedural steps is far outweighed by the delays, which serve to age the evidence in the veteran's file and drive the need for additional development through remand.

Under the proposal, once the veteran determines he or she wishes to appeal to BVA, the NOD will serve as the only requirement to initiate an appeal. Further-

more, the notice elements statutorily required in this provision, if executed properly, improve upon the current notice and SOC. Elimination of post-NOD procedure will not only allow the veteran to get an appeal to BVA faster, it should free up VA personnel to decide and rate claims faster at the agency of original jurisdiction.

A veteran is assured favorable findings made by VA will continue throughout the life of a claim/appeal.

Newly created section 5104A mandates that any favorable findings made on behalf of a veteran are binding on all subsequent adjudicators within VA, absent clear and convincing evidence to the contrary. This provision not only protects a veteran during the adjudication process, it saves VA time because there will be no need to reconsider resolved elements of a claim in subsequent decisions.

A veteran retains the right to engage an attorney.

Under existing 38 U.S.C. § 5904, a veteran may enter into a fee agreement with an attorney or agent at the time the NOD is filed. The proposed bill changes that language to allow a veteran to exercise this right at the time the initial rating decision is issued. Since VA is now providing more than one adjudicatory choice to a veteran after the initial decision, it makes sense that a veteran should have the freedom and personal choice to engage an attorney at that time to obtain counsel on the best option to choose.

LEGISLATIVE PROVISIONS OF CONCERN TO NOVA

The draft bill limits effective date relief after judicial review.

It is inconsistent to limit effective date relief solely to decisions of the agency of original jurisdiction and BVA. Specifically, under the draft bill, a veteran who is dissatisfied with any rating decision has one year to seek higher level review, submit new evidence in the form of a supplemental claim, or file an appeal to BVA, while preserving the effective date of the first claim. The proposal also allows for the same one-year period after a BVA decision to submit new evidence in the form of a supplemental claim. However, there is no such allowance for the same one-year period after a final decision of the United States Court of Appeals for Veterans Claims.

NOVA believes this limitation will result in far fewer veterans exercising their hard-fought right of judicial review, because it is rare that a conscientious advocate would risk the loss of an effective date by appealing to the court when the effective date could be preserved with the submission of "new and relevant" evidence.

NOVA therefore recommends section (a)(2)(E) be added to 38 U.S.C. § 5110: "(E) a supplemental claim under section 5108 of this title within one year of any final decision issued by the United States Court of Appeals for Veterans Claims."

Furthermore, VA has taken the position during its appeals summit meetings that a veteran could not simultaneously seek review of a BVA denial before the United States Court of Appeals for Veterans Claims and exercise his or her right to submit new evidence before VA within a year of that decision to preserve the original effective date. Under the current appeals structure, a veteran may seek judicial review and file a reopened claim as contemplated under the existing version of section 5108.

By foreclosing the opportunity to pursue both avenues of relief, VA is forcing a veteran to choose between seeking review of legal error in BVA's decision or filing a supplemental claim in the hope of preserving the original effective date. Such a result is not only contrary to the veteran-friendly scheme designed by Congress, it potentially prevents the court from correcting prejudicial legal errors, e.g., statutory violations or misinterpretations of law.

To remedy this situation, Congress should add the following language to 38 U.S.C. § 5108:

> After a decision of the Board of Veterans' Appeals that disallows a claim, nothing in this title shall be construed to limit the right to pursue at the same time both (i) an appeal of such Board decision to the United States Court of Appeals for Veterans Claims under chapter 72 of this title and (ii) a supplemental claim under this section seeking readjudication of the claim disallowed by such Board decision.

Furthermore, under 38 U.S.C. § 5110, subsection (a)(3) should be redesignated as subsection (a)(4) and the following subsection (a)(3) be added:

> (3) For purposes of subsection (a)(2), a claim is continuously pursued by filing a supplemental claim under section 5108 of this title within one year of a decision of the Board of Veterans' Appeals without regard to either (i) the filing under chapter 72 of this title of a notice of appeal of such Board

decision or (ii) the final decision of the Court of Appeals for Veterans Claims under chapter 72 of this title.

Proper docket management is essential to ensure veterans receive equal treatment.

This proposal creates one docket at BVA for cases in which a veteran requests a hearing or submits evidence following an NOD and another docket for cases in which nothing is added to the record after the NOD. We disagree with the creation of two dockets, as there is simply no good reason to treat these cases differently. We have seen from VA's past treatment of claims not defined as part of "the backlog" that, whatever VA's current intent may be, if a law creates an incentive for one kind of case to be adjudicated over another type of case, that is what will occur. Veterans who request a hearing or submit evidence should not be punished with a longer wait. We therefore recommend that there be only one docket at BVA, and that all cases before BVA be worked in docket order.

At the very least, if two dockets are created, a formula needs to be developed for docket management and included in section 7107. A formula is necessary to ensure every case is in a measurable "lane," so data can be collected and accountability achieved. VA should be required to provide stated goals for timely adjudication of both dockets as well as a formula. In the alternative, there should be language to require VA to create such a formula within a reasonable period after enactment to ensure dockets are maintained fairly.

Furthermore, if two dockets are created, VA should allow a veteran who chooses to submit "evidence only" to join the "non-hearing" docket. Given that this evidence will not trigger any duty to assist obligation for BVA, there is no reason BVA cannot consider these appeals in the "non-hearing" lane. Under this scenario, NOVA recommends 38 U.S.C. § 7107(a) be amended to read as follows:

> (a) DOCKETS—IN GENERAL.—The Board shall maintain two separate dockets. A non-hearing docket shall be maintained for cases in which (1) no Board hearing is requested and no evidence is submitted or (2) no Board hearing is requested and evidence is submitted. A separate and distinct hearing option docket shall be maintained for cases in which a Board hearing is requested. Except as provided in subsection (b), each case before the Board will be decided in regular order according to its respective place on the Board's non-hearing docket or hearing docket.

Section 7105 as rewritten unnecessarily burdens veterans.

NOVA maintains section 7105 as rewritten is too restrictive. The United States Court of Appeals for the Federal Circuit recently upheld VA's standard forms regulations, to include 38 CFR § 20.201. *Veterans Justice Group, LLC, et al.* v. *Secretary of Veterans Affairs*, No. 2015–7021 (April 7, 2016). Under 38 CFR § 20.201(a)(4), a veteran is required to specify those determinations with which he disagrees or "clearly indicate" his intent to appeal all issues.

By contrast, newly drafted section 7105(b)(2) requires the claimant to set forth "specific allegations of error of fact or law." This standard places a higher burden on the claimant as a predicate for a valid NOD. While NOVA understands VA intends for the NOD to be the sole vehicle to initiate an appeal, requiring veterans to provide "specific allegations of error of fact or law" is not veteran-friendly and is particularly detrimental to pro se veterans. Because the current standard NOD form does not require the level of specificity contained in this provision, NOVA recommends the veteran only be required to specify the determinations with which he disagrees in the NOD.

Section 7105(b)(3) also puts a burden on veterans at the time an NOD is filed by requiring the veteran to make a decision at that moment about whether a BVA hearing is warranted and whether any evidence will ever be submitted. Given that veterans often are unrepresented until after the filing of an NOD, there is no reason to require that irreversible legal decisions be made at that exact moment. NOVA therefore recommends that the proposed language be changed to allow a veteran to decide to submit evidence or request a BVA hearing up until the date a decision is actually issued by BVA.

Related to this concept is the question of "lane-changing," both in the "middle lane" and at BVA. During the appeals summit meeting, VA stated that a veteran would be able to switch lanes. More clarity is needed on the scope of this concept.

Finally, the provision allowing BVA to "dismiss" an appeal because the NOD is deemed insufficient is a troublesome one, as it is unclear what protections a veteran whose appeal is dismissed would receive. NOVA therefore recommends 38 U.S.C. § 7105(d) either be stricken in its entirety or revised to read as follows: "The Board of Veterans' Appeals will not deny any appeal which fails to allege error of fact or

law in the decision being appealed without providing the claimant with notice and an opportunity to cure the defect."

The veteran should have the ability to submit evidence until BVA issues a decision.

Section 7113(b)(2)(A)(ii) as written provides for evidence to be submitted at BVA "within 90 days following receipt of the notice of disagreement." This provision is too restrictive; if the case is waiting to be reviewed by BVA, it is more veteran-friendly (and does not unduly burden BVA) for that period to be open until the decision is made. Therefore, NOVA recommends 38 U.S.C. § 7113(b)(2)(A)(ii) be amended to read as follows: "Evidence submitted by the appellant and his or her representative, if any, within 90 days following receipt of the notice of disagreement or until the Board issues a decision."

VA should only require "new" evidence for supplemental claims.

During the course of the appeals summit meetings, there was general agreement that the standard of "new and material" should be eliminated. There was significant discussion on this topic, with the stakeholders generally agreeing the standard should be "new" only. VA has inserted the term "relevant" to replace "material."

Although VA officials have repeatedly stated that the "relevant" evidence standard would be much easier to meet than the "material" standard, NOVA maintains merely trading "relevant" for "material" will not significantly reduce the adjudication burden on VA. Removing "relevant" allows VA to adjudicate the merits every time and eliminates the need to make a threshold determination.

Therefore, NOVA recommends the words "and relevant" be deleted from 38 U.S.C. § 5108 and the definition of "relevant" found at 38 U.S.C. § 101(35) be stricken.

It needs to be clear BVA's review is de novo.

While BVA views itself as an appellate body, its function has always been to provide de novo review of the agency of original jurisdiction's decisions. It must continue to conduct de novo review, find facts, apply relevant law, and issue new decisions. Therefore, NOVA recommends the term "de novo" be added as follows:

> 38 U.S.C. § 5103B(c)(2)—If the Board, during a de novo review on appeal of an agency of original jurisdiction to satisfy its duties under section 5103A of this title, and that error occurred prior to notice in accordance with section 5104 of the agency of original jurisdiction decision on appeal, unless the claim can be granted in full, the Board shall remand the claim to the agency of original jurisdiction for correction of such error and readjudication.
>
> 38 U.S.C. § 7105(a)—Appellate de novo review will be initiated by the filing of a notice of disagreement in the form prescribed by the Secretary.
>
> 38 U.S.C. § 7105(b)(2)—Notices of disagreement for de novo review must be in writing . . .

VA should clarify the veteran's right to be heard and to submit evidence.

The stakeholders participating in the appeals summit meetings insisted VA not eradicate the veteran's right to be heard and submit evidence before BVA. The language needs to be stronger to indicate the right to a hearing and to submit evidence is mandatory, not discretionary. Therefore, NOVA recommends the following sentence be added at the beginning of section 7105(b)(3): "The claimant shall have the right to a hearing before BVA and the right to submit evidence."

ADDITIONAL CONCERNS

The current proposal ignores fundamental flaws in the system.

The proposed framework deals largely with the *process* of filing claims and appealing adverse decisions. Successful execution of VA's proposed process hinges on its ability to *consistently meet its goals* of adjudicating and issuing decisions in the 125-day window identified in its "middle lane" and deciding appeals within the one-year period before BVA. As demonstrated with the prior backlog of original claims and scheduling of medical appointments, VA often struggles to meet its own internal goals to the detriment of veterans.

Furthermore, while focusing solely on process, the proposal is devoid of reform to the foundational underpinning of the claims adjudication and appeals process, i.e., the need for an adequate medical examination and opinion. At the January 2013 hearing addressing the appeals process, BVA acknowledged the problem: "The adequacy of medical examinations and opinions, such as those with incomplete findings or supporting rationale for an opinion, has remained one of the most frequent reasons for remand." *Why Are Veterans Waiting Years on Appeal?: A Review of the Post-Decision Process for Appealed Veterans' Disability Benefits Claims: Hearing Before*

the Subcommittee on Disability Assistance and Memorial Affairs of the House Committee on Veterans' Affairs, 113th Congress, 1st Sess. 23 (2013)(prepared statement of Laura H. Eskenaki, Executive in Charge, Board of Veterans' Appeals). Two years later, the Subcommittee on Disability Assistance and Memorial Affairs requested appeals data from VA, to include the top five remand reasons for the six fiscal years between 2009–2014. While not particularly detailed, in five of the six years, "nexus opinion" was listed as a top five reason. *Department of Veterans Affairs (VA) Appeals Data Requested by House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs* (January 2015). Other consistently reported reasons included "incomplete/inadequate findings," "current findings (medical examination/opinion)," and "no VA examination conducted." *Id.*

While VA often cites the veteran's submission of evidence as triggering the need for additional development, the reality is VA has consistently demonstrated difficulty fulfilling its fundamental obligation to provide veterans with adequate medical examinations and opinions in the first instance. Without substantive reform to this process, to include consideration of a greater role for private and treating physician evidence, it is unlikely procedural reform alone can solve systemic problems.

The proposal fails to address how the pending inventory will be resolved.

Although stakeholders and VA flagged the issue of how the pending inventory will be addressed if extensive appeals reform is passed as an area of concern needing resolution, there was not time to fully consider this issue in the first round of meetings. Although one subsequent shorter meeting was convened for consideration of this issue, no significant agreement was reached. Given that the 455,000 pending appeals are in various stages of the appeals process and greatly affect the resources required by VA, this issue must be resolved. Veterans who have already been waiting for many years must not be denied a fair resolution to their pending appeals while newer appeals are being handled faster in a simplified system.

DISCUSSION DRAFT OF VA PROPOSAL TO MODIFY REQUIREMENTS UNDER WHICH VA IS REQUIRED TO PROVIDE COMPENSATION AND PENSION EXAMINATIONS TO VETERANS SEEKING DISABILTY BENEFITS

NOVA opposes VA's draft proposal to heighten the evidentiary threshold for medical examinations and opinions under 38 U.S.C. § 5103A(d)(2), which was originally added as part of the Veterans Claims Assistance Act of 2000 and clarified VA's duty to assist the veteran in obtaining the evidence necessary to substantiate the claim. VA's proposed changes would require a veteran to provide "objective evidence" of in-service incurrence. VA explained its intent, as well as what constitutes "objective evidence," in its 2017 budget proposal:

> *Clarify Evidentiary Threshold at Which VA is Required to Provide a Medical Examination.* This proposal seeks to amend 38 U.S.C. § 5103A(d) to clarify the evidentiary threshold for which VA, under its duty to assist obligation, is required to request a medical examination for compensation claims. This amendment would clarify section 5103A(d)(2) to require, prior to providing a medical exam, the existence of objective evidence establishing that the Veteran experienced an event, injury, or disease during military service. VA would still consider lay evidence as sufficient to show a current disability or persistent symptoms of a disability. However, except in special circumstances, objective evidence such as medical records, service records, accident reports, etc., must also be of record to trigger an exam. Benefit savings to the Compensation and Pensions account are estimated to be $120.1 million in 2017, $124.9 million in 2018, $650.3 million over 5 years and $1.4 billion over 10 years.

Department of Veterans Affairs, *Congressional Submission, FY 2017, Vol. III* at VBA–78 (February 9, 2017). Not only is this provision in complete opposition to the veterans-friendly benefits scheme designed by Congress, such a heightened standard would effectively shut out many veterans who are not entitled to the relaxed standards of 38 U.S.C. § 1154(b) as combat veterans. Many in-service symptoms or incidents may not be documented because a veteran does not consider them serious enough to require treatment or in some instances, e.g., psychological symptoms, may choose not to report them for fear of demotion or separation.

While VA seeks this change to effectuate cost savings, as noted above, other measures should be considered to improve the system, to ensure veterans obtain adequate medical examinations and opinions, and to ultimately provide cost savings.

CONCLUSION

NOVA shares VA's concern that veterans wait too long for a final and fair decision on appeal. NOVA welcomes the opportunity to work with VA and this Committee to ensure a fair and comprehensive reform of the system. NOVA further recommends adoption of the revisions outlined in our testimony.

In addition, NOVA opposes VA's draft proposal that revises the evidentiary threshold for medical examinations and opinions.

Mr. Chairman, we would like to thank you again for allowing us to address these proposed bills. I would be pleased to take any questions.

Chairman ISAKSON. Thank you very much for your testimony.

Master Sergeant Ensminger.

STATEMENT OF JEROME M. ENSMINGER, MSGT (RET.), U.S. MARINE CORPS

Mr. ENSMINGER. Good afternoon, Mr. Chairman, Ranking Member Blumenthal, and to all the esteemed Members of this Committee. I want to expressly thank Chairman Isakson for including S. 2888 in this legislative hearing.

My name is Jerry Ensminger. I am a retired U.S. Marine who spent more than 11 of my 24½ years of service at Camp Lejeune, NC.

I would like to commend both Senators Burr and Tillis for writing and introducing this bill. This bill confirms to the hundreds of thousands of Marines, sailors, their families, and the thousands of civilian employees who were negligently exposed to the highest levels of harmful contaminants ever recorded in a major drinking water system, that the U.S. Senate delegation of North Carolina has our backs.

Not only is this legislation another step in rectifying the gross injustice committed against the Camp Lejeune victims, it also has the potential of saving the American taxpayers hundreds of thousands, if not millions of dollars in the future. This bill, when passed, will require the Veterans Administration, or the VA, to utilize the Agency for Toxic Substances and Disease Registry, or ATSDR, rather than exclusively contracting external government entities to perform evaluations or opinions on health effects related to the Camp Lejeune drinking water issue.

ATSDR was created and mandated by Congress in 1980 to investigate, evaluate, and remediate human exposures to potentially harmful contaminants found at National Priority listed sites, such as Camp Lejeune. We all need to take a step back and ask ourselves why the VA refuses to utilize these preeminent governmental institutions, such as ATSDR, or the National Centers for Environmental Health, or the National Institute for Environmental Health Sciences, or NIEHS, for those evaluations and/or opinions relating to issues where veterans have been exposed to hazardous substances. Why does the VA automatically and exclusively resort to contracting external governmental entities for these evaluations?

Here are some findings we have made concerning those questions. You can draw your own conclusions. One, when the VA contracts an external entity to provide them with an evaluation or an opinion, the VA writes a charge to the contractor. This is where the legitimacy of this practice comes into serious question. Every Member of this Committee is a politician, and the best analogy that I can use to describe the flaws in this process is political poll ques-

tions. A pollster with an agenda can write poll questions in a fashion which would provide them the response or responses they desire. There is no difference when writing a charge to a contractor. The person or persons writing the charge can fashion it in such a way or manner as to narrow the final evaluation or opinion.

Number 2, none of the work performed by these external governmental entities falls under the Freedom of Information Act. We have no access to the procedures or what scientific materials the contractor used in creating their evaluations. Where is the transparency in this process? There is none.

Every time the VA contracts an external government entity for an evaluation or opinion, the American taxpayer is paying double. We are paying to maintain, equip, and staff our governmental agencies who are fully capable of performing these tasks. We are also paying the VA's contracted price for these external government entities to execute this work.

Several years ago, I asked VA's Dr. Teri Walters why the VA constantly insists on using external government entities when seeking evaluations or opinions regarding potentially harmful exposures. She claimed that the VA uses those external contractors for such work because the veterans would not trust the work product of a governmental agency. Her response almost made me choke.

Of course, most veterans do not know that the VA, an interested party, writes a charge to an external governmental entity, another interested party, to provide them with an evaluation. On the other hand, governmental agencies, such as ATSDR, NCEH, and the NIEHS, are uninterested parties who would give an evaluation based on available scientific evidence instead of a charge which could restrict the evaluation to the desires of the contractee. Furthermore, all of the procedures and scientific materials utilized by the aforementioned governmental agencies would be accessible under the Freedom of Information Act.

Mr. Chairman, if the VA truly had the best interest of Camp Lejeune veterans and their families at heart, they would never have created and utilized the training PowerPoint that I have attached to my written testimony as Attachment A. This PowerPoint presentation was utilized to train the VA clinicians who would be screening Camp Lejeune veterans and their family members pursuant to the passage and the President signing the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. This PowerPoint not only regurgitated outdated and disputed science, it reads like a road map for how to deny veterans and their families the care outlined in the law.

Finally, the description of Dr. Walters' vision of a Camp Lejeune veteran's wife, which shows on Slides 10 and 12 of Attachment A, went beyond the pale. It was demeaning and outright despicable. What makes this even worse is the fact that when Dr. Walters was asked if this depiction was a real individual, she replied, "No. I took several actual individual cases and lumped them together to create that one example." Does anyone need to wonder why we do not trust the VA?

I challenge every Member of this Committee to research how much money the VA has expended since fiscal year 2012 on external governmental contracts for evaluations or opinions. I would

venture a guess that between Camp Lejeune and the C–123 aircraft Agent Orange issues alone, hundreds of thousands of taxpayers' dollars were spent, a lot of money that could have been spent caring for our veterans rather than devising methods and attempts to cheat them out of the benefits they deserve.

Thank you, and I look forward to answering any questions that you may have.

[The prepared statement of Mr. Ensminger follows:]

PREPARED STATEMENT OF JEROME ENSMINGER, U.S. MARINE (RET.)

J. M. Ensminger
61 Hunters Run
Elizabethtown, NC 28337
jmensminger@hotmail.com
May 24, 2016

Good afternoon Mr. Chairman, ranking member Blumenthal and to all of the esteemed members of this committee. I want to expressly thank Chairman Isakson for including S-2888 in this legislative hearing. My name is Jerry Ensminger. I am a retired U.S. Marine and I spent more than 11 of my 24 ½ years of service at Camp Lejeune, NC.

I would like to commend both Senators Burr and Tillis for writing and introducing this bill. This bill confirms to the hundreds of thousands of Marines, Sailors, their families, and the thousands of civilian employees who were negligently exposed to the highest levels of harmful contaminants ever recorded in a major drinking water system that the U.S. Senate delegation of NC has our backs. Not only is this legislation another step in rectifying the gross injustice committed against the Camp Lejeune victims, it also has the potential of saving the American taxpayers hundreds of thousands, if not millions of dollars in the future. This bill when passed, will require the Veterans Administration (VA) to utilize the Agency for Toxic Substances and Disease Registry (ATSDR) rather than exclusively contracting external government entities to perform evaluations and/or opinions on health effects related to the Camp Lejeune drinking water issue. ATSDR was created and mandated by Congress in 1980 to investigate, evaluate, and remediate human exposures to potentially harmful contaminants found at National Priority Listed (Super Fund) contamination sites such as Camp Lejeune. We all need to take a step back and ask ourselves why the VA refuses to utilize the preeminent governmental institutions

such as ATSDR, the National Center for Environmental Health (NCEH), or the National Institute for Environmental Health Sciences (NIEHS) for those evaluations and/or opinions relating to issues where veterans have been exposed to hazardous substances? Why does the VA automatically and exclusively resort to contracting external government entities for these evaluations and/or opinions? Here are some of the findings we have made concerning those questions. You can draw your own conclusions;

1) When the VA contracts an external entity to provide them with an evaluation and/or opinion, the VA writes a charge to the contractor. This is where the legitimacy of this practice comes into serious question. Every member of this committee is a politician and the best analogy I can use to describe the flaws in this process is political poll questions. A pollster with an agenda can write poll questions in a fashion which would provide them the response(s) they desire. There is no difference when writing a charge to a contractor. The person(s) writing the charge can fashion it in such a manner as to narrow the final evaluation and/or opinion.

2) None of the work performed by these external government entities falls under the Freedom of Information Act. We have no access to the procedures or what scientific materials the contractor used in creating their evaluations and/or opinions. Where is the transparency in this process? There is none!

3) Every time the VA contracts an external government entity for an evaluation and/or opinion, the American taxpayer is paying double. We are paying to maintain, equip, and staff our governmental agencies who are fully capable of performing these tasks. We are also paying the VA's contracted price for those external governmental entities to execute

this work.

Several years ago, I asked VA's Dr. Terry Walters why the VA constantly insists on using external government entities when seeking evaluations and/or opinions regarding potentially harmful exposures. She claimed that the VA uses external government contractors for such work because the veterans wouldn't trust the work product of a Governmental agency. Her response almost made me choke! Of course, most veterans don't know that the VA (an interested party) writes a charge to the external government entity (another interested party) to provide them with an evaluation and/or opinion. On the other hand, governmental agencies such as ATSDR, NCEH, and the NIEHS are uninterested parties who would give an evaluation / opinion based on available scientific evidence instead of a "charge" which could restrict the evaluation to the desires of the contractee. Furthermore, all of the procedures and scientific materials utilized by the aforementioned governmental agencies would be accessible under the Freedom of Information Act.

Mr. Chairman, if the VA truly had the best interests of Camp Lejeune veterans and their families at heart, they would never have created and utilized the training power point (Attachment A). This power point presentation was utilized to train VA clinicians who would be screening Camp Lejeune veterans and their family members pursuant to the passage and the President signing the "Honoring America's Veterans and Caring for Camp Lejeune Families Act" of 2012. This power point not only regurgitated outdated and disputed science (Attachment B), it reads like a "road map" for how to deny these Veterans and their families the care outlined in the law. Finally, the description of Dr.

Walters' vision of a Camp Lejeune veteran's wife (slides #10 & #12 of Attachment A) went beyond the pale. It was demeaning and outright despicable. What makes this even worse is the fact that when Dr. Walters was asked if this depiction was a real individual, she replied, "No, I took several actual individual cases and lumped them together to create that one example." Does anyone need to wonder why we don't trust the VA?

Lastly, the VA created a Camp Lejeune task force in 2012 to map out a direction forward supposedly to meet the requirements of the new law. It wasn't until last month that we were finally made aware of the make-up of that VA task force (Attachment C/D) and oddly enough, we discovered that Dr. Kelly Brix, Division Director, Research Development, Department of Defense, Defense Health Headquarters, and a Mr. Scott Williams, DoD liaison, were members of this Camp Lejeune task force. It is our belief that this task force was directly responsible for the creation and eventual implementation of the now infamous so-called VA Camp Lejeune SME Program. We can't confirm our suspicions on this subject because the VA has refused to honor our FOIA requests.

I challenge every member of this committee to research how much money the VA has expended since FY-2012 on external governmental contracts for evaluations and/or opinions. I would venture a guess that between Camp Lejeune and the C-123 aircraft Agent Orange issues alone, hundreds of thousands of taxpayers dollars were spent. A lot of money that could have been spent caring for our veterans rather than devising methods in attempts to cheat them out of the benefits they deserve. Thank you and I look forward to answering any questions you may have.

Attachments:
Attachment A—VA Training Power Point dated August 2013
Attachment B—Director ATSDR letter dated October 22, 2010
Attachment C—VA Camp Lejeune Task Force Roster (1)
Attachment D—VA Camp Lejeune Task Force Roster (2)

ATTACHMENT A—VA TRAINING POWER POINT DATED AUGUST 2013

Domestic Environmental Exposures

Terry Walters MD MPH
Deputy Chief Consultant Post-Deployment Health

August 2013

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Agenda

- Historical water contamination at Camp Lejeune
- Potential Case History
- Implementation of the Section 102 of the "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012"
- Implications
- Other U.S. installations with possible contamination issues
- Residual Agent Orange contamination issues

VA Implementation of Section 102 of the "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012"
Camp Lejeune Historical Water Contamination

- 1950s – mid 1980s drinking water at Camp Lejeune contaminated with volatile organic compounds (VOCs)
  - Dry cleaning chemical – perchloroethylene (PCE), trichloroethylene (TCE)
  - Leaking Underground Storage Tanks (yes LUST!) - Benzene

- Over 1 million individuals may have been exposed
- 2009 National Research Council (NRC) report:
  - Identified 14 adverse health outcomes with limited/suggestive evidence of an association with exposure to TCE or PCE.
  - "The available scientific information does not provide a sufficient basis for determining whether the population of Camp Lejeune has, in fact, suffered adverse health effects as a result of exposure to contaminants in the water supply."
- Agency for Toxic Substances and Disease Registries (ATSDR) studies ongoing
- Section 102 of H.R. 1742 signed August 6, 2012
- VA Implementation Task Force

VETERANS HEALTH ADMINISTRATION

Information known at present

- Water supplies at Camp Lejeune were contaminated from approximately 1953 to 1985
- Long term benzene exposure strongly associated with increased risk of leukemia (AML)
  - Supported by occupational and epidemiological studies
  - Classified as a "known human carcinogen"
- TCE associated with possible increased risk of kidney cancer
  - Increased risk shown in rats exposed to high levels of TCE
  - The National Toxicology Program (NTP) determined that TCE is "reasonably anticipated to be a human carcinogen."
  - The International Agency for Research on Cancer (IARC) has determined that trichloroethylene is "probably carcinogenic to humans."

VETERANS HEALTH ADMINISTRATION

Information that is Unknown

- Is there any difference in the prevalence of disease in the Camp Lejeune population as compared with a similar population?
  - Studies by ATSDR pending
- At what level and for how long were Camp Lejeune residents exposed to contaminated water?
  - Pending further studies by ATSDR
- Was benzene a significant contamination?
  - Water modeling by ATSDR suggests that benzene was not a significant contaminant in the aquifer
  - National Research Council opines that this will not produce useful information

Review of Epidemiologic Studies

- Occupationally exposed workers
  - Limited/Suggestive evidence of an association (TCE, PCE)
    - Esophageal, Lung, Breast, Bladder, Kidney cancers
    - Miscarriage
  - Cohort studies of benzene exposed workers & those environmentally exposed → ↑risk of AML & other leukemias
- Exposure through contaminated water supplies
  - The epidemiological studies of solvent contaminated water supplies and adverse health effects are of limited quality.
  - All studies are limited by ability to determine exposure levels.
- Epidemiological studies on the Camp Lejeune population
  - Pregnancy outcome study – possible association between PCE exposure & low birth weight. (study later withdrawn due to new information that invalidated some of the study assumptions; study presently being redone)
  - All other epidemiological studies are pending

Exposure Levels

- Maximum measured concentrations (1982-1985)
  - TCE = 1,400 µg/L
  - Benzene 2,500 µg/L (one time spike, most levels non detectable)
- The estimated human adult dose of TCE at Camp Lejeune is 12,500 times lower that twice the highest measured concentration of TCE found to be associated with rats developing kidney cancer after TCE exposure

TABLE 4-3 LOAELs from Animal Studies Used for Comparison with Estimated Daily Human Doses to TCE Related to Water-Supply Measured Concentrations

Range of Doses	End Point	LOAEL, mg/kg per day
High	Kidney cancer, rats	1,000
Medium	Kidney toxicity, rats	250
Low	Immunosuppression, mice (sensitive strain)	22

TABLE 4-4 From Animal Studies Used for Comparison with Estimated Daily Human Doses to PCE Related to Water-Supply Measured Concentrations

Range of Doses	End Point	LOAEL, mg/kg per day
High	Kidney toxicity, rats	600
Low	Neurotoxicity, rats	50

$$\frac{1{,}400\ \mu g/L\ \text{(higest TCE level)} \times 4\ L/day\ \text{(amt of water per day)}}{70\ kg\ \text{(body wt)}} = 80\mu g/Kg\ \text{per day} = \mathbf{0.08\ mg/Kg\ per\ day}$$

Useful References

- VHA Office of Public Health
  - http://www.publichealth.va.gov/exposures/camp-lejeune/index.asp
- National Research Council report "Contaminated Water Supplies at Camp Lejeune" (2009)
  - http://www.nap.edu/catalog.php?record_id=12618
- Agency for Toxic Substances and Disease Registries
  - http://www.atsdr.cdc.gov/sites/lejeune/
- United States Marine Corps website on the Historic Drinking Water issue
  - https://clnr.hqi.usmc.mil/clwater/index.aspx

Potential Case History

- Former Marine Sgt. C (now a Veteran) comes to see his provider because he has heard that there is a new law covering Camp Lejeune. He wants a registry exam so he can file a claim. What do you tell him?
  - There is a new law that allows him to enroll in the VA.
  - There is no Camp Lejeune Registry.
  - He can file a claim but the new law only covers health care.
  - Registry exams are not the same as compensation exams. You direct him to the office where he can file a claim.
  - You direct him to the local office that enrolls Veterans into the VA.
- Because you have helped him he returns to your office after enrolling and asks "Is my health and my family's health at risk?" What do you tell him?
  - Take an exposure history
  - Provide information sources
  - Provide risk assessment
- He then goes on to tell you about his wife .....

Potential Case History

- Mrs. Joan C is a 63 year old female who claims to have lived at Camp Lejeune with her Marine husband from 1975 to 1979. She now lives in Boone, NC.
  - Diagnosed with breast cancer in the right breast and currently having chemotherapy. Only available oncologist located 100 miles away. Does not have a car and finds it very difficult to travel.
  - Previously diagnosed with breast cancer in the left breast about 6 years ago. Very strong family history of breast cancer (mother and all of her sisters have breast cancer).
  - Other medical problems include a 20 year history of poorly controlled diabetes, 30 year history of smoking, obesity, and hypertension.
  - Presently unemployed & bankrupt due to medical bills, relies on Medicaid for her health care. House being foreclosed.
  - Her daughter, who was born August 1987 at CL, married last year and has had a miscarriage. She is now having trouble getting pregnant.
- What do you say to Veteran C?

Section 102 of the "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012"

- Provides health care for 15 conditions to Veterans and Family Members who were stationed or resided at Camp Lejeune (CL) for ≥ 30 days between 1957 to 1987:
  - Veterans on active-duty status assigned to Camp Lejeune
  - Family Members who were residents on Camp Lejeune or in-utero
- Care provisions:
  - Cannot provide care for conditions found to have another cause
  - Family Member care requires Congressional appropriation (March 2013)
  - VA is the last payer for family member care

Esophageal cancer	Non-Hodgkin's lymphoma	Breast cancer	Bladder cancer
Kidney cancer	Myelodysplastic syndromes	Multiple myeloma	Leukemia
Renal toxicity	Hepatic steatosis	Female infertility	Miscarriage
Scleroderma	Neurobehavioral effects	Lung cancer	

Need to implement a system to answer the following:

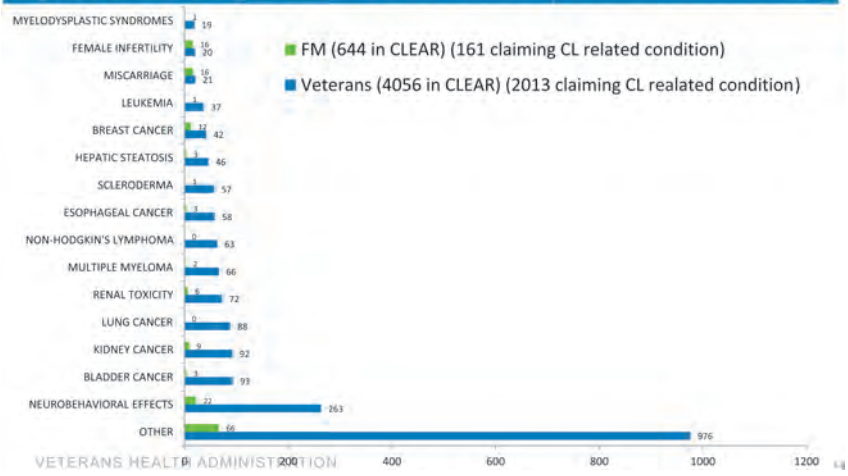
- What does VA do with the following requests?
- Mrs. C wants:
  - Reimbursement for all medical bills.
  - Wants her daughter tested and treated for her pregnancy and fertility issues
  - She wants a wig and reconstructive surgery
  - Since her chemotherapy she has noted that her teeth are getting worse. Is VA going to pay her dental bills?
  - She wants to be paid for travel expenses to get health care.
  - She wants compensation.
- What does VA do when her claim to have lived at Camp Lejeune cannot be verified?

Implementation Steps

- VA began implementing the law for the Veterans on August 6, 2012 - Priority 6
- Implementation Task Force was organized to engage and coordinate subject matter experts from across multiple work centers within VA (VHA, VBA, OGC, OCLA).
- VA created mechanism to track requests for care from CL Veterans and Family Members (Camp Lejeune Environmental Action Report (CLEAR).
- Developed outreach campaign.
- Social workers and eligibility clerks at all VA medical centers alerted to ensure that Family Members seeking care are sent to social work for assistance with identifying alternate care until congressional appropriation is provided.
- Worked with DoD to create system to verify administrative eligibility.
- Identified method to provide care to family members. They will receive care from their usual civilian providers and VA will pay out of pocket costs → VA Financial Services to enter (FSC) to pay bills.
- Identified IT issues and started implementing solutions.
- Created Clinical guidelines.
- Drafted Regulations.

VETERANS HEALTH ADMINISTRATION

CLEAR Data - Current CL Contact Data



VETERANS HEALTH ADMINISTRATION

Outreach

- VA public health web page updated

- Banner on all VA medical center web pages

- Updates for health care providers and other VA staff began in August; announced as they occur
- Briefings provided to congressional staff, VSOs, and Veterans on how VA is implementing the law
- Used USMC mailing to send a Fact Sheet for Veterans/Family Members
- Briefed the ATSDR Camp Lejeune (CL) Community Assistance Panel (CAP) members

VETERANS HEALTH ADMINISTRATION

Verifying Eligibility

Service Member Eligibility Process

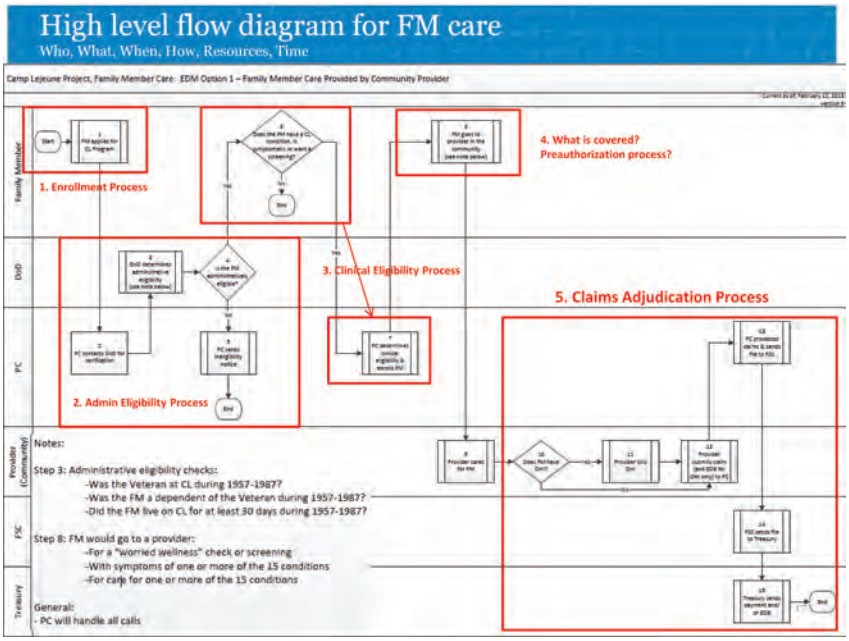
Step 1 – Request OMPF files from NPRC
↓
Step 2 – Search Digitized Muster Rolls**
↓
Step 3 – Search Digitized Housing Card Info
↓
Step 4 – Evaluate Applicant Supplied Info (training certs, schools)
↓
Step 5 – Eligibility Unclear - Sign Affidavit***
or
↓
Step 6 - Formal Finding of Unavailability of service records (memo)***

Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012
***To be completed for field use by 31DEC13*
**** Under review and consideration by VA*
OMPF – Official Military Personnel Files
NPRC – National Personnel Records Center
DEERS - Defense Enrollment Eligibility Reporting System

Dependent Eligibility Process

Step 1 - Search CLEAR
↓
Step 1 – Request OMPF files from NPRC
↓
Step 2 – Search Digitized Muster Roll**
↓
Step 3 – Search Digitized Housing Card Info
↓
Step 4 – Search DEERS and other VA sources for Dependent Info
↓
Step 5 – Evaluate Applicant Supplied Info (marriage cert, birth cert)
↓
Step 6 – Eligibility Unclear - Sign Affidavit***
or
↓
Step 7 - Formal Finding of Unavailability of service records and other necessary documentation (memo)***

VETERANS HEALTH ADMINISTRATION

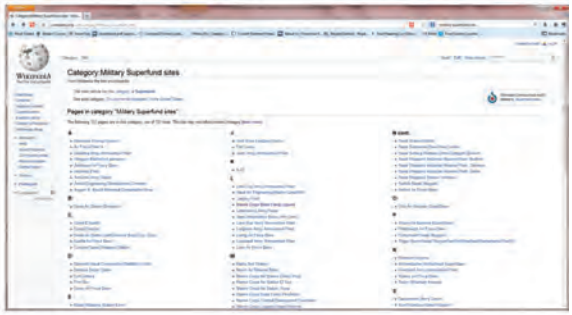


Camp Lejeune Clinical Guidelines

- Guidance for clinicians to determine if a qualified Camp Lejeune Veteran or FM has a medical condition or illness that is covered under the law
- 12 of the 15 medical conditions specified in the law have clear relatively unambiguous diagnostic criteria (example kidney or bladder cancer).
- 3 conditions specified in the law have less well established diagnostic criteria or many potential causes. In these cases determining if a CL Veteran or FM is covered will require medical judgment which integrates the clinical guidelines and the unique history of the individual Veteran or FM.
  - Hepatic steatosis has many common causes (alcohol abuse , obesity, medication side effects) not related to exposure to contaminated water at Camp Lejeune.
  - Neurobehavioral effects – many non-specific common symptoms such as headache and fatigue. Time course of symptoms is important.
  - Kidney toxicity – not a specific clinical diagnosis, many common causes such as long term diabetes
- If a clinician comes to the conclusion that it is more likely than not that the patient's medical condition is due to causes other than exposure to contaminated water at Camp Lejeune, then VA should not waive copayments for Veterans or reimburse care for FM.

Implications & Complications

- Law provides health care to family members - this requires new systems.
- Separates compensation health care benefits
- How does VA pay for partial health care?
- Does this set a precedent for other military camps, posts, & stations that are potentially contaminated?



Fort McClelland

- Proposed legislation: Fort McClellan Health Registry Act
- Alleged contaminants:
  - Barracks asbestos exposure
  - Chemical Corps and Edgewood Test Veterans
  - Leeching PCB's on the north end of the base from an improperly capped WW II landfill
  - The Pelham Range Radiological Contamination
  - TCE contamination of the Anniston water supply by the Army Depot
  - Monsanto air pollution

Residual Agent Orange Contamination – Gagetown, Canada

- Agent Orange, Agent Purple, and other herbicides were tested at CFB Gagetown for 3 days in June 1966 (June 14-16) and four days in June 1967 (June 21-24).
- The Canadian government has paid one-time, lump sum payments of $20,000 to those who worked on or lived within five km of the base between 1966 and 1967, and have illnesses associated with Agent Orange exposure.
- Maine National Guard Veterans were present at CFB Gagetown years later but are concerned that they were exposed to Agent Orange.
- Epidemiological studies of communities surrounding CFB Gagetown have shown a **lower** incidence of illness compared to the province of New Brunswick.
- Veterans who believe they were exposed to Agent Orange outside of Vietnam and have illnesses related to Agent Orange may apply for compensation. These cases are adjudicated on a case-by-case basis by the Veterans Benefit Administration.

Residual Agent Orange Contamination (AO) – C-123 Planes

- Small number of these C-123s (approximately 30) were rotated through Vietnam and used for the aerial spraying of tactical herbicides, such as AO.
- All C-123s in Southeast Asia were sent back to the United States where they were used by Air National Guard or Reserve units for the remainder of their useful life.
- Stateside C-123 crewmembers claim AO exposure based on a hexane wipe test sample of residual TCDD found in only one C-123 named "Patches".
- Analysis of surface wipe samples taken from four mothballed Operation Ranch Hand C-123 aircrafts between 1996 and 2009 showed no evidence of TCDD in two of the aircraft and only trace amounts of TCDD in the other two.
- Air samples from all four planes showed no TCDD.
- The % of TCDD in a wipe sample obtained with a solvent does not translate into a high dose that would be absorbed by the human body.
  - The skin is a strong barrier against absorption.
  - Extremely high temperatures would be required to vaporize TCDD and make it available for absorption through the lungs.

Residual Agent Orange Contamination (AO) – C-123 Planes

- The 20-year longitudinal *Air Force Health Study*, initiated in 1982, followed and studied 1,261 Vietnam Veterans who were actual pilots and crew members of Operation Ranch Hand C-123s.
- As such, they were exposed to tactical herbicides on a daily basis and testing showed the presence of TCDD in their bodies.
- Current health data (obtained as late as 2012) fail to show a general increased risk of adverse long-term health effects when compared to other populations.
- Given that the evidence from actual participants in Operation Ranch Hand does not show a health risk from direct exposure to TCDD, it is difficult to ascertain a basis upon which to find a health risk among crew members of post-Vietnam Operation Ranch Hand C-123s.
- Veterans who believe they were exposed to Agent Orange outside of Vietnam and have illnesses related to Agent Orange may apply for compensation. These cases are adjudicated on a case-by-case basis by the Veterans Benefit Administration.

Summary

- All VA health care providers need to be aware of environmental exposure issues as they continue to be of significant concern to Veterans and their family members.
- It is essential but very challenging to provide good risk communication about the absolute and relative risks of environmental exposures.

QUESTIONS?

ATTACHMENT B—DIRECTOR ATSDR LETTER DATED OCTOBER 22, 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30341-3724

October 22, 2010

Mr. Donald R. Schregardus
Deputy Assistant Secretary of the Navy
Environment
1000 Nay Pentagon
Washington, D.C. 20350-1000

Lt. General Frank A. Panter
Deputy Commandant, Installations and Logistics
3000 Marine Corps, Pentagon, Room 4E516
Washington, D.C. 20350-3000

Dear Mr. Schregardus and Lt. General Panter:

I recently met with Senator Kay Hagan (D-NC) regarding our work on the potential for health effects from exposure to contaminated drinking water at Marine Corp Base Camp Lejeune (Camp Lejeune). During our conversation, it became evident that there was still some confusion regarding the position of the ATSDR regarding the 2009 National Research Council (NRC) report, *Contaminated Water Supplies at Camp Lejeune – Assessing* Potential Health Effects. Because of our collaboration and joint concern regarding exposures to military personnel, their families and others at Camp Lejeune, I wanted to be certain you understood our position regarding this report. This letter is intended to clarify our position and to provide a brief explanation on how we reached this position.

There is one constraint and five conclusions in the NRC report that are essential to the issue of whether harm may be expected in populations exposed to Camp Lejeune contaminated drinking water. These relate to:

1. the contaminants and health outcomes considered by the NRC;
2. the dose-response assessment used by the NRC;
3. the water modeling for Tarawa Terrace published by the ATSDR;
4. the use of alternative modeling strategies;
5. the need for detailed statistical analysis plans;
6. the utility of the epidemiological studies proposed by the ATSDR.

I will address each of these issues in sequence.

The NRC report only focused on tetrachloroethylene (PCE) and trichloroethylene (TCE), without considering other drinking water contaminants at Camp Lejeune such as benzene, vinyl chloride and mixtures of volatile organic compounds (VOCs). As noted in the very recent International Agency for Research on Cancer (IARC) Monograph Volume 100, benzene causes acute myologenous leukemia and is associated with other leukemias. The National Toxicology Program (NTP) Report on Carcinogens (ROC) reaches the same conclusion. Both reports reach a similar conclusion for vinyl chloride with regard to liver tumors. Both the IARC and the NTP label benzene and vinyl chloride as "known human carcinogens". The failure of the NRC Committee to consider these contaminants may lead one to conclude that the NRC findings of "*limited/suggestive evidence of an association*" pertains to all contaminants in the drinking water at Camp Lejeune. This conclusion would be incorrect based upon the evidence of the occurrence of these other exposures in Camp Lejeune drinking water. Thus, the review of cancer risks by the NRC was incomplete and only partially addressed concerns at Camp Lejeune. Finally, the NRC conclusions for PCE and TCE differ from the NTP and IARC which classify these chemicals as "probable human carcinogens" (IARC) or "reasonably anticipated to be a human carcinogen" (NTP) with various cancers including most notably kidney tumors.

Thus, let me be perfectly clear; there was undoubtedly a hazard associated with drinking the contaminated water at Camp Lejeune. The epidemiological studies and the associated exposure modeling will hopefully help us to decide on the level of risk associated with this hazard.

Although the availability of definitive reviews on other health endpoints besides cancer is limited, another shortcoming of the NRC review pertains to other health outcomes including adverse birth outcomes and immunotoxicity. In deciding what needed to be done to evaluate the potential health effects at Camp Lejeune, the ATSDR has taken all contaminants and all health outcomes into account and is acting accordingly.

ATSDR has studied the NRC report regarding the remaining issues. The use of the "lowest observed adverse effect level" (LOAEL) from animal studies without consideration of the uncertainties inherent in the LOAEL and the appropriateness of the use of this metric for assessing genotoxic cancer risks is a major shortcoming of the NRC report. Most regulatory agencies would either address the uncertainty in the LOAEL through the use of multiplicative factors to reduce the acceptable exposure or use an entirely different metric, such as the slope of the dose-response curve or a confidence bound around this curve, to arrive at values for comparison against environmental exposures. By doing neither, the NRC report suggests a much wider difference between exposure and effect

than would normally be derived. In determining potential risks in order to develop power calculations for our epidemiological investigations, the ATSDR used the slope of the dose-response curve.

ATSDR disagrees with the NRC Committee's conclusion that the results of the water modeling for Tarawa Terrace were not sufficiently reliable to do dose characterization in the epidemiological studies. Modeling of the movement of contaminants through sub-surface water is a well established area of science and has been used on multiple occasions to address exposures in communities throughout the United States [reference: Anderson, MP. 1979. Using models to simulate the movement of contaminants through ground water flow systems. Critical Reviews in Environmental Control, 9(2): 97–156.] The state-of-the-art modeling being conducted by ATSDR shows sufficient concordance between the modeled PCE results and the actual measurements of PCE in the finished water at Tarawa Terrace to conclude that one could characterize exposure into several different groups. This conclusion is critical to the future epidemiological studies since it allows ATSDR to separate highly exposed individuals from individuals exposed to moderate and/or low exposures from the drinking water thus limiting exposure misclassification and the resulting bias in the direction of no effect on the study populations. Without these different classifications, ATSDR would need to rely on a simple grouping of exposed versus unexposed, severely limiting the utility of the epidemiological evaluations.

ATSDR agrees with the NRC report that, due to the complexity of the situation at Hadnot Point, alternative modeling strategies should be considered. We have addressed this issue in the current modeling activities and are moving forward with a strategy that will yield sufficiently reliable estimates for this complex exposure scenario.

ATSDR also agrees with the NRC recommendation that detailed plans for the statistical analyses should be and have been developed by ATSDR for the re-analysis of the adverse pregnancy outcome study and the birth defect/childhood cancer case-control study. ATSDR disagrees with the NRC that these studies should be completed as soon as possible; data analysis will not proceed until the drinking water modeling has been completed and is available for both Hadnot Point and Tarawa Terrace.

ATSDR disagrees with the NRC report's conclusion that the mortality study and the health survey/morbidity study lack sufficient statistical power and would be so limited by biases that they would not produce useful scientific information or be definitive. In the June 2008 ATSDR report Assessment of the Feasibility of Conducting Future Epidemiologic Studies at USMC Base Camp Lejeune, statistical power calculations were presented showing that the studies would have sufficient power for the cancers of interest, in particular, cancers associated with benzene, vinyl chloride, TCE or PCE exposure such as kidney cancer, non-

Hodgkin's lymphoma, leukemias, liver cancer, and esophageal cancer. Moreover, ATSDR emphasized that the studies would use standard research methodologies to minimize biases.

ATSDR is proceeding with the USMC Camp Lejeune Mortality Study and the Health Survey. ATSDR will establish a panel of experts to recommend adequate participation rates and consider potential biases in using the health survey for the follow-up morbidity study. We appreciate your financial support for these studies and your cooperation in the Data Discovery Technical Working Group. We are currently working on a request for additional FY 2011 funding requirements which should be completed soon.

Thank you again for your support.

Sincerely,

Christopher J. Portier, Ph.D.
Director, National Center for
Environmental Health, and
Agency for Toxic Substances and
Disease Registry

ATTACHMENT C—VA CAMP LEJEUNE TASK FORCE ROSTER (1)

Camp Lejeune Integrated Project Team

Core Team		Title	Organization	Member Status
Terry	Walters	Co-Chair Camp Lejeune Task Force; Deputy Chief Consultant, Post Deployment Health, Office of Public Health	Veterans Health Administration	Current
Stephanie	Mardon	Chief Business Officer, Chief Business Office (CBO)	Chief Business Office	Current
Kristin	Cunningham	Director, Business Policy	Chief Business Office	Current
Denise	Kitts	Strategic Business Integration Officer	Chief Business Office	Current
Shane	Walker	Project Manager	Chief Business Office	Past
Workstream Leaders				
Administrative Eligibility				
Peter	Petrich	Assistant Director, EED, Health Eligibility Center (Veterans)	Veterans Health Administration	Past
Paul	Albamonte	Program Manager (Veterans)	Chief Business Office	Current
Debbie	Malkovich	Requirements Team Lead, CPAC (Family Members)	Veterans Health Administration	Past
Brady	White	Program Manager, Camp Lejeune (Family Members)	Chief Business Office	Current
Clinical Eligibility				
Dr. Wendy	Dick	Director, Pre 9-11 ERA, Deployment Health, OPH	Veterans Health Administration	Past
Dr. Terry	Walters	Deputy Chief Consultant, Post Deployment Health, OPH	Veterans Health Administration	Current
Delivery of Care				
Dr. Richard	Stark	Director, Primary Care Operations	Veterans Health Administration	Current
Communications				
Susan	Poff	Communications Specialist	Veterans Health Administration	Past
Prachi	Patel	Public Affairs Specialist, OPH	Veterans Health Administration	Current
Regulations				
Ethan	Kalett	Director, Regulatory Affairs	Veterans Health Administration	Current
Gordon	Ohlsson	Publications Manager	Veterans Health Administration	Current
Matt	Solis	Regulatory Specialist	Veterans Health Administration	Current
Legal				
Jennifer	Gray	General Attorney	Office of the General Counsel	Current
Task Force Support and Advisers				
VBA (Support Function)				
Janice	Jacobs	Deputy Under Secretary for Disability Assistance	Veterans Benefit Administration	Current
Mr. Brad	Flohr	Senior Advisor for Compensation Services	Veterans Benefit Administration	Current
DoD (Support Function)				
Dr. Kelly	Brix	Division Director, Research and Development Directorate, Defense Health Headquarters	Department of Defense	Current
Mr. Scott	Williams	DoD Liaison	Department of Defense	Current

ATTACHMENT D—VA CAMP LEJEUNE TASK FORCE ROSTER (2)

Camp Lejeune Steering Commitee Members
Past/Current

Name		Title	Organization	Member Status
Terry	Walters	Co-Chair Camp Lejeune Task Force; Deputy Chief Consultant, Post Deployment Health	Veterans Health Administration	Current
Gerald	Cox	Assistant Deputy Under Secretary for Health for Policy and Services	Veterans Health Administration	Current
Alan	Constantian	Assistant Deputy CIO for Product/Platform Management	Veterans Health Administration	Past
Stanlie	Daniels	Director, Inpatient Evaluation Center	Veterans Health Administration	Past
Catherine	Dischner	Deputy Under Secretary for Organizational Integration	Veterans Health Administration	Past
Walter	Hall	General Counsel	Office of the General Counsel	Past
Dan	Hoffman	Network Director, VISN 6	Veterans Health Administration	Current
Janice	Jacobs	Deputy Under Secretary for Disability Assistance	Veterans Benefit Administration	Current
Paul	Kearns	Chief Financial Officer	VA Finance	Past
Craig	Luigart	CIO	Veterans Health Administration	Current
Stephanie	Mardon	Chief Business Officer	Chief Business Office	Current
Philip	Matkovsky	Assistant Deputy Secretary for Health for Administrative Operations	Veterans Health Administration	Past
Ann	Patterson	Deputy Director, Office of Patient Centered Care & Cultural Tran	Veterans Health Administration	Past
Susan	Schiffner	Clinical Executive of the PDUSH	Veterans Health Administration	Past
Katie	Shebesh	Deputy Chief Business Officer	Chief Business Office	Past
James	Tuchschmidt	Acting Principal Deputy Under Secretary for Health	Veterans Health Administration	Past

Chairman ISAKSON. Thank you very much for your compelling testimony, Mr. Ensminger. Thank you.

I will acknowledge at the outset the kind words you said about Senator Tillis. He was not in the room when you said them, so I want him to be sure to know you bragged about him.

Senator TILLIS. Would you mind repeating those comments? [Laughter.]

Chairman ISAKSON. Let me make sure I have got this. With the exception of Sergeant Ensminger, every one of you testified in support of the veterans' appeal process, the new one, is that right?

Mr. FUENTES. That is right.

Ms. RAUBER. Not completely.

Chairman ISAKSON. But partially.

Ms. RAUBER. Partially.

Mr. FUENTES. Mr. Chairman, if I may, we do not support and that is because we feel that there are certain aspects of it that need to first be addressed, most importantly, like you explained in the beginning, the 450,000 pending.

Chairman ISAKSON. Let me finish. I think you will see where I am going with this. I appreciate you acknowledging that.

We all want the appeals process to be improved, and I know you all have had input and collaborated with the VA, trying to make a new policy work. Is that right? In your testimony, Mr. Fuentes—and I want to make sure I have got this right—you said you applaud what is being done on the appeals, but you want to make sure, first of all, it is paid for; second of all, that the personnel are there to take care of the old claims and the old claims are resolved as a part of reforming the appeals process. Is that correct?

Mr. FUENTES. That is correct, Mr. Chairman.

Chairman ISAKSON. I think each and every one of you made an oblique reference to the same type thing, that although reforming

the process prospectively is something we all want to do, we have 445,000, or 450,000 veterans still waiting for a final appeal disposition. We need to make sure whatever we do does not leave them out, but includes a way for us to get them taken care of. So, I want you to take that back to the Secretary and be sure to let them know about that.

Mr. FUENTES. Yes, sir.

Chairman ISAKSON. Second, and I think the VFW said it, if I have got it right, is the concern about Choice being a move away from VA health care to the extent that it is privatization of the Veterans Administration health services. There is no Member of our Committee that I know of who has made a statement one way or another that it is in any way possible for anybody to believe that we are for privatizing the VA, first and foremost.

I want to say that, at the risk of bragging about the Ranking Member, myself, and the other Members at the dais, if you read the Veterans First bill, it enhances Choice access for veterans to get provider agreements and things like that for care in the community, but it in no way moves toward the VA going out of business and privatizing the VA. Instead, it improves the Choice aspect and choices for you. Do you all understand that?

[Witnesses nodding heads.]

Chairman ISAKSON. Then please help us get the remaining few holds we have got on that bill in the Senate off our bill so we can get it to the floor and pass it, because it is a major reform of the VA that is going to make a significant effect and significant difference.

Mr. Blake, you talked about the certification of adaptive mobility equipment, is that correct?

Mr. BLAKE. Yes, sir.

Chairman ISAKSON. I am always—I am an honest broker. I never leave things off the table. I have been approached by people who are concerned that to have a certification process might be a conflict of interest if a provider was certifying in competition with others who provide the same thing. Is there a protection to see that does not happen in the bill Mr. Moran has introduced?

Mr. BLAKE. I think that there is a little bit of language that could still be refined in the bill to address that concern. I think it was inadvertently left in to potentially create a problem with conflict of interest.

Mr. Chairman, I will just offer this. The amusing thing about the debate over this bill is we found that when you bring the business entities together and debate it, they hate each other and want to push each other out; that is what we have seen with this bill. We are trying to mitigate all of the conflict of interest problems to ensure that everybody is an honest broker and fair player in this, which is why we had argued for the changes we did in the House side bill.

Chairman ISAKSON. Well, I know what you have been dealing with, because those issues rose to my level yesterday when I was made aware of them, so I thought I would bring them up in open hearing so everybody could deal with it forthrightly.

Let me thank all of you for the tremendous work that you do for us and the Committee. The VSOs do a great job of keeping us on

track and on task. We all have the same goals, which are to make veterans health care more accessible and best for our veterans and see to it we do it in the best way for the taxpayers, as well. I thank each and every one of you for doing that.

Mr. Ensminger, I appreciate what you said about Camp Lejeune and about Senator Tillis and Senator Burr, who have been outspoken critics to make sure we finally deal with those issues which long since should have been dealt with. I appreciate it very much.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman. I want to reaffirm my own feeling that the VSOs have been really instrumental in the past year's efforts by the Congress and by the VA to improve performance, which includes eliminating delays as well as improving the quality of care. It also includes more community care, enabling veterans who have to wait too long or live too far from VA hospitals or other facilities to have access to the care that they need without having to wait. When it comes to medical care, time is not on our side. Time is never a good thing when the wait is only going to aggravate the medical condition. So, you have really been steadfast advocates and extraordinarily important in advising us, every one of your organizations, on how best to address improving the health care system, educational benefits, accountability within the VA, the home caregiver program, all of the reforms that are included in the Veterans First bill.

One of the lessons learned is about VA construction, talking about taxpayer dollars. As you well know, every one of the major construction projects undertaken by the VA in the past several years has been way over budget and way behind schedule, the most egregious example being in Denver, where the cost overruns have totaled about $1 billion. That is money that could have been spent on veterans.

In your testimony, Mr. Fuentes, you express support for the construction reform provisions in the discussion draft. I have told Secretary McDonald that I expect the Department to be much more transparent, as well as effective, with Congress and taxpayers who are footing the bill for this gross mismanagement that led to the delays and cost overruns at the Denver facility and at other facilities around the country. Denver is only the poster child. Tell me and your fellow veterans how these provisions will help to reform the process and eliminate those cost overruns.

Mr. FUENTES. Thank you for the question, Senator. I think what this bill does is takes some lessons learned from Denver and from other facilities that had huge cost overruns and essentially ensures that the process is transparent, but also that it builds on those lessons learned, like improving the communication through the project management plan. So, it does not take a lot of lessons learned and we fully support it.

Mr. CELLI. If I may add to that, one of the reasons The American Legion supports it is because it integrates a third-party oversight in a way that brings that focus in at the beginning of the process.

When you create a design-build process, the design has to match the dollars that you say that you can build it for, and if that is askew at the very beginning and then there is no oversight throughout the process where you have got a client who wants dif-

ferent things than what was in the original design-build, before you know it, you have got an unmanageable project. So, that is why we appreciate this bill which will bring additional oversight into that process.

Senator BLUMENTHAL. Thank you both.

Mr. Atizado, I want to second what has been said about the importance of reforming the appeals process. If you have a result in a trial court and it is done quickly but then you have to wait years, perhaps decades, for justice on an appeal, the speed of the result in the trial court is irrelevant, and the same principle applies to the VA adjudicatory process. You have made that point, I think, not necessarily in those words, but about the importance of reforming the appeals process. In fact, you said in your testimony before us today that to achieve reform in this appeals process is to achieve historic reform this year, and it should be this year.

I understand there are some reservations. I hope you agree with me, and I hope members of the panel agree, that we can overcome those criticisms on the issue of cost, for example, so that we are not taking away from other VA programs, other reservations that have been mentioned. As usual, we, I think, will produce a better bill if we take account of those kinds of reservations.

So, let me ask you, do you think it will be historic and important that we do this bill?

Mr. ATIZADO. Thank you for that question, Ranking Member Blumenthal. I do agree it would be historic if we can enact a bill that every stakeholder who has been engaged gets their issues addressed in a satisfactory manner.

I must say, though, I want to reiterate what was said, and I want to make sure it is highlighted. The manner in which the current bill was created, I think, is also quite extraordinary. Everybody came to the table with a clean slate, fully committed and fully leaning forward to try to address this problem. This is one of the reasons why we support the bill as it is currently drafted, notwithstanding the issues that are outstanding, but the fact that the people involved, the organizations involved, VA, their commitment, we believe we can—we have a real possibility to get this down the finish line.

Senator BLUMENTHAL. Thank you very much.

I might say, Mr. Chairman, just by way of a footnote to this conversation, that I understand that Secretary McDonald has issued a statement. Not my place to talk about it, but I think it has been made public and perhaps Deputy Gibson might be willing to share it with us. But I think it expresses regret for the remarks that were made.

Chairman ISAKSON. You are recognized, Sloan.

Mr. GIBSON. If I could just—do you want me up here?

Chairman ISAKSON. Turn the microphone on.

Senator TILLIS. Welcome to the team. [Laughter.]

Mr. GIBSON. It does feel a whole lot different over here. [Laughter.]

A statement from the Secretary dated today. "On Monday, I made some remarks on how we are working to improve veterans' satisfaction with the care they receive from VA. It was never my intention to suggest that I do not take our mission of serving vet-

erans very seriously. In fact, improving access to care is my number 1 priority and the priority I have set for the entire Department.

"For the last 2 years, the huge majority of VA employees have worked tirelessly to improve the timeliness of the care and benefits we provide to veterans. As I have told Veterans Service Organizations, Members of Congress, and myriad other groups of veteran stakeholders, our goal is to ensure VA becomes the number 1 customer service organization in government. To do that, we are following many of the best practices of private sector health care providers and exceptional customer service organizations. At VA, we take our mission of caring for those who shall have borne the battle very seriously. We have the best and most noble mission in government.

"If my comments Monday led any veteran to believe that I or the dedicated workforce I am privileged to lead do not take that noble mission seriously, I deeply regret that. Nothing could be further from the truth. As we approach the Memorial Day holiday and pay tribute to the sacrifices of courageous men and women who placed the interests of others above their own, we at the VA remain focused on our mission to care for those who bravely served our Nation."

Thank you for the opportunity, Mr. Chairman.

Chairman ISAKSON. Thank you, Sloan, and thank Secretary McDonald for that statement, which I think is most appropriate.

Senator BLUMENTHAL. I second that sentiment.

Chairman ISAKSON. Senator Tillis.

Senator TILLIS. Thank you, Mr. Chair and Ranking Member, and really all the Members of this Committee to put forth legislation. We hope you all can help us work out a few of the kinks and get it passed into law.

I also want to thank the Committee staff and the staff of all of our offices who we all know do a lot of the work to get these bills moving.

I will be fairly brief. I think all of you all were present during my earlier comments. One thing I am really counting on you all to help us with is identify good ideas, it is a matter of timing; not so good ideas, it is a matter of evolving maybe the original aims of the bill, but I really, speaking for my office, want to make sure that you all know my door is wide open. We want to make sure that we deal with all the competing priorities, funding and otherwise, so that we can get this right, mainly for the sake of the veterans.

On that note, just very quickly, for the bills that I have had any sponsorship in—I think that you have already heard me talk about the Care Veterans Deserve Act and how I think there are a lot of aims in there that we can reconcile with the current transformation program or figure out when and if they make sense.

But more than anything else—I am not going to speak for Senator McCain, but speaking as a Member of this Committee and among members that I have spoken with, there has never been an attempt to privatize the VA for the reasons that I have said before. It does not make sense. There is a great setting. If you have done as I have, gone to all your VA hospitals, all your health care centers, all the places where care is provided to veterans, when veterans come together in a group, there is a value to that that even

goes beyond the medical treatment that they receive in this facility, oftentimes from a person who is a veteran themselves.

So, if you have any other, outside of what you have documented in your written testimony, I would be happy to hear it. I do appreciate the fact that I believe most of the bills that we are working on, you all generally support. We need to work on appropriations and those sorts of things.

Mr. Ensminger, I thank you for being here. I was a minute late into your testimony. Apparently, I missed the best part, but——

[Laughter.]

Senator TILLIS. No, in all seriousness, I know this is deeply personal to you. This is something that Senator Burr has been working on for quite some time. My predecessor worked on it. I actually think this is an instance where the ATSDR, it makes sense to really put the onus back on the VA. If they want to provide science or evidence-based counters to the ATSDR's decisions, that is OK, but I really think in this case that we should bias our decisions to go along with their recommendations, and if on an exception basis the Department wants to come back, I would be open to that, where the science would lead us there. But, I think the benefit of the doubt always has to go to the veterans, particularly with the situation that happened down at Camp Lejeune. I thank you for your continued work. We are going to continue to work on this and I am optimistic that we will produce a good outcome.

Mr. ENSMINGER. Thank you, Senator.

Senator TILLIS. The last thing I will say relates to Senator Blumenthal's questions about capital projects and construction. There are a lot of things that are working well now when we use contemporary models for building facilities. Since I have been Senator—these were decisions made before I was elected, but the outcome has been three new health care centers in North Carolina, increasing capacity that came online over the last 15 or 16 months by a million square feet in three different facilities in Fayetteville, Kernersville, and Charlotte. I am very proud of that. These are projects that are coming in on time. They are coming in on budget.

We have got to make sure that we fund the operational till that is going to be necessary for them to fully build out their capabilities. There is some good work being done there and now they are having to correct some of the mistakes that were made in Denver and other places. But, I think, on the whole, if we follow those models, we are going to be in a lot better place. Now what we have to do is figure out how to modernize in some cases 70-year-old facilities like down in Fayetteville to get them up to modern standards, the standards that our veterans deserve.

But, the last thing I want to leave you with is a commercial. This is not a political commercial, Mr. Chair. Our caseload down in North Carolina—we have a couple of dozen people that work on cases. We have opened and closed literally thousands of veterans' cases in the 15 months that I have been in the Senate. I need your help in making sure—we have gotten to a point now where we are trying to reach out and find people who may not know that they can get help from their Congressional member or their Senator and we need to make sure that we get the word out that you contact the VA, you contact any area of government and hope that you are

on a good path to getting your needs fulfilled. But, if the first call or two does not look like it is going in the right direction, the next call should be to your Congressional member's office.

For the Senate, I know that is as easy as going to the Internet and looking up Tillis.senate.gov. You can open a case there. We need to get the VSOs to communicate that to veterans and use us as a facilitator for helping you navigate these challenges until we get to a point to where, hopefully, that will be a rare circumstance. Right now, we are dealing with thousands of those a year and that is something that I want the veterans of North Carolina, and I speak, I believe, for all Congressional members, it is a service that they should take advantage of, so I would appreciate your help getting the word out.

Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

I want to thank everyone from the VSOs for their testimony and the members of the Veterans Administration for their testimony in the previous panel. We will continue to work on this legislation. You were very helpful to us and very effective in your testimony. We appreciate your being here today.

The Senate Veterans' Affairs Committee stands adjourned.

[Whereupon, at 4:32 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, VETERANS OF FOREIGN WARS

MENTAL HEALTH SERVICES PROVIDED TO FEMALE VETERANS

Question 1. Mr Fuentes, in your testimony you reference a survey of women veterans by the VFW. 40% of respondents indicated that they are currently using mental health care services, or have in the past. Have you received any input from your members about their satisfaction with mental health services that they have accessed? Have your members responded with any recommendations on improving mental health care for women veterans offered by the VA?

Response. Overall, 64 percent of the women veterans who responded to the VFW's survey indicated they were at least "somewhat" satisfied with their VA health care experience. Women veterans who reported they used VA mental health were slightly less likely to be satisfied with their overall health care experience—60 percent. However, women veterans who used VA mental health care were more likely than the the overall average to prefer to receive their care at VA instead of private sector doctors (57 percent vs. 53 percent). This indicates that women veterans who use VA mental health may see needs for improvement, but prefer to receive their mental health at VA rather than outside doctors.

The VFW did not ask for specific recommendation on how women veterans would improve VA mental health, but noticed a general trend in comments that women veteran would like more gender specific care. A particular example was a veteran who recommended that VA hold group therapy for sexual assault victims who suffer from mental health conditions instead of requiring sexual assault victims to share their stories in groups with veterans with combat related mental health conditions.

PERMANENT EXPANSION OF THE CHOICE PROGRAM

Question 2. Your testimony states that VFW has serious concerns with permanently expanding the Choice program, and have stated in your testimony that Choice has yet to achieve what Congress envisioned when legislation was passed in 2014. VFW has also received a number of complaints from Veterans who either face delays in receiving care through the Choice Program, or experience billing problems. Have your members indicated to you that they prefer care from the VA, or through the Choice Program? What if any recommendations do you have to address the disparate and uncoordinated nature of care that your members have reported?

Response. VFW members believe VA must leverage the capacity of community doctors to meet the growing demand on its health care system. With nearly 80 percent of VFW members reporting they use VA health care and the majority of them

reporting that they prefer to get their care at VA health care instead of private sector doctors, VFW members believe that VA must serve at the primary provider and coordinator of care for veterans. As the coordinator of care for veterans, VA would be charged with ensuring veterans receive timely, high-quality, comprehensive and veterans centric care.

RESOURCES TO ADDRESS CLAIMS BACKLOG

Question 3. You have indicated that VFW would not endorse any changes to the benefits appeals process until Congress allocates sufficient resources for VA to implement a comprehensive plan to address the current backlog of pending appeals. How would you, in this instance, define "sufficient resources" that must be provided to reduce the appeals backlog?

Response. The VFW believes that VA must make a concerted effort to hire more staff and improve current systems and processes to ensure veterans in the current appeals backlog do not have to wait 5 years for a decision on their appeals. In order to implement new IT systems and hire more staff, the *Independent Budget* recommends Congress provide $23.1 million in fiscal year 2017 for the Board of Veterans Appeals. *The Independent Budget* has also recommended that Congress provide VA's compensation service $171 million in fiscal year 2017 to hire 1,700 new full time equivalent employees so VA can make progress in its workload of initial appeals.

A P P E N D I X

PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, thank you for the opportunity to present the views of the American Federation of Government Employees, AFL–CIO and its National Veterans Affairs Council (AFGE). AFGE represents nearly 700,000 non-management Federal employees. Over forty percent of AFGE members are veterans working in the VA, Department of Defense, Department of Homeland Security and many other agencies. AFGE represents nearly 230,000 VA employees working in the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA).

S. 2049

AFGE supports efforts to provide non-Departmental providers with information that enable them to provide quality, appropriate care to veterans when non-VA care is needed. However, AFGE is very concerned about the cost of setting up such a massive non-VA continuing medical education (CME) program and its impact on VA's information technology system and the availability of funds for CME for VA's own providers. Therefore, AFGE urges the Committee to address the more urgent and longstanding problem of lack of adequate support for the CME needs of VA providers. VA physicians and dentists are entitled to a woefully inadequate amount of CME reimbursement under 38 U.S.C. 7411. The $1000 maximum reimbursement level has not been updated since 1991. Many other health care employers provide 3–4 times as much reimbursement. Other VA medical professionals who also need CME to maintain their licenses and credentials often get no reimbursement because managers have complete discretion over this matter and frequently assert a lack of funds for CME.

Alternative recommendations:

- Amend 38 U.S.C. 7422 to provide VA physicians and dentists with a competitive amount of CME reimbursement.
- Conduct oversight of the CME needs of other VA medical professionals.

S. 2896

AFGE strongly opposes this bill to make the Choice Program permanent. AFGE believes that it is premature to establish a permanent Choice program at this time. AFGE urges the Committee to defer any action that would make what reports suggest is a flawed temporary program permanent halfway through its authorization period. Instead, Congress should conduct immediate oversight of the many serious problems that veterans are experiencing in trying to access non-VA care under the current pilot program.

Congress established the current Choice program as a temporary fix to severe access problems. The current Choice program does not expire until the end of FY 2017. It is too early to determine whether the current pilot program has been a success or failure, and whether its high price tag and adverse impact on VA's own capacity justifies its continuation.

Since enactment of the Choice Act, the Department has made significant progress toward its goal of hiring more front-line clinicians and support personnel who provide veterans with the exemplary health care services that they rate highly and strongly prefer. We also note that there is bipartisan support in the Committee to implement VA's Congressionally-mandated plan to consolidate non-VA care programs.

Veterans deserve great care and strong accountability from VA and non-VA providers alike. Therefore, we strongly recommend that the Committee take adequate time to address the many troubling reports regarding the Choice Act that have been made by veterans and the VA health care personnel trying to assist them. These include the Choice Program's alleged failure to provide community clinics with consults containing diagnoses and physician instructions, or alert veterans that their evaluations have been scheduled, or notify the VA that a non-VA appointment has been made. This last item has resulted in many wasted in-house appointment slots.

In addition, many veterans are being harassed by bill collectors in connection with Choice Act care. Veterans face longer wait times for in-house VA care because the VA employees assisting them often have to spend hours on the phone trying to deal with HealthNet and TriWest. Similarly, short staffing at VA's own primary clinics has worsened because staff have to be diverted to the time-consuming Choice referral process. AFGE has also received reports of providers under pressure to act outside the scope of their licenses to justify referrals to non-VA providers.

Alternative recommendations:

- Conduct additional oversight of impact of Choice on quality and access of non-VA care and on VA's in-house capacity to provide timely care during the remainder of the pilot program period.
- Expedite implementation of VA's plan to consolidate non-VA care programs.

DISCUSSION DRAFT ON VA PROPOSAL TO MODIFY REQUIREMENTS RELATED TO COMP AND PEN EXAMS

AFGE strongly opposes this discussion draft bill. This bill would greatly increase the burden that veterans must meet to prove their claims. The proposed requirement for "objective evidence" would arbitrarily and significantly raise the evidentiary threshold for triggering a VA comp and pen exam. Without VA exams, many veterans will not be able to provide sufficient evidence of their meritorious claims.

This draft bill is likely to result in additional appeals, impacting both the veteran waiting even longer to receive an accurate decision on his or her claim, and worsening the appeals backlog for other veterans with pending appeals.

Thank you for considering the views of AFGE.

PREPARED STATEMENT OF DIANE M. ZUMATTO, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

INTRODUCTION

Distinguished members of the Senate Veteran Affairs Committee, It is my pleasure, on behalf of AMVETS, to offer this statement on the following pending pieces of legislation: S 2919; S 2896; S 2888; S 2883; S 2679; S 2520; S 2487; S 2049 & various draft legislation.

It is encouraging to acknowledge at this time that, despite the extraordinary sacrifices being asked of our men and women in uniform, the best and the brightest continue to step forward to answer the call of our Nation in its time of need. I know that each of you is aware of and appreciates the numerous issues of importance facing our military members, veterans, retirees, families, and survivors and for that AMVETS is extremely grateful.

PENDING LEGISLATION

S. 2896, the Care Veterans Deserve Act of 2016—AMVETS strongly supports this legislation which seeks to:

- eliminate the sunset date of the Veterans Choice Program;
- expand eligibility for the program; and
- to extend the operating hours for pharmacies & medical facilities

The current program limitations severely impact the value of the program to veterans. This is especially true for those working veterans who are essentially forced to take time off from work in order to see a VA doctor and/or pick up a prescription from a VA pharmacy.

Furthermore, AMVETS sees the Veterans Choice Program as a nearly perfect solution to the ongoing VA healthcare access problem.

S. 2888, the Janey Ensminger Act of 2016—AMVETS supports this legislation because the issue of Toxic Wounds is a critically important to us, however, we are dis-

appointed that Ft. McCleallan, as well as others, and its veterans have once again been ignored. (It is my understanding that there are approximately 140 military bases in CONUS that are on the EPA's Superfund list.) This legislation seeks to, among other things:

• require the Secretary, through the Agency for Toxic Substances & Disease Registry, to reveiew the relevant scientific literature related to exposure to toxins at Camp Lejeuen to specific illnesses or conditions incurred by those individuals;
• determine each illness or condition for which there is evidence that exposure to toxins at Camp Lejeune may be a cause of;
• categorize the evidence of the connection or the illness or condition to such exposure;
• require the publication, in the *Federal Register* and on the DHSS website, a list of each illness or condition for which a determination is made;
• require the Secretary to transfer $2,000,000 in 2017 & 2017 to be used to continue building and enhancing the claims processing system, eligibility system and web portal for the Camp Lejeune Family Member Program.

S. 2883, Appropriate Care for Disabled Veterans Act of 2016—AMVETS supports this legislation which would extend the requirement of the VA Secretary to submit a report on the capacity of the VA to provide for the specialized treatment and rehabilitative needs of disabled veterans.

S. 2679, Helping Veterans Exposed to Burn Pits Act—AMVETS fully supports this legislation which seeks to: establish a Center of Excellence in the prevention, diagnosis, mitigation, treatment and rehabilitation of health conditions relating to exposure to burn pits.

AMVETS has consistently been a staunch supporter of burn pit legislation and we are very encouraged by the depth of this legislation, which would finally bring the appropriate recognition and treatment to veterans suffering the ill effects of burn pit exposure.

Furthermore, AMVETS believes that it is absolutely critical that DOD and VA be required to work collaboratively on this important issue and that additional environmental hazards, such as: dust, sand and smoke will be included in the activities of the Center.

S. 2520, Newborn Care Improvement Act—AMVETS does not have a position on this legislation.

S. 2487, Female Veteran Suicide Prevention Act—Preventing veteran suicide has been, and continues to be, a top priority for AMVETS. It is for this reason that we fully support this important legislation which seeks to specifically identify mental health care and suicide prevention programs and metrics that better meet the needs of our female veterans.

S. 2049, a bill to establish within the VA a continuing medical education program for non-department medical professionals who treat veterans and their family members to increase knowledge and recognition of medical conditions common to this population. AMVETS supports this bill because the ever growing expansion of veteran community care essentially necessitates a program of this kind to ensure that veterans receiving care in the community get the best and most informed care possible.

S. 2919, the State Outreach for Local Veterans Employment Act of 2016—AMVETS fully supports this legislation which recognizes the unacceptably high unemployment rate among veterans and seeks to provide greater flexibility to individual States in their efforts to provide the services of DVOPs & LVERs to veterans within their state.

Draft Legislation to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of VA—As everyone on this Committee is aware, large numbers of VA disability appeal cases are sent back for review—sometimes multiple times—and these cases must be addressed before any new cases can be opened. This slow and cumbersome process leads to many veterans having to wait years for a final decision on their case.

AMVETS believes that the status quo is simply unacceptable! There is absolutely no justifiable excuse for 440,000 veterans being forced to wait extended periods for their earned benefits due to bureaucratic and administrative inefficiencies. No doubt the VA's tendency to shift their focus back and forth from one crisis area to the next greatly exacerbates the backlog problems.

What is truly needed, and is certainly a reasonable expectation, is for the VA to make the right decision, in a timely manner, the first time, so that veterans, and American taxpayers, are not repeatedly punished by the seemingly endless cycle of wrong decisions.

It is also undeniably critical that VA develop a system/process that, among other things:

- allows for quick, yet consistent decisions on all claims and appeals at both the RO and BVA;
- provides effective date protection; . allows for the establishment of clear, legal precedents;
- provides veterans with multiple processing options throughout the life of their claim or appeal based on their personal circumstances;
- provides VBA and the Board with all the necessary resources (human, financial, IT, etc.) to efficiently accomplish its mission;
- addresses the current appeals backlog;
- evaluates and addresses the shortcomings in the VBMS;
- accepts competent and credible private medical evidence as part of an eligible veteran's claim and/or appeal; and
- establishes realistic goals for dealing with both legacy and new appeals

As you know, AMVETS has always worked to enhance and defend the earned benefits of all Americans who are serving or have served honorably and selflessly in the Armed Forces. AMVETS has also simultaneously worked closely with both Congress and the VA to help develop and improve both the claims and appeals processes.

AMVETS fully supports this critically important legislation which seeks, among other things, to:

- modernize and remedy a number of problems within the current VA appeals processing system by creating three distinct 'lanes' which will address specific veteran needs;
- improve VBA decision notices; and
- provide effective date protection

Draft Legislation to make certain improvements in the provision of automobiles and adaptive equipment by the VA—this seems like a pretty straight forward and common sense bill which seeks to ensure that eligible veterans have some personal choice in the vehicle or other conveyance they receive from the VA. It also requires the Secretary to develop a comprehensive policy regarding quality standards for providers who modify vehicles for veterans, including in part: standards of safety and quality of equipment, as well as the installation of such equipment. AMVETS believes that this type of legislation is long overdue and we support its intent of better meeting the needs of our disabled veterans.

Draft Legislation to expand eligibility to hospital care and medical services under section 101 of the Veterans Access, Choice and Accountability Act of 2014 to include veterans in receipt of health services under the pilot program of the VA for rural veterans—AMVETS has always advocated for the special needs of our rural veterans and this appears to be a simple and economical solution to help our veterans who face the greatest roadblocks to healthcare access; therefore, AMVETS supports this legislation.

Draft Legislation to require the VA Secretary to use industry standards, standard designs, and best practices in carrying out the construction of medical facilities—It seems clear that if we had had this legislation previously, we wouldn't be in the current situation with the Aurora, Colorado VA medical center. If this legislation prevents a similar situation from occurring, then our support will be justified.

The bill requires the Secretary to contract for forensic audits when expenditures exceed projected costs by 25% or more and to provide quarterly reports indicating progress, adherence to the budget and any cost or schedule variances of the project. What's not to like?

Draft Legislation to revise the evidentiary threshold for medical exams and opinions—AMVETS supports this legislation which seeks to expand the medical evidence which can be taken into consideration by the VA when evaluating a veteran's claim for benefits.

This completes my statement and I would be happy to provide written responses to any questions the Committee may have.

STATEMENT OF HARMAR, KEMPF, INC., PRIDE MOBILITY PRODUCTS CORP., AMS VANS, MOBILITY PLUS, HOMECARE MOBILITY, PATRIOT MOBILITY, AMERIGLIDE ACCESSIBILITY SOLUTIONS, AMERICAN ACCESS, JOHN GEORGE WELDING AND ROLLX VANS

HEARING ON PENDING LEGISLATION
SENATE COMMITTEE ON VETERANS AFFAIRS
MAY 24, 2016

Mr. Chairman, Ranking Member Blumenthal, and Members of the Committee:

Our companies are grateful for the opportunity to submit this statement for the hearing record on the draft Veterans Mobility Safety Act of 2016 (VMSA), which is a companion bill to H.R. 3471. On behalf of our employees and the disabled veterans whom they serve, we are hopeful that your Committee will modify the draft legislation and insist on changes to the House bill so that the proposed new regulatory regime does not create unintended consequences that could limit veterans' access to the services of certified providers of certain mobility solutions such as wheelchair and scooter lifts and could ultimately increase prices for the VA by limiting true competition.

Highlights

The VMSA is intended to develop a new regulatory framework for the Veterans Administration to implement minimum safety standards and require certification from mobility dealers it chooses to perform Automotive Adaptive Equipment (AAE) work. We support the notion of ensuring that veterans' vehicles are safe to operate when they've benefited from accessibility modifications paid for by the VA. And, we are pleased that the legislation continues the current practice of manufacturer certification of the installers that provide the actual services to the veterans. However, the legislation still would benefit greatly from some minor improvements and we urge you not to facilitate Senate passage of this legislation until the flaws are cured.

Specifically, we believe that the bill: (1) needs a more robust conflict of interest provision related to the use of a third party certification organization for the new safety standards and (2) should differentiate better between simple and complex modifications of vehicles, as explained below. Simple changes to the bill could accomplish these goals and ensure that a new regulatory regime does not create more problems for veterans and the businesses that service them.

Background

Manufacturers of AAE and their independent dealers are critical to helping the Department of Veterans Affairs address the growing need for mobility solutions for our nation's veterans. Many companies in this field are small businesses, often owned by veterans with service-connected disabilities. Ironically, their livelihoods and the accessibility of the veterans they serve are at risk due to this legislation in its current form.

As the Committee knows, tens of thousands of disabled veterans each month are provided vehicle lifts and/or fully modified vehicles, based upon the degree of their mobility limitations. This benefit permits them to be able to maintain as much freedom to go about their daily lives as they deserve. Veterans with limited mobility (as opposed to no mobility) are often able to have their needs

satisfied with an exterior lift that is installed on their vehicles via a standard trailer hitch and which allows for the transport of a scooter or power wheelchair. Under current law, the vast majority of these lifts are installed in the driveway of the veteran's home in as little as 30 minutes, as opposed to an equipment dealer's place of business, which is far more convenient for veterans and their families. These driveway installations are completed by our installers that have been trained and certified by the manufacturers of the equipment. Our home service has historically worked quite well because disabled veterans do not have to contend with weather, traffic, parking, and wait times as they would in a brick and mortar commercial establishment. This is important to preserve in any new regulatory environment.

The Need for An Improved Conflict of Interest Provision

It is possible that the "minimum standards" promulgated under this legislation would impose new limitations on where one can add a lift, with no corresponding evidence that such a restriction would improve safety. Further, the bill puts at-home installations at risk because it reflects the significant influence of a trade group that represents only a portion of the industry and which wants to shift to a more centralized installation process for the benefit of its own members at the expense of convenience to veterans. This trade group has made it clear that it is seeking to have an affiliated entity become the "third party organization" designated by the Department of Veterans Affairs to certify dealer/installers. It would then be in a position to exert market dominance on behalf of its members. That would have a coercive effect on small business dealers, who would have to pay this organization that could charge unlimited rates for the certification, and who may choose to leave the program rather than absorb significant new costs.

We are not alone in having this concern, as VA Undersecretary Janet Murphy, appearing before the House Veterans Affairs Subcommittee on Health last year, provided testimony that echoes our concerns when she stated that HR 3471 "*may be too restrictive and cause undue hardship for small businesses that are not members of a certified organization and/or certified by the state in which the modification service is performed. This, in turn, may restrict the access and choice Veterans have.*"

Accordingly, we need the Senate to amend this legislation to prohibit an organization from becoming a certifying body if it is comprised of members that engage in the same commercial activities as other companies that would have to seek certification. There are plenty of independent and neutral third party organizations that could certify compliance with new standards, in addition to the manufacturers in our field. There is no reason for Congress to depart from its usual custom of enacting conflict of interest provisions for third party accreditation in other contexts that prohibit such self-dealing. The current bill provision is insufficient to protect manufacturers, dealers, and their veteran customers from market manipulation.

We have taken it upon ourselves to provide the Committee with legislative language that would do a great deal better to protect against the conflict of interest that could occur if the current bill were enacted:

"(e) CONFLICTS.—

(1) In developing and implementing the policy under subsection (a), the Secretary shall minimize the possibility of conflicts of interest, to the extent practicable.

(2) The Secretary may approve a private organization as a third party certification organization pursuant to Section 3(b)(4) of this Act if the third party organization meets conflict of interest standards as described in paragraph (3).

(3) The Secretary shall establish standards for conflicts of interest for third party organizations selected to certify providers, including—

(A) standards that prohibit such organizations from having members that are businesses engaged in commercial activities related to automotive adaptive equipment; and

(B) standards that ensure that a third party organization is not owned, managed, or controlled by any person that owns or operates a provider eligible to be certified by such organization.

(4) Any third party organization selected by the Secretary to certify providers shall establish and implement measures that the Secretary shall approve to reduce the possibility of conflict of interest or bias on the part of individuals acting on the organization's behalf."

Amending the VMSA Discussion Draft would be consistent, for example, with the Food Safety Modernization Act, which requires FDA to ensure competence and independence of third-party auditors/certification bodies that conduct foreign food safety audits. It ensures the reliability of food and facility certifications issued by third-party auditors/certification bodies that FDA will use in making certain decisions relating to imported food (including pet food and animal feed). The law provides that an accredited third-party auditor "shall not be owned, managed, or controlled by any person that owns or operates an eligible entity to be certified by such auditor." 21 USC § 384d(c)5. The Senate Discussion Draft of the VMSA and H.R. 3471 would permit a trade association to become a certification organization, which is the equivalent of a third party auditor under these FDA regulations, and to certify providers that are its own members or potentially to disadvantage non-members that seek certification.

Similarly, a more robust conflicts provision in the VMSA would be consistent with regulations related to the Occupational Safety and Health Administration (OSHA). To make sure equipment is safe in the workplace, OSHA relies upon a group of private sector organizations that it recognizes as Nationally Recognized Testing Laboratories (NRTLs) to perform testing and certification of products using consensus-based standards. Under federal law, any NRTL must demonstrate "complete independence from users (i.e., employers subject to the tested equipment requirements) and from any manufacturers or vendors of the certified products." 29 CFR § 1910.7(b)(3) The Senate Discussion Draft and H.R. 3471 contain no such independence requirement.

Lastly, to implement the National Organic Program, USDA relies upon certifying organizations that inspect farms and other food production operations to ensure that they adhere to federal organic standards. Federal regulations list multiple requirements for preventing conflicts of interest in the certification process which a certifying organization must follow. 7 CFR § 205.501(a)(11) The Discussion Draft and H.R. 3471 contain no such conflict analysis or independence.

Simple Modifications vs. Complex Modifications

Another way to ensure the continued ability of veterans to receive home installations is to modify the bill to distinguish specifically between installations of wheelchair and scooter lifts to the outside of the vehicle and the more complex vehicle modifications that change the structure or controls of a vehicle. Exterior lifts for unoccupied motorized wheelchairs or scooters are fundamentally different as they do not directly affect the operation of, or alter the structure of the vehicle and thus should not be included in such new regulations. An exterior lift is more like adding a bike rack to a

vehicle, as opposed to the taking apart of the actual vehicle or its operational controls to install a new adaptive steering system, for example.

We believe that the Senate could improve this legislation by letting the Department of Veterans Affairs decide whether a new set of standards is essential for simple modifications. Such a determination should be made based on available safety information and a cost-benefit analysis. If the Department believes such safety standards are needed, then the consultation provisions of the bill will be very helpful in ensuring that manufacturers and dealers have a seat at the table to provide key input from the perspective of the entities that actually provide the veterans the equipment and services.

Conclusion

It would be easy for the Senate to take the House bill, which has bipartisan cosponsors, and pass it using an expedited procedure. After all, any bill that speaks of veterans and their safety should be a high priority for Congress. However, if you get in the weeds on the issues surrounding the Department's AAE program, the aspirations of a trade group that is only partly representative of the sector, and the plain meaning of the proposed legislation, you'll find that this is a matter worth studying further and that modifications to the bill that we have outlined above would be in the public interest. Our suggested amendments would ensure continued access for veterans to safe vehicles and would also preserve small businesses by creating a level playing field within the new regulatory regime that the bill would establish.

Thank you for the chance to share our views with you on this important public policy issue.

Harmar
Sarasota, FL

Kempf, Inc.
Sunnyvale, CA

Pride Mobility Products Corp.
Exeter, PA

AMS Vans
Tucker, GA

Mobility Plus
Salem, VA

HomeCare Mobility
Franklin, OH

Patriot Mobility
West Babylon, NY

AmeriGlide Accessibility Solutions
Raleigh, NC

American Access
Bartlett, TN

John George Welding
Simi Valley, CA

RollX Vans
Savage, MN

PREPARED STATEMENT OF MILITARY OFFICERS ASSOCIATION OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, Military Officers Association of America (MOAA) is pleased to present its views on veterans' health care and benefits legislation under consideration by the Committee today, May 24, 2016.

MOAA does not receive any grants or contracts from the Federal Government.

On behalf of our more than 390,000 members, MOAA thanks the Committee for its steadfast commitment to the health and well-being of our servicemembers, veterans and their families and for considering the very important provisions in this legislation related to the Department of Veterans Affairs (VA) health care and benefits programs.

MOAA's position and recommendations are provided on the following bills:

- S. 2896, Care Veterans Deserve Act of 2016
- S. 2883, Appropriate Care for Disabled Veterans Act of 2016
- S. 2679, Helping Veterans Exposed to Burn Pits Act
- S. 2520, Newborn Care Improvement Act
- S. 2487, Female Veteran Suicide Prevention Act
- Draft Legislation, Reform the Rights and Processes Relating to the Appeals of Decisions
- Draft Legislation, Modify Requirements for VA Compensation and Pension Examinations

Health Care:

S. 2896, CARE VETERANS DESERVE ACT OF 2016

This bill would eliminate the sunset date of the current Veterans Choice Program, expand eligibility for the program, and extend operating hours for VA Health Administration (VHA) pharmacies and medical facilities.

MOAA thanks Senators John McCain (R-AZ) and Thom Tillis (R-NC) for their effort to improve the Choice Program so more veterans will have access to VA and community health care programs.

The bill is a good start in addressing some of the underlying problems in the Choice Program, but doesn't address the other six disparate Care in the Community Programs which are not integrated with the Choice Program, thus continuing to add more complexity and confusion to the program, further limiting veterans access to health care.

MOAA supports the following provisions in the legislation:

- Requires VA to provide information about the availability of care and services for veterans enrolled in the health system.
- Allows VA to contract with a national chain of walk-in clinics to provide hospital care and medical services to enrolled veterans. While MOAA is supportive of this section of the bill, we are concerned about the additional costs on VHA by allowing all veterans, including those with non-service-connected conditions, to access this care at no cost. Such a change deviates from VHA's current payment practices where veterans with non-service-connected conditions are typically required to pay a copayment for their care.
- Grants VA the authority to allow licensed health care professionals at any location in any State, regardless of where the health professional or patient is located, to provide treatment through the use of telemedicine.
- Requires VA to conduct best-practices peer review of each medical center to evaluate the efficacy of health care delivered in the facility. MOAA recommends adding a provision in this section to require VA to also conduct an assessment of capacity to determine existing gaps in furnishing care and services, including forecasting the short- and long-term demand and its impact on the system.

While the bill provides a number of positive improvements to the current health system, the bill lacks the necessary funding and resources needed to support the requirements of the legislation. Given the current rates of usage of all Care in the Community Programs, including Choice, VA expects demand to continue for the foreseeable future.

In fact, the months of March and April 2016 were the highest performing months for VA community care authorizations, including Choice—approximately 374,000 in March and 319,000 authorizations were created in April. And for Choice, VA projects the funding for the program will run out sometime in May 2017, well before the end of the fiscal year when the program is scheduled to sunset.

Implementing the requirements outlined in S. 2896 without the associated funding would place additional budget pressures on an already fiscally constrained sys-

tem, and, would likely result in further fragmentation of the system, ultimately limiting veterans' access to care—outcomes opposite of what the bill intends to achieve.

Instead, MOAA believes VA's Plan to Consolidate Care in the Community provides the best strategy forward. We urge Congress to fully fund and to consolidate all VA Care in the Community Programs, including the Veterans Choice Program as requested by the Department, in legislation to give the Secretary greater flexibility in managing community care dollars.

S. 2883, APPROPRIATE CARE FOR DISABLED VETERANS ACT OF 2016

MOAA supports this bill, which would require a report to Congress on VA's capacity to provide specialized treatment and rehabilitative needs of disabled veterans.

The bill reestablishes the requirement in law indefinitely, eliminating the original expiration date of 2008.

The need for specialized treatment and rehabilitative care and services has never been greater.

We thank Senators Sherrod Brown (D-OH), Patty Murray (D-WA), and Bernard Sanders, (I-VT) for introducing the bill so our most vulnerable veterans get the care they need for a better quality of life.

S. 2679, HELPING VETERANS EXPOSED TO BURN PITS ACT

MOAA supports the intent of S. 2679, which would establish a VA center of excellence for preventing, diagnosing, mitigating, treating, and rehabilitating veterans with health conditions relating to exposure to burn pits.

While the bill attempts to address illnesses and other health conditions found in veterans exposed to toxins from burn pits in Iraq and Afghanistan, MOAA believes a center of excellence for all toxic wounds and illness, integrating the collective research, prevention, and treatment efforts, would be a better option for leveraging limited resources and funding to address not only burn pit exposures, but also other conditions such as Agent Orange and Gulf War Syndrome.

S. 2520, NEWBORN CARE IMPROVEMENT ACT

MOAA fully supports this bill. The Newborn Care Improvement Act would extend the period of health care and services VA provides to newborns from seven to 14 days.

MOAA has long supported extending the period of newborn care as it provides for the best health outcomes for both the child and the veteran. We recommend Congress provide VA with the additional funds to support the requirement.

S. 2487, FEMALE VETERAN SUICIDE PREVENTION ACT

This bill would direct the VA to identify the most effective mental health care and suicide prevention programs and metrics in treating female veterans.

MOAA strongly supports this bill as well as its companion in the House, H.R. 2915.

The rising rate of suicides among female veterans is staggering. The VA reports, for female veterans ages 18–29, the risk of suicide is 12 times the rate of civilian women; for the period 2000–2010, suicides among female veterans rose by 40 percent.

Yet little research has been done to address these alarming rates and the underlying physical and mental conditions. This legislation will go a long way in addressing suicide rates and improving the medical care and services necessary to promote physical and psychological health and well-being of all veterans and servicemembers.

Benefits:

DRAFT LEGISLATION, REFORM THE RIGHTS AND PROCESSES RELATING TO THE APPEALS OF DECISIONS

MOAA agrees the current number of appeals pending a decision by VA is wholly unacceptable for veterans and thanks Senator Richard Blumenthal for his leadership in this area. MOAA is very sympathetic to VA's assertions that it is unable to provide veterans with timely appeals decisions given the current claims process. The solution proposed by VA; however, contains no reliable indication that it will solve the backlog and also removes important procedural protections from veterans.

VA has been unable to provide any statistics or estimates of how this new system will reduce their workload or how VA will be able to provide decisions within the 125-day target goal. In the meantime, the new claims process takes away the vet-

eran's right to have VA assist him or her in their claim development after VA renders its first decision in a claim. This is a dramatic change from the current procedure where VA is required to assist in claim development through the final agency decision. This change renders the entire VA claims system, following the initial ratings decision, an adversarial process where previously it was a paternalistic, non-adversarial process.

For that reason, MOAA believes the duty to assist a veteran should continue following the initial rating decision and end only when a claim reaches the Board of Veterans' Appeals. This will satisfy VA's goal of avoiding additional claims development at the Board, but ensure a veteran obtains needed assistance without having to pay for assistance in an adversarial system.

Elements of the proposed changes could reduce the number of appeals filed by veterans, and thus the backlog, without prematurely ending VA's duty to assist. During meetings between VA and VSOs earlier this year, the general consensus reached by both sides was that many veterans file appeals because they simply do not understand why VA did not grant their claim. Improving the notice provided to veterans so it is thorough and understandable would reduce the number of appeals by itself. The proposed changes to Notices of Decisions would accomplish this.

Another provision in the proposed legislation that would reduce the number and duration of appeals would make favorable factual findings binding upon VA. This is another way to reduce the appeals backlog while not making the entire post-decision process adversarial by ending VA's duty to assist a veteran.

MOAA also believes if this change in the claims proceedings is enacted, veterans who have filed a Notice of Disagreement prior to the passage of the legislation should be allowed to opt into the new claims processing system to allow them to take advantage of the faster processing times. This will allow those veterans to receive quicker decisions, presuming VA is able to meet its 125-day target goal of issuing them. There is no apparent reason to prevent veterans with existing appeals from opting into this new system.

DRAFT LEGISLATION, MODIFY REQUIREMENTS FOR VA COMPENSATION AND PENSION EXAMINATIONS

MOAA does not agree with the proposed modifications to 38 U.S.C. 5103A (d) (2), to modify the requirements under which VA is required to provide compensation and pension examinations to veterans seeking disability benefits. These proposed changes would require all veterans to objectively corroborate in-service incidents, which they may not possibly be able to obtain evidence for, before VA would allow the medical examination to take place.

This scenario would further deteriorate VA's duty to assist a veteran—in this case, before an initial ratings decision is even made. MOAA does not support such a modification.

MOAA thanks the Committee for considering this important legislation and for your continued support of our veterans and their families.

PREPARED STATEMENT OF CDR JOHN B. WELLS, USN (RET.), EXECUTIVE DIRECTOR, MILITARY-VETERANS ADVOCACY

Introduction

Distinguished Committee Chairman Johnny Isakson, Ranking Member Richard Blumenthal and other members of the Committee; thank you for the opportunity to present the Association's views on the pending legislation before the Committee.

About Military-Veterans Advocacy

Military-Veterans Advocacy Inc. (MVA) is a tax exempt IRC 501[c][3] organization based in Slidell Louisiana that works for the benefit of the armed forces and military veterans. Through litigation, legislation and education, MVA works to advance benefits for those who are serving or have served in the military. In support of this, MVA provides support for various legislation on the State and Federal levels and engages in targeted litigation to assist those who have served.

As well as legislative advocacy, Military-Veterans Advocacy represents veterans in all facets of the veterans law system. MVA practices before the Department of Veterans Affairs, the Court of Appeals for Veterans Claims, the Court of Appeals form the Federal Circuit and the Supreme Court of the United States.

Military-Veterans Advocacy's Executive Director Commander John B. Wells USN (Ret.)

MVA's Executive Director, Commander John B. Wells, USN (Retired) is a 22 year veteran of the Navy. Commander Wells served as a Surface Warfare Officer on six different ships, with over ten years at sea. He is well versed in the actual and potential harms caused by toxic exposure in the five military services.

Since retirement, Commander Wells has become a practicing attorney with an emphasis on military and veterans law. He is counsel on several pending cases at various levels in the veterans legal system. He is very familiar with the veterans law rules and actually presents Continuing Legal Education on this subject to other attorneys.

Proposed Veterans Appellate "Reform" Bill

MVA **does not** support the proposed "reform" legislation as currently written.

General Comments

As often happens with the Department of Veterans Affairs, their proposal concentrates too much on form rather than substance. The Secretary seems to be asking Congress to trust them to work for the benefit of the veteran. Repeated scandals including document destruction and falsification as well as criminal conduct on the part of the VA should put the Congress on notice that the Department, in its present form, is not worthy of trust. We hope that this review and our

recommendations will be helpful in crafting legislation that is results oriented.

The proposed legislation does nothing to fix the systemic problems within the VA Appellate system. Instead it seems to make the process easier for the VA, at the expense of the veteran. The proposed legislation flies in the face of the non-adversarial, pro-veteran system envisioned by Congress. Currently the VA takes an adversarial anti-veteran approach designed to provide the illusion of efficiency while denying veterans their earned benefits.

Areas of Concern Not Addressed in the Proposed Legislation

The proposed legislation does not address the pending inventory of over 450,000 appeals. The actions of the VA in clearing the backlog through increased claim denials has expanded the appellate backlog. For some unfathomable reason, the Secretary and Acting Executive of the Board of Veterans Appeals, have failed to take action to resolve this backlog. Currently, the Chairman has the power to appoint temporary Board members from within the VA. This needs to be changed legislatively to remove the qualification that the temporary board member be VA employees. MVA recommends, allowing the appointment of retired Military Judges to adjudicate the backlog near their local residence. While that would require some training in VA law, the retired Military Judges are conversant with the hazard of military service. Additionally, they are trained to make decisions in an equitable and efficient manner.

The proposed legislation does address the Board of Veterans Appeals but it does not speak to the crux of the problem. The key to solving the appellate backlog is addressing issues at the Board. Initially, and as a matter of priority, the President must appoint a qualified chairman of the Board. Secondly, MVA recommends that all members of the Board, acting or permanent, be certified as Administrative Law Judges. The lack of training and learned reasoning in the opinions of the Board members is frankly striking,

The controllable remand rate is definitely unsatisfactory. Too many cases are remanded because the board member simply does not do his or her job. MVA proposes that if more than 30% of any Board member's decisions are remanded within a given year, the Chairman should review the performance and recommend action to the Secretary including probation, suspension or termination. Remands based upon a change in law or regulation would not be considered in computing the remand percentage. Given the high level of remands, MVA recommends that the remand percentage and action taken be included in the annual report to Congress.

Currently, the veterans record is not released to the Court of Appeals for Veterans Claims, the veteran or the veteran's representative until the veteran signs and return by mail a VA form allowing the VA to release the record. Current law, 38 U.S.C. § 7332[b][2] allows exceptions to allow records to be released but des not address the Court proceeding. MVA recommends adding the following subsection to 38 U.S.C. § 7332[b][2].

(H) To the veteran, the veteran's representative or attorney and the Court of Appeals for

Veterans Claims upon the filing of a notice of appeal and docketing of such appeal by or on behalf of a veteran in the Court of Appeals for Veterans Claims

Although this might seem inconsequential, given the fact that the veteran is often not co-located with the representative, meeting this rather silly requirement can add two to three weeks to the process.

MVA also recommends the addition of a statutory provision that ensures that a change in the interpretation of a statute or regulation which clarifies or explains an existing law or regulation, or merely represents the agency's reading of statutes and rules, rather than an attempt to make new law or modify existing law is to be considered clear and unmistakable error. The clear and unmistakable error (CUE) statute does not address the impact of the VA reversing themselves in an interpretive regulation. The VA, without authority ruled in 38 C.F.R. § 20.1403(e) that such a reversal should not be considered CUE although there was no basis to do so and most courts hold that changes in interpretive regulations are retroactive. *See, Patrick v. Shinseki*, 668 F.3d 1325, 1329 (Fed. Cir. 2011)*; Paralyzed Veterans of Am. v. West,* 138 F.3d 1434, 1436 (Fed.Cir. 1998) and *Nat'l Org. of Veterans' Advocates, Inc. v. Sec'y of Veterans Affairs,* 260 F.3d 1365, 1375 (Fed. Cir. 2001).

Although not addressed in the proposed legislation, MVA recommends the following to streamline the appeal process:

- Promulgate a scheduling order for each appeal with cutoff dates that can be extended for good cause shown.
- Assign a board attorney to monitor the appeal and resolve disputes concerning the events in the scheduling order.
- The board attorney should attend all hearings.
- Absent unique or special circumstances, require the decision to be issued within 30 days of the hearing.
- Hold Veterans Service Managers accountable for improper adjudications.
- Establish and publish a training program for Veterans Service Officers.

MVA specifically recommends the addition of the following section:

§ 7101(f) to read as follows:

[1] Any member of the board conducting hearings shall be a certified Administrative Law Judge.

[2] Any member of the Board whose decisions shall be remanded by the Court of Appeals for Veterans Claims or higher authority shall not be assigned to any subsequent readjudication.

[3] When the Court of Veterans Claims or higher authority remands in excess of thirty percent of any decisions of a particular Board member in any given year, that Board member's performance will be reviewed by the Chairman. If performance is found to be deficient the

Chairman will recommend probation, suspension or decertification to the Secretary. Remands based on changes in the law or regulation, to include judicial action, shall not be considered in computing the percentage of remands.

[4] The Chairman in his annual report to Congress will include a discussion of the number of remands, and actions taken under this paragraph.

Amend Section 7101(c)(1)(A) of Title 38 United States Code by substituting the words *"qualified persons"* for *"employees of the Department.*

Duty to Assist

The proposed legislation guts the existing duty to assist. While the Board normally covers up the failure of the Secretary to perform that statutory duty, this proposal virtually eliminates it subsequent to the initial decision.

The VA proposal seems to limit the entire appellate review to the original record submitted to the agency. While this is common in Administrative Procedures Act reviews, it is not appropriate here. Unlike most administrative hearings, attorneys are not able to engage in paid representation, even if the veteran so desires, until the initial denial has been received. This effectively leaves the veteran without legal representation. Secondly, the system as it currently exists (and would exist under the proposed legislation) does not allow for any discovery. As a result, information and witnesses are discovered throughout the process. Attorneys and appellate level VSOs are trained to prepare a proper record which often results in the discovery and production of new evidence. MVA believes the statute should allow for evidence to be submitted at all stages of the proceeding. It further requires the VA, as part of their duty to assist, to provide reasonable discovery. This would include contact information for decision makers and medical referrals, to allow the veteran to conduct an interview. At the discretion of the veteran the interview could be recorded or otherwise transcribed to be used at the hearing.

As a case in point, an illustrative incident occurred this week. MVA was retained as counsel for veteran WS in late January 2016 and the proper information was submitted within the required 30 day period. A copy of the veterans claims file was requested along with other matters under the duty to assist. Subsequent to faxing this information to the Evidence Intake Center, the case was transmitted back to the Board. In mid-April, the Board mailed out a notification that the case was docketed and that the veteran had 90 days "or until the decision was rendered" to provide supplemental evidence. Still waiting for the claims file, MVA began to gather what evidence it could and prepared to make a submission. Three weeks later the Board acted to deny the claim, without providing the claims file or the information requested under the duty to assist. This was an obvious attempt to "stream roll" a case to prevent MVA from preparing a proper submission.

In the same case, the Board claimed that the veteran withdrew his request for a hearing. The veteran believed he requested to reschedule the hearing. Without access to the Claims file,

there was no way for MVA to address this issue.

Removal of the restriction on attorney representation and the agency of original jurisdiction would help to relieve this matter. More importantly, basic discovery should be allowed. Once a case is docketed at the Board, the use of a scheduling order with milestones would ensure that the case proceeds efficiently. Assigning a board attorney to shepherd the process would help resolve matters. Providing the veteran and his representative with contact information would help expedite the process. Too often there are long delays becaus eof the inability to contact the appropriate VA employee.

Unless the duty to assist continues, the VA will be able to suppress information favorable to the veteran. In that event, matters such as the WS case will become even more commonplace

MVA recommends the addition of the following:

§ 5103 C. Discovery.

Upon request by the veteran or his or her representative, the Secretary, as part of his duty to assist, shall provide the following within 60 days of the request:

- *Veteran's Claims File*
- *Copy of the pertinent parts of all documents used in adjudicating the claims. If a document more than 10 pages is provided, all pages that were considered are appropriately marked.*
- *Contact information for the person adjudicating the claim*
- *Contact information and curriculum vitae of any medical professional conducting a Compensation and Pension examination.*
- *A copy of any other document in the possession of Secretary requested by the veteran.*
- *A copy of any other document in the possession of any Department of the United States requested by the veteran.*
- *Copies of any and all documents including but not limited to correspondence, both paper and electronic, between any employees of the Secretary or between an employee of the Secretary and any other person concerning the case. (Ongoing requirement).*

Reasonable discovery will allow the process to be expedited. More importantly, it will ensure that the veteran is given a fair hearing. Additionally if the claims file is provided prior to the appeal, remands should be reduced which will help reduce the backlog.

Information Provided Upon the Denial of Benefits

The proposal requires the notice of certain items as a substitute for the Statement of the Case. In administrative proceedings, the agency is required to explain and justify their decision. *Motor Vehicles Mfrs. Ass'n of the United States v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The boilerplate citations to Part 3 of Title 38 of the Code of Federal Regulations

which make up the majority of the present Statement of the Case should be included in an appendix. They are often not material and are sometimes confusing to a non-lawyer. The notification should, however, include a narrative of the reason for denial and in the case of the assignment of a percentage of disability, the diagnostic codes used in the determination of the disability percentage and the proper citation to the appropriate section of Part 4 of Title 38 of the Code of Federal Regulations. Often when there is a disagreement over the percentage of disability, MVA copies the pertinent provisions of Part 4 and provides it to the veteran for evaluation by his or her treating physician. This information is then included in any review. Often the treating physical highlights symptoms consistent with a higher level of disability.

A properly prepared notice should refer to the law as well as policy and allow the veteran insight into the VA position. This is necessary to preparing a proper appeal and to make an intelligent decision as to whether a hearing is required. Currently the VA merely generalizes their decision leaving the veteran to speculate on what type of magical mystery tour was embarked upon by the adjudicator.

MVA recommends that the enumerated notice requirements proposed as § 5104[b] e modified to read as follows:

(1) identification of the issues adjudicated;

(2) a summary of the evidence considered by the Secretary to include a listing of every document relied upon. In the instance where the document is more than 10 pages, the summary will include a citation to the proper page number;

(3) a summary of the applicable laws and regulations which will be included in an appendix to the document.;

(4) identification of findings favorable to the claimant;

(5) identification of elements not satisfied leading to the denial;

(6) an explanation of how and where to obtain or access evidence used in making the decision; and

(7) if applicable, identification of the criteria that must be satisfied to grant service connection or the next higher level of compensation." This should include the diagnostic codes used in the determination of the disability percentage and the proper citation to the appropriate section of Part 4 of 38 C.F.R.

(8) the appeal rights of the veteran.

Such Form as the Secretary May Prescribe

Without question VA has a form for every use and some of them actually make sense. Many do not. The forms are drafted by VA employees who are more concerned with bureaucratic achievement than helping the veterans. Although the VA is obviously fascinated by their own forms, they are often confusing and require intrusive information that is not material to the claim. Although the forms are available to those who can navigate the VA web site, many veterans cannot. Older veterans and those suffering from PTS/TBI have difficulties with some forms and the inane requests and bureaucratese cause confusion and frustration. While MVA

supports having **sample** forms, their mandatory use is unnecessary. As long as basic contact information is provided, the VA employee needs only to pick up the phone to secure additional information.

Notices of Disagreement

The proposal requires notices of disagreement to be mailed within a year. There should be a provision to allow submission by fax and e-mail.

MVA is also very concerned about the provision requiring the veteran to affirmatively request a hearing or the right to submit additional evidence. The right to a hearing and to submit evidence should be the default. Many veterans are unrepresented at the time they submit the initial notice of agreement. Flexibility is required to ensure that the do not unconsciously waive their rights or bind future representatives to that waiver, as happened in the illustrative case of WS discussed above. For the same reason, the notice of disagreement should not be the vehicle to limit factual and legal issues. Attorneys may develop additional issues not know by the veteran at the time the Notice of Disagreement is submitted. The requirement to define issues should be fixed at a later time in the process.

Nor should the veteran be required to identify all errors of fact or law at the notice of disagreement stage. Most veterans cannot provide such detailed information, especially at such an early stage in the proceeding. The VA seems to be trying to hold the veteran to the standards expected of an attorney by applying requirements that exceed those found in judicial proceedings. This process was designed to be non-adversarial but the VA is trying to adopt strict technical rules that hamper the veteran's ability to present his or her case. Given the lack of discovery, factual and legal issues may be developed after the notice of disagreement is filed.

The proposed legislation also deprives the veteran of the opportunity to have a hearing or submit supplemental evidence. The VA proposal requires the veteran to affirmatively request a hearing and the right to submit additional evidence. This proposal is contrary to the "pro-veteran" approach that Congress has always required. VA forms are often technical and confusing to the veteran and to some service officers. Too often, veterans may fail to request a hearing or the right to submit additional evidence because of a lack of understanding of the form Waiver through inattention or misunderstanding should never be allowed and the default should be in favor of a hearing and the ability to submit additional evidence. While an affirmative waiver should be allowed for both the hearing and additional evidence, the waiver should be knowing and voluntary.

Any waiver should not be required in the notice of disagreement. It is too early in the process. The veteran may well have not secured legal help at that point and additional issues may not have been developed and additional evidence may not have been discovered or constructed. Often attorneys will be able to secure affidavits in support of claims or identify additional issues. A premature waiver would severely limit the attorney or other representative

in pursuing the appeal. If a veteran presented to an attorney after having waived his right to a hearing or to submit additional evidence, it is unlikely that the attorney will take the case. If appellate rights are waived in the notice of disagreement, then attorneys must be allowed to charge a fair fee at the initial claim stage.

A veteran should never be deprived of the right to submit additional evidence to the higher level review at the Agency of Original Jurisdiction or the Board of Veterans Appeals. Once the initial denial has been made the veteran may choose to hire an attorney. At this point a significant amount of evidence may be generated. As an example, MVA has a large library of evidence on the Blue Water Navy issue. Additionally, MVA routinely obtains affidavits from the veteran's family and friends to establish the nexus between the disability and military service. Often that information is missing from the original claim. Trained attorneys often develop supplemental evidence that could change the decision. Finally, the proposal would seem to run afoul of the notice and hearing requirements of the due process clause. Under no circumstances should the veteran be deprived of this right.

While MVA has no objection to the dual docket approach, a case should not be assigned to the non-hearing docket unless and until the veteran makes a knowing and voluntary waiver. The waiver form should encourage the veteran to consult with legal counsel. Additionally, transfers between dockets should be liberally granted.

Conclusion

MVA cannot in good conscience support this bill and asks that the Senate incorporate the recommendations provided herein. Frankly, MVA s amazed at the fact that some Veterans Service Organization support the legislation. MVA takes no position on that support but as an organization designed to defend the veterans against the VA we must most strongly disagree with the supporting comments of the DAV, VFW, American Legion, AMVETS, IAVA and MOPH. . Perhaps more than anything, this underlines the need for attorneys to begin paid representation at the initial claim level to prevent the type of abuse discussed herein.

Discussion Draft of Amendment to 38 U.S.C. § 5103A

Subject to the discovery proposals discussed above, MVA has no objection to the proposed discussion draft.

Discussion Draft on Proposed Construction Requirements

MVA support this provision. MVA also recommends a study comparing the more successful construction at New Orleans with the disaster at Denver.

Janey Ensminger Act of 2016 - S 2888

MVA most strongly recommends the passage of this bill. The VA has been negligent concerning the identification and provision of benefits for the victims of Camp Lejune. As with the Blue Water Navy legislation (S 681) the VA has ignored scientific evidence to support their bureaucratic intrasiegence.

Care Veterans Deserve Act of 2016 S 2896

MVA strongly recommends passage of this bill. MVA believes that this bill is long overdue. Working veterans should not be forced to conform to the whims of VA bureaucrats. This bill will not only expand the "Choice" program but will force the VA to become more responsive to the needs of the veterans.

State Outreach for Local Veterans Employment Act of 2016

MVA supports the praiseworthy goals of the program envisioned by this bill, however is concerned by the lack of additional funding. MVA proposes that a system of grants be made available to States to enact pilot programs at the Governor's discretion. MVA proposes that $300 million be transferred from the Secretary's administrative budget to create a fund to be used to finance these additional pilot programs.

Closing Comments

MVA thanks the Committee for the opportunity to submit comments based on our unique expertise in veterans matters. We hope that our comments have been helpful. May God bless this Committee, the United States Senate and the United States of America.

//s// John B. Wells
John B. Wells
Commander, USN (Retired)
Executive Director

PREPARED STATEMENT OF MARTIN CARAWAY, LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF COUNTY VETERANS SERVICE OFFICERS

Good afternoon Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, the National Association of County Veterans Service Officers (NACVSO), is honored to present to you the views we have concerning the pending legislation before you today.

The National Association of County Veterans Service Officers is an organization made up of 1,600 local government employees, who work with veterans every day to aid in the delivery of veterans' benefits, advocacy, health care enrollment amongst others. We would like to thank you for your commitment in remedying some of the largest struggles we as advocates' face and more importantly that veterans face.

The following provides NACVSO's position and recommendations on the following bills:

- S. 2896 Care Veterans Deserve Act of 2016
- S. ____ (Blumenthal), Appeals Reform

S. 2896, Care Veteran Deserve Act of 2016: Generally, NACVSO supports this bill with exceptions. This legislation does not provide additional financial resources necessary for permanently running a program as robust as Choice. Second it does not remedy the payment mechanism to community providers. The third party administrators have failed to pay claims promptly and thus have had negative credit implications on the veterans utilizing the service. While the VA is working to resolve these credit disputes, it is alarming that we would continue to utilize these contractors to implement this long term.

The expansion to pharmaceutical services is most certainly a step in the right direction. NACVSO encourages VA with the support of Congress to fund guaranteed 72-hour delivery of medications ordered on "my healthevet." We believe that this mechanism would greatly enhance users ability to order medications when they realize the medication needs to be refilled without having to expend addition VA resources by calling and requesting urgent shipping.

Last, contracting with national chains of of walk-in clinics along with the elimination of pre authorization and co-pays would go a long way in improving the Veterans Choice Bill in practical application. Veterans frustrations are born of communicating with multiple parties to utilize services for medical services that urgent or semi-urgent in nature.

S. ____(Blumenthal), a bill to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs: NACVSO strongly supports appeals/claims reform. It does not need to be reiterated at how the current appeals process is a disservice to claimants, with a current inventory of 445,000 appeals and with no action the appeals inventory will surpass two million cases in the next decade. NACVSO is committed to continuing to work with the VA and service organization partners to aid in the expeditious treatment of veterans claims but not at the sacrifice of quality. We feel that this proposed language is the change we as local advocates need to ensure that their cases are heard and appropriately adjudicated in a timely fashion, while maintaining claimant rights under the current regulation.

This legislation does not propose a mechanism in which the Board of Veterans Appeals (BVA) can significantly reduce/eliminate their current inventory. NACVSO is in support of short term increased funding allocated to the BVA designated for this purpose. NACVSO also strongly recommends, if this is enacted that current claimants in the BVA claims inventory be given the option to opt into this new process. By doing so, the appeals inventory will be reduced while the veteran claimants are given the option of having their newly submitted evidence heard at the Agency of Original Jurisdiction (AOJ).

PREPARED STATEMENT OF DAVID BRASUELL, PRESIDENT, NATIONAL ASSOCIATION STATE DIRECTORS OF VETERANS AFFAIRS AND ADMINISTRATOR, IDAHO DEPARTMENT OF VETERANS SERVICES

INTRODUCTION

Mr. Chairman and distinguished members of the committee, my name is David Brasuell, current President of the National Association of State Directors of Veterans Affairs (NASDVA) and Administrator of the Idaho Department of Veterans Services. NASDVA is comprised of the State Directors of Veterans Affairs for all fifty states, the District of Columbia, and five territories: American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands. I am honored to submit a written statement for the record, in agenda order, addressing the legislative items for today's SVAC hearing.

AGENDA

S. 2896 (McCain/Tillis), Care Veterans Deserve Act of 2016: NASDVA supports the overall (aim) of S. 2896; to increase access for veterans. The bill's intent to eliminate the sunset date for the Veterans Choice Program of the Department of Veterans Affairs, provide expansion of eligibility for all veterans, provide information about the availability of care to each veteran enrolled, provide access to care through walk in clinics, provide for an expanded telemedicine program, extend operating hours at the VA medical facilities for all their pharmacies and provided medical services, and provide a Peer Review for Best-Practices at each medical center are changes (to Choice) NASDVA would like to see in future legislation. However, given the need to ensure the proper balance between VA provided care and purchased care (outside VA) for all our veterans, more study is needed to determine the optimum care delivery mix.

In any future legislation, NASDVA recommends three additional items:
First, request that payer of last resort be dropped as a requirement for our veterans. All across the nation we have veterans placed into financial difficulties due to this requirement. For example: a 100% service connected veteran who is covered for all medical conditions if care is provided at a VA facility incurs no cost. If this same veteran is forced to use the Choice program due to either living location or inability to receive the service at the local VA facility could be liable for large deductibles due to a primary insurance that covers the veteran's family. On the average most veterans impacted by the payer of last resort requirement in the Choice Act incur on average $3,000 to $5,000 expenses per year.

Our second issue is the 40-mile limitation. In order for the Choice program to be a true choice than veterans should be able to use the plan as needed. Today our veterans within the 40-mile limit must first make an appointment with their local VA facility and if the appointment is over 30 days away they are then provided authorization to make an appointment outside the VA network under choice. Sometimes just receiving the authorization is an issue due to the local policies on the definition of within 30 days. We think that if the veterans have a true choice up

front, then veterans would be able to make the appointment in either program. This would alleviate the frustration felt by our veterans and ensure they receive timely quality care.
Third, expansion projects for Community Based Outpatient Clinics (CBOC) are either eliminated or put on hold. Since the passage of the Veterans Choice Act veterans complain of several CBOC expansion projects being put either on hold or canceled. The veterans around these facilities were told to utilize the Choice program for the lack of required services. It seems that the Choice program is driving needed CBOC expansion decisions. Please don't make strategic decisions regarding CBOC improvement/expansion on tenuous funding of the Choice program.

NASDVA requests your support for the above three (3) changes to the Choice Act, itself. We are confident the Choice Act has merit and over time it will mature into a good program of record.

S. 2888 (Burr/Tillis), Janey Ensminger Act of 2016: NASDVA supports this Act as it provides for the care for all diseases that can be medically linked to toxic chemicals at Camp Lejeune. In addition, it provides for a revision every three years of additional conditions found to be caused by the exposure. This means that veterans and families will not have to wait for medical care as researchers learn more about the exposure.

S. 2883 (Brown/Murray/Sanders), Appropriate Care for Disabled Veterans Act of 2016: NASDVA supports this Act since it will ensure that VA maintains adequate capacity to provide specialized services to catastrophically disabled veterans. With the original reporting requirement expiring in 2008, this legislation reinstates the needed requirement for VA to report on its capacity to provide specialized services, to include spinal cord injury or disease, blinded care, mental health care, and long-term care.

S. 2679 (Klobuchar/Tillis/Rounds), Helping Veterans Exposed to Burn Pits Act: NASDVA supports this Act as it will establish a Center of Excellence in the prevention, diagnosis, mitigation, treatment and rehabilitation of health conditions relating to exposure to burn pits. The Burn Pit Registry was established in 2011 and this Act will provide the means to support the exposed veterans.

S. 2520 (Klobuchar/Tillis), Newborn Care Improvement Act: NASDVA strongly supports S.2520, which increases newborn healthcare coverage from 7 to 14 days, adds a reporting requirement for the number of newborns who receive that care, and the healthcare services required/provided by VA. Post Traumatic Stress and combat injuries can cause many women veterans to face high-risk pregnancies. Women suffering from Post Traumatic Stress in the year before a pregnancy increase their chances of a premature delivery by 35 percent. This increase in VA maternity benefits will provide extra time in the hospital if their newborn needs it. The tracking/reporting component of the bill is a necessary component in order to gather data that might be needed to make future determinations of gaps in services that may or may not exist.

S. 2487 (Boxer/Blumenthal/Brown/Hirono/Tester/Tillis), Female Veteran Suicide Prevention Act: NASDVA supports this Act and recommend an addition to S.2487, as written, to include minority veterans. The rate of suicide among women veterans is increasing at a higher proportion than males. The proposal as written does include a requirement for the Secretary to "include metrics ..." (pertaining to mental healthcare and suicide prevention programs) and does add a requirement for the Secretary to "identify the most effective healthcare and suicide prevention programs...and measure satisfaction rates" of those programs among women veterans. However, we recommend that each of those requirements should be specific to both women and minority veterans. The subsection title (2) as annotated in USCS is specific to mental health care and suicide prevention requirements and this bill adds specifications pertinent to women veterans but we believe it should also be amended to be inclusive of minority veterans as well.

S. 2049 (Brown), USDVA establish a continuing medical education program for non-Department medical professionals: NASDVA supports this bill as it will provide for the continuing education, military culture awareness and recognition of medical conditions common to veterans and their families. It will also provide familiarization with federal benefits. Expanding the knowledge of non-VA medical health care providers will allow better treatment for our nation's veterans and their families.

S. ____ (Blumenthal), a bill to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs: NASDVA strongly supports reform and modernization of the appeals process and Senator Blumenthal's bill is a significant and positive step in affecting changes that are desperately needed. NASDVA continues to work with VA and major Veterans Service Organizations to develop language and strategies to improve the appeals process for our Nation's Veterans. To that end, we request, in addition to Senator Blumenthal's current bill language, the following items be added/changed in any final version:

§ 5103B - Add a subsection to § 5103B, to make clear that the Board Of Veterans Appeals (Board) remand for correction of a duty to assist error that occurred prior to the Agency of Original Jurisdiction (AOJ) decision on appeal may include directing the AOJ to obtain an advisory medical opinion under § 5109.

§ 5104B - Revise to make clear that higher-level review by the AOJ will be "de novo." Remove the term "de novo" from § 5104B to avoid any confusion as to whether or not de novo review must be requested. Add new subsection to § 5104 to clearly state that higher-level review shall be de novo.

§ 5109 - Add a subsection that states that the Board may remand a claim to direct the AOJ to obtain an advisory medical opinion to correct a duty to assist error that occurred prior to the AOJ decision on appeal. The Board's remand instructions should include the questions to be posed to the independent medical expert providing the advisory medical opinion.

We all must agree the current appeals process is failing our Veterans. With an inventory of over 450,000 appeals and at current rates, with no change in process, it is projected the inventory could grow to over two (2) million appeals over the next decade. Congress' recognition of this problem and the proactive approach being taken to find innovative ways to correct it are greatly appreciated and will, if implemented, serve our Veterans and our Nation's taxpayers well into the future. In addition to transforming to a streamlined appeal process, which is more efficient and less costly for taxpayers, VA will also require (and NASDVA supports) a short-term funding increase to be able to resolve the inventory of appeals that are pending in the current system.

S. 2919 (Toomey), State Outreach for Local Veterans Employment (SOLVE) Act of 2016: NASDVA strongly supports this legislation and appreciates the work by Senator Toomey, Senator Cornyn and the entire committee and staff. This bill provides greater flexibility to States in carrying out the DVOP/LVERs (Disabled Veterans' Outreach Program and employing local veterans' employment representatives). The SOLVE ACT is a common sense approach designed to increase the effectiveness and cooperation between the Department of Labor, Veterans Employment & Training (DOL-VETS) and each state.

With our economy still struggling and many veterans still without jobs, time is of the essence to provide the necessary support our veterans deserve. This bill will provide each state greater flexibility in the administration of the Jobs for Veterans State Grant (JVSG), encourage states and DOL-VETS to work together to identify the Significant Barriers to Employment (SBE) unique to each state, and improves cooperation at the American Job Centers. The SOLVE ACT simply encourages and empowers those on the front lines to reevaluate and maximize their efforts to support veterans in their state.

Veterans have unique needs depending on their individual circumstances, which can vary from state to state, county to county. JVSG should be designed to assist as many deserving veterans as possible, while ensuring those most in need receive the priority they have earned. The SOLVE ACT requires no additional resources, maintains the existing DOL-VETS oversight of the program, and ensures that DOL-VETS and the states work together to address these needs. NASDVA recognizes and shares the committee's unwavering commitment to our veterans and looks forward to working with all parties toward enactment of this legislation.

S. ____ (Moran), Improvements in the provision of Automobiles and Adaptive Equipment: NASDVA supports this Act. An eligible disabled veteran provided an automobile, or other conveyance, would be given the opportunity to make personal selections. Each person with a mobility issue is unique and has individual requirements and specific features that will allow them to have confidence and be comfortable while they drive - a good example of a veteran centric initiative. To ensure the safety of the driver and the public, this Act will also require vendors to be certified to make vehicle modifications.

S. ____ (Moran), Expand eligibility for hospital care and medical services under section 101 of the Veterans Access, Choice, and Accountability Act of 2014 to include veterans in receipt of health services under the pilot program of the USDVA for rural veterans: NASDVA strongly supports increased opportunities to advance access to care for rural Veterans. To that end, the lessons learned and best practices from the Project ARCH (Access Received Closer to Home) pilot, should be subsumed within the consolidation of purchased care programs already proposed by VA to Congress under the (proposed) improved Choice Program.

Discussion draft, Construction Reform Act of 2016: NASDVA supports this Act with the provision for more non-conflicted audits and quarterly reports when excessive overruns are experienced. This could be of assistance to Congress as these events occur instead of learning about them from the media. Some of the terminology in the language of the legislation could be substantially clarified e.g. "industry standards."

Discussion draft, Modify requirements under which the Department is required to provide Compensation and Pension examinations: NASDVA supports that the Secretary shall treat an examination or opinion as being necessary to make a decision on a claim. Compensation and Pension examinations can reiterate the condition's nexus to military service, wherein "an injury or disease was incurred or aggravated in service; a disease became manifest during an applicable presumptive period; or the claimant experienced an event in service capable of causing injury or disease."

Mr. Chairman and distinguished members of the SVAC "thank you" for this opportunity to submit a written statement for the record in this important hearing. We respect your continuing efforts to improve support for veterans who answered the call to serve our great country. Likewise, NASDVA remains dedicated to doing our part.

LETTER FROM THE NATIONAL MOBILITY EQUIPMENT DEALERS ASSOCIATION

Chairman Isakson, Ranking Member Blumenthal, and esteemed Senators of the Veterans' Affairs Committee: The National Mobility Equipment Dealers Association (NMEDA) thanks you for this opportunity to comment on Senator Moran's Discussion Draft, entitled the Veterans Mobility Safety Act of 2016. Last week, identical legislation, H.R. 3471, was marked up and unanimously passed by the House of Representatives Committee on Veterans' Affairs. We are hopeful that the full House of Representatives will soon have an opportunity to vote on this common sense, bipartisan legislation.

This is an exciting time for our organization that stands in full support of Senator Moran's draft legislation, which would establish enforceable, minimum standards for providers participating in the Automobile Adaptive Equipment (AAE) program, administered by the U.S. Department of Veterans Affairs (VA). As you are aware, there are numerous problems with how the VA currently administers the AAE program.

For far too long, the VA has allowed unqualified providers performing unsafe and unreliable vehicle modifications and equipment installations to participate in the AAE program. If the provider fails to properly install, or modify, the equipment, this scenario quickly becomes a safety hazard for the veteran and the driving public. Unfortunately, this is an all too common occurrence. Further, because the AAE program provides reimbursement (either to the provider or to the qualifying veteran), the taxpayer ends up paying for the inadequate modification services to be corrected. Simply put, Senator Moran's draft legislation would put an end to this dangerous and costly practice.

The VA's AAE program assists disabled veterans by providing reimbursement for the sale, installation, maintenance, and repair of automobile adaptive equipment. Automobile adaptive equipment, including unoccupied wheelchair and scooter lifts, driving controls, and vehicle access modifications enable veterans with disabilities to accomplish daily tasks and participate in work, education, and recreational activities. The AAE program has wonderful potential, but unfortunately, the current administration of the program is alarming, due to the absence of enforceable standards for participating providers.

Inferior providers are also paid by the VA for their work. NMEDA has seen inferior modifications done by: Providers operating out of home garages/parking lots/mobile trucks, vendors lacking insurance coverage, vendors employing uncertified welders and technicians, vendors lacking the specialized tools and equipment necessary to perform AAE vehicle modifications, and vendors unwilling to provide emergency services. Quality concerns range from installing faulty wiring to completing the modifications with chronically unreliable power, steering, and braking systems. Such poor quality installations have very real safety implications and can result in automobile accidents, vehicle fires, injuries, or worse. All modifications to a vehicle involve a degree of complexity. Tinkering with the drivability of a vehicle, particularly a disabled veterans' vehicle, requires skill and workmanship. As such, NMEDA believes that anyone that modifies an automobile in the AAE program should be certified to work on all modifications and installations for our veterans.

Contrast this scenario, where the VA requires an individual to be certified in order to sell a bottle of oxygen to a veteran, yet someone who is not certified can install a $30,000, high-tech electronic driving control system on a disabled veterans' vehicle. In practical terms, this means that anyone can provide this service to veterans, and receive taxpayer dollars for doing so.

The problems do not stop with the first installation. When a veteran complains to the VA about an unsafe installation, the VA has a history of referring the repair work to a vendor certain to complete the job properly. It often costs the VA more money to fix the inferior installation than it would cost to have the installation performed properly to begin with. Senator Moran's draft legislation would get ahead of this problem, and require standards to be set so that veterans know that they are getting work done by a quality, certified provider.

Some have raised unwarranted concerns about the "conflict of interest" section of this draft legislation, particularly the certification of providers by a third party organization or manufacturer. The draft legislation correctly protects against those entities that may stand to unreasonably gain from a certification program, and steps are taken in the bill to minimize the possibility of that happening. NMEDA agrees and supports this language.

However, NMEDA believes that the certification of providers by any one third party organization does not mean that the organization itself has a conflict of interest that is financial, or otherwise. In order to have such a conflict, the VA should analyze whether the third party organization stands to unreasonably gain from the

VA designating the organization's quality standards high enough so that it can certify providers of modification equipment.

NMEDA is dedicated to ensuring that people with disabilities are provided with safe and reliable automotive transportation through the establishment of industry guidelines and quality procedures for the proper and safe installation of automobile adaptive equipment. As such, NMEDA fully supports the Veterans Mobility Safety Act of 2016, as it would require the VA to address disabled veterans' unique mobility needs responsibly and with long-overdue concern for quality, performance, and safety.

Respectfully Submitted,

NMEDA

PREPARED STATEMENT OF BARTON F. STICHMAN AND RONALD B. ABRAMS, JOINT EXECUTIVE DIRECTORS, NATIONAL VETERANS LEGAL SERVICES PROGRAM

Mr. Chairman and Members of the Subcommittee: Thank you for inviting us to submit written testimony concerning legislative efforts to reform the veterans claims and appeals process in the United States Department of Veterans Affairs (VA). Our testimony addresses two discussion drafts: (1) the draft bill "to reform the rights and processes relating to appeals of decisions regarding claims for benefits under laws administered by the Secretary of Veterans Affairs, and for other purposes" sent to the Committee for discussion by Senator Blumenthal (hereinafter "VA appeals reform draft") and (2) the discussion draft to amend 38 U.S.C. § 5103A(d)(2) to change the evidentiary threshold for VA medical examinations and opinions.

The National Veterans Legal Services Program (NVLSP) is a nonprofit veterans service organization founded in 1980 that has been providing free legal representation to veterans and assisting advocates for veterans for the last 36 years. NVLSP has represented veterans and their survivors at no cost on claims for veterans benefits before the VA, the U.S. Court of Appeals for Veterans Claims (CAVC), and other Federal courts. As a result of NVLSP's representation, the VA has paid more than $4.6 billion in retroactive disability compensation to hundreds of thousands of veterans and their survivors.

NVLSP publishes numerous advocacy materials, recruits and trains volunteer attorneys, trains service officers from such veterans service organizations as The American Legion, the Military Order of the Purple Heart and the Military Officers Association of America in veterans benefits law, and conducts local outreach and quality reviews of the VA regional offices on behalf of The American Legion. NVLSP is one of the four veterans service organizations that comprise the Veterans Consortium Pro Bono Program, which has, since 1992, recruited and trained volunteer lawyers to represent veterans who have appealed a Board of Veterans' Appeals decision to the CAVC without a representative. In addition to its activities with the Pro Bono Program, NVLSP has trained thousands of veterans service officers and lawyers in veterans benefits law, and has written educational publications that thousands of veterans advocates regularly use as practice tools to assist them in their representation of VA claimants.

VA APPEALS REFORM DRAFT BILL

This part of our testimony focuses on the VA appeals reform draft bill sent to the Committee for discussion by Senator Blumenthal. We very much appreciate the opportunity to share our views on this important piece of potential legislation. Over the last several months, NVLSP has participated with a workgroup of veterans service organizations convened by the VA to find common ground on a set of reforms to address the serious dysfunctions that exist in the current VA appeals process.

We believe the VA appeals reform draft bill is a welcome attempt to address the serious problems veterans and their dependents face in processing appeals in the VA. We are generally favorable to the bill, with several important caveats discussed below. To be clear, we believe the problems we have identified below can be addressed now. If they are, we support this bill as an innovative means of addressing the systemic delays claimants face in the dealing with their VA appeals.

Before we address the merits of the proposed legislation in more detail, we begin with a general point that is important to remember. The proposed structuring of the administrative appeals process envisioned under the bill is far-reaching. As with any change to a complex system, there will clearly be effects that we cannot now predict. We have considered this reality quite seriously. If the system were functioning generally well, a concern with unintended consequences might be sufficient to oppose such a comprehensive change in the system. But we are not dealing with a well-functioning system. Given that state of affairs, we have ultimately concluded

that the proposed legislation—even without being able to predict all of its effects—is a necessary step. We support it with the changes we discuss below.

I. Positive Features of the Proposed Legislation

We briefly highlight the significant positive features of the changes envisioned under the proposed legislation. Taken together, we believe these features of the draft bill will decrease appeal times while providing claimants with various options for pursing their appeals. The most significant positive features in the proposed legislation are:

• The draft bill provides for enhanced "notice letters" to veterans and other claimants concerning the denial of their claims. Enhanced notice is critically important to veterans as they make determinations about how to proceed when they are dissatisfied with a VA decision.

• The draft bill also eliminates the requirements under current law concerning the preparation of a Statement of the Case (SOC), the veteran's corresponding need to complete an additional step to perfect an appeal to the Board (i.e., VA Form 9) and VA's subsequent need to certify the appeal by completing VA Form 8. While there may have been a time at which the SOC served a useful function in this system, the enhanced "notice letters" required by the proposal eliminate the need for an SOC. Thus, the SOC process serves only to delay the processing of claims.

• The draft bill lowers the standard necessary for re-opening a claim under Section 5108. The current standard of "new and material evidence" is replaced with "new and relevant evidence." While we address below two concerns—one involving supplemental claims and one involving the wording of the new lower standard—the lowering of the standard is critically important. In addition, and as we discuss in more detail below, the revised Section 5108 will allow veterans to obtain earlier effective dates in many circumstances than they would be able to do under the current version of this provision.

• The draft bill allows veterans a meaningful choice when they appeal to the Board of Veterans' Appeals (Board). A veteran may elect to forgo the submission of new evidence and a hearing in cases in which he or she determines such an approach is best. This would provide for more expeditious treatment of such appeals. On the other hand, a veteran can elect to proceed on a track in which the submission of new evidence and a hearing is allowed. This dual-track approach recognizes the reality that not all appeals are alike.

• The draft bill allows a claimant to seek the assistance of a lawyer for pay after an initial denial but before the filing of a Notice of Disagreement (NOD). This is a change from current law in which a lawyer may not charge a fee before the filing of an NOD. While seemingly a small change, we believe this is significant because the structure of the proposed new system provides claimants with myriad ways in which to proceed. Advice to such claimants will be critical and the proposed change allows more options for that advice.

• We believe the draft bill also reduces the means by which the VA can "develop to deny." NVLSP has reviewed many regional office and BVA cases in which the existing record before the VA supports the award of benefits, but instead of deciding the claim based on the existing record, VA has delayed making a decision on the claim by taking steps to develop additional evidence for the apparent purpose of denying the claim. Certain aspects of the current proposal—for example, the restriction on the application of the duty to assist at the Board—will likely reduce such actions.

II. PROBLEM ONE: The Need to Clarify the Right to Both Appeal to the CAVC and File a Supplemental Claim Simultaneously to Protect the Claimant's Effective Date

NVLSP's support of the critically important positive changes to the administrative appeals process contained in the bill comes with several critical caveats. The first caveat is contained in this part of our testimony.

Currently, after a Board decision that disallows a claim, the claimant may file both (i) an appeal with the Court of Appeals for Veterans Claims (CAVC) under Chapter 72 and (ii) a claim with the Agency of Original Jurisdiction (AOJ) under Section 5108 to "reopen the claim" disallowed by the Board "and review the former disposition of the claim," when the claimant submits "new and material evidence." In other words, the claimant does not have to choose between appealing to the CAVC and filing a claim with the AOJ to reopen under Section 5108. The claimant may freely take both actions.

The draft bill renames a Section 5108 claim as a "supplemental claim" and lowers the threshold requirement to obtain readjudication of the previously disallowed claim by substituting the language "new and relevant evidence" for "new and mate-

rial evidence." In addition, no language in the draft bill indicates an intent to change existing law allowing a claimant, after a Board decision that disallows the claim, to file simultaneously both a timely appeal with the CAVC and a Section 5108 claim with the AOJ.

Nonetheless, VA officials have repeatedly represented to the veterans service organizations that if the draft bill is enacted as currently worded, the options available to a claimant will change. According to these VA officials, including Secretary McDonald, after a Board decision disallowing a claim, the claimant would now be required by law to make a choice between appealing to the CAVC and filing a supplemental claim with the RO in order to preserve the date of filing the initial claim as the potential effective date if the claim disallowed by the Board is ultimately granted. As background, after a Board decision disallowing a claim, the claimant may file under the proposed bill a Section 5108 supplemental claim within one year of the Board decision disallowing the claim. If that supplemental claim were ultimately granted, the proposed bill's amendment to Section 5110 would enable the claimant to be assigned the date of filing the initial claim, rather than the date of filing the supplemental claim, as the effective date of the award, as long as the other Section 5110 criterion for assignment of that early effective date is satisfied.

We strongly support this part of the draft bill. Nonetheless, VA officials have repeatedly represented that under the draft bill, if a claimant, after a Board decision disallowing a claim, were to file a timely appeal of the Board decision with the CAVC and lose on appeal, the claimant would incur the following penalty: the claimant could not lawfully be assigned the date of filing the initial claim as the effective date even if the claimant filed a Section 5108 supplemental claim within one year of the Board decision and the VA granted the supplemental claim.

If the draft bill is enacted without a change in language to clarify this matter, and VA continues to insist that a claimant must choose between an appeal to the CAVC and a supplement claim under Section 5108 in order to preserve the date of filing the initial claim as the potential effective date, this matter will inevitably have to be resolved by the Federal courts. Final judicial resolution would likely take years. To be clear, we believe the VA's currently articulated approach is not consistent with the draft bill. But we also realize that it is difficult to predict how courts will resolve legal disputes. No matter how this legal dispute is ultimately resolved, during the years this litigation is pending in court, there would likely be a significant disruption to the VA claims adjudication process and further delays experienced by VA claimants.

Congress should clarify this matter before passing this draft bill to avoid litigation and a disruption to the claims adjudication process. We suggest adding the following clarifying language. First, add the following to the end of line 16 on page 8 of amended Section 5108:

> After a decision of the Board of Veterans' Appeals that disallows a claim, nothing in this title shall be construed to limit the right to pursue at the same time both (i) an appeal of such Board decision to the United States Court of Appeals for Veterans Claims under chapter 72 of this title, and (ii) a supplemental claim under this section seeking readjudication of the claim disallowed by such Board decision.

Second, on line 10 of page 10, redesignate subsection (a)(3) as subsection (a)(4) and add a new subsection (a)(3) containing the following language:

> (3) For purposes of subsection (a)(2), a claim is continuously pursued by filing a supplemental claim under section 5108 of this title within one year of a decision of the Board of Veterans' Appeals without regard to either (i) the filing under chapter 72 of this title of a notice of appeal of such Board decision or (ii) the final decision of the Court of Appeals for Veterans Claims under chapter 72 of this title.

It is contrary to the interests of justice and the pro-claimant process that Congress has created to require claimants to make a choice between filing an appeal with the CAVC and filing a supplemental claim with the RO within one year of the Board decision in order to preserve the date of filing the initial claim as the potential effective date. Each of these two options serves an entirely different purpose. Claimants appeal to the CAVC to correct a prejudicial legal error that they believe the Board made in disallowing the claim, such as a misinterpretation of the law or a violation of the statutory duty to assist by failing to provide the claimant with an adequate medical examination or medical opinion. Claimants file a Section 5108 claim for an entirely different reason. They file a Section 5108 claim in an effort to add positive evidence to the record so that the weight of the positive evidence is equal to or greater than the weight of the negative evidence of record, in an at-

tempt to convince VA that the claim should be granted even under VA's existing view of its legal requirements.

What VA seeks is to force veterans whose claims are disallowed by the Board to make an unfair choice between two options. According to VA's interpretation of the draft bill, each choice alone has a potentially fatal consequence. If the veteran chooses the option of appealing to the CAVC, the veteran cannot add evidence to the record and is essentially limited to arguing that the Court should vacate and remand the Board's decision due to legal error. A fatal consequence occurs if the Court upholds the Board's interpretation of law (as it does in approximately 30% of all appeals). The veteran's right to the date of filing of the initial claim as the potential effective date is lost forever. While the veteran may be able to file a Section 5108 supplemental claim with new and relevant evidence despite the Court defeat, VA's position is that success on that supplemental claim cannot validly lead to an award of benefits retroactive to the date of filing the initial claim that was disallowed by the Board.

On the other hand, if the veteran gives up the right to appeal to the CAVC to challenge the Board's interpretation of the law by choosing the other option—filing a Section 5108 supplemental claim within a year of the Board decision—the veteran enjoys the benefit of being able to add new positive evidence to the record. But the VA's view of what the law requires will most likely be the same as the Board's view of the law when it disallowed the initial claim. Thus, the veteran must shoulder the burden of attempting to convince VA that it should award benefits under an unfavorable view of the law with which the veteran disagrees. Thus, the chance of success is obviously lower than it would be if VA was required to adjudicate the supplemental claim under the veteran's more favorable view of what the law requires.

To be clear then, under the VA's proposed approach, a veteran would need to decide between preserving his or her effective date by filing a supplemental claim or potentially correcting a legal error in the Board's decision through the judicial process. A veteran should not be put in such a position. The interests of justice and maintenance of the pro-veteran claims process that Congress has nurtured for decades should lead Congress to clarify the proposed bill by adding language that makes it plain that after a Board decision disallowing a claim, the veteran has the right to protect the date of filing the initial claim as the effective date by both filing an appeal with the CAVC to correct a prejudicial legal error made by the Board and filing a Section 5108 supplemental claim in an effort to convince VA that the newly added evidence shifts the weight of the evidence so that VA awards benefits even under its unfavorable view of its legal requirements.

III. PROBLEM TWO: The Draft Bill Needs to be Amended to Provide An Effective Date and for Handling the Inventory of Pending Appeals

The draft bill lacks an effective date. In addition, it does not address how VA should integrate the streamlined appeals process contained in the draft bill with the inventory of more than 400,000 currently pending VA appeals. The draft bill needs to be amended to address both of these issues.

During the ongoing discussions between the VA and the veterans service organizations and other stakeholders regarding the reforms contained in the draft bill, the VA recently staked out a position on both of these two important issues. Under the VA's proposal, it appears that the VA would ultimately issue decisions on many new appeals filed after the effective date of the draft bill *before* it issues decisions on many of the 400,000 currently pending appeals. Indeed, it appears to us that under VA's recent proposal, many of the currently pending appeals would be decided by VA years after many new appeals are decided by the VA. NVLSP objects to such an unfair system.

NVLSP has three suggestions regarding the effective date and the need to address the existing inventory of pending appeals. First, NVLSP urges Congress to appropriate a significant amount of additional money on a temporary basis for VA to use exclusively to tackle the backlog of currently pending appeals.

Second, the VA should propose in advance both an effective date for the draft bill and provisions that address the following two issues regarding VA allocation of its resources under the draft bill:

(1) The formula that VA will use to allocate its resources between adjudicating appeals on the non-hearing option Board docket versus adjudicating appeals on the hearing option Board docket under the draft bill's amendment to Section 7107 of Title 38. It is important to address this issue to ensure that BVA decisions on hearing docket cases are not unduly delayed in comparison to cases on the non-hearing option docket due to over allocation of BVA resources to deciding appeals on the non-hearing docket. Transparency in this matter is very important.

(2) Before the bill is passed, it should be amended to provide the formula VA will use to allocate its resources between adjudicating appeals pending at the VA prior

to the proposed effective date of the draft bill and appeals docketed after that effective date. It is important to address this issue to prevent the unfairness to veterans with appeals already pending when the bill goes into effect. It would be fundamentally unfair if these appellants have to wait many years longer to receive a BVA decision than do veterans who file appeals after the draft bill goes into effect because the VA assigned most of its resources to deciding appeals filed after the draft bill goes into effect.

Third, after VA submits its proposal on these matters, veterans service organizations and other stakeholders should be given an opportunity to provide Congress with their views on the VA proposal.

DISCUSSION DRAFT ON REVISION TO EVIDENTIARY THRESHOLDFOR VA MEDICAL EXAMINATIONS AND OPINIONS

NVLSP strongly opposes enactment of the changes to 38 U.S.C. § 5103A(d)(2) contained in this discussion draft. At the outset, it is important to understand the legislative process that led to enactment of current 38 U.S.C. § 5103A(d)(2). That provision was adopted by Congress as part of the VA Claims Assistance Act of 2000 (VCAA) after a long legislative debate in which all stakeholders participated, including the VA and the major veterans service organizations. It contains a carefully crafted compromise. As discussed below, the case law developed over the last 16 years provides clear guidance to both veterans and the VA on their respective obligations with regard to VA assistance. The only significant problems that currently exist involve individual cases in which the VA regional offices or the Board of Veterans' Appeals fails to comply with VA's clear legal obligations.

Under the current statute, VA is required to assist a veteran in substantiating the claim for benefits by affording him/her a VA medical examination or opinion unless there is no reasonable possibility that a VA medical examination or opinion would help the veteran substantiate the claim for VA benefits. Providing a medical examination or opinion is possibly the most important feature of VA's duty to assist, and in many cases, a VA medical examination or opinion will provide the claimant with the evidence needed to substantiate his or her claim. The U.S. Court of Appeals for Veterans Claims correctly determined a decade ago that under the current statute, a claimant has a "low threshold" to satisfy the threshold requirement to obtain a VA medical examination or opinion. See *McLendon* v. *Nicholson*, 20 Vet. App. 79, 81 (2006).

NVLSP agrees that VA has a legitimate interest in not providing examinations in every single disability claim, including those claims that are frivolous. However, the current statute already has protections in place that adequately serve that interest. Under the current statute, if there is no indication that a veteran's current disability or symptoms may be related to an event or injury in service, then the VA does not have to provide the claimant with an examination or opinion. *See McLendon*, 20 Vet. App. at 81; *see also* 38 U.S.C. § 5103A(a)(2) ("The Secretary is not required to provide assistance to a claimant under this section if no reasonable possibility exists that such assistance would aid in substantiating the claim."). Therefore, the VA already has flexibility under the current version of the statute in determining who should be afforded a VA examination. There is simply no need for a revision.

This discussion draft would make it much easier for the VA to deny a veteran's disability claim without the need to provide the veteran with a VA medical examination or opinion. It does so by adding a fourth threshold requirement to the three threshold requirements that already exist in 38 U.S.C. § 5103(d)(2) before the VA is required to provide a VA medical examination or opinion. Under this new fourth threshold requirement, the record must contain "objective evidence" of an in-service injury, disease, or event capable of causing an injury or disease. The discussion draft contains two exceptions to this fourth threshold requirement: cases covered by 38 U.S.C. § 1154(b) involving events that occur during combat and cases involving a disease that became manifest during an applicable presumptive period.

We strongly object to the addition of "objective evidence" to the duty to assist statute because the currently worded statute is working well and the discussion draft suffers from the flaw that it contains no definition of the phrase "objective evidence." The discussion draft inappropriately leaves the task of defining the broad phrase "objective evidence" to the VA in regulations promulgated by the Secretary. That phrase is susceptible to many different interpretations. Thus, nothing would prevent the VA from promulgating regulations that define "objective evidence" of an in-service injury, disease, or event as contemporaneous military department evidence that corroborates the fact that an in-service injury, disease or event oc-

curred—thereby overturning the 2006 Federal Circuit decision in *Buchanan* v. *Nicholson*, 451 F.3d 1331 (Fed. Cir. 2006).

Thus, the "objective evidence" requirement could lead to situations where veterans who provide lay statements about in-service events or their symptoms are not provided with VA medical examinations. For example, if a veteran states that he or she was in an in-service jeep accident that resulted in post-service symptoms or disability and provides multiple buddy statements from witnesses to the in-service event, the VA could discredit these lay statements on the ground that the accident is not corroborated by any contemporaneous military medical or other evidence. Military records do not capture every single injury, disease, or event that takes place in the active duty service of military personnel. And even when military records are created that corroborate these matters, these records are often lost or destroyed. This proposed amendment will likely lead to unfair denials placing an insurmountable burden on the veteran. This would, in our view, be unacceptable.

The fact that veterans currently only have to meet a low threshold in order to be provided with an examination is a positive feature of the system. After all, most disability benefits claims need a medical opinion to substantiate the claim, and many claimants lack the financial resources to obtain a medical opinion from a private physician. Therefore, VA examinations are crucial in helping veterans receive the benefits to which they are entitled. The low threshold established by Congress 16 years ago for what a veteran must meet to require the VA to provide him or her with an examination should be celebrated by Congress, not amended. The only logical rationale for this discussion draft is to reduce the number of examinations that VA must provide. Congress should not make things harder for veterans for the bureaucratic convenience of the VA.

CONCLUSION

Thank you for this opportunity to present our views, and we would be pleased to respond to any questions that Members of the Committee may have.

PREPARED STATEMENT OF THE TEXAS VETERANS COMMISSION

STATE OUTREACH FOR LOCAL VETERANS EMPLOYMENT (SOLVE) ACT 2016

VETERANS EMPLOYMENT

The Texas Veterans Commission (TVC) greatly appreciates the opportunity to submit the following testimony in support of S. 2919, The State Outreach for Local Veterans Employment (SOLVE) Act. TVC would like to express our deepest appreciation to Senator Pat Toomey (R-PA), and Senator John Cornyn (R-TX), Majority Whip, for introducing this timely and important legislation. In addition, we would like to thank every member and staff of the Senate Committee on Veterans' Affairs for their dedicated commitment to providing veterans the support they deserve.

Currently, the Department of Labor's Veterans Employment and Training Services (DOL-VETS) administers the Jobs for Veterans State Grants (JVSG) program. The Federal Government, through JVSG, provides states approximately $173 million to support services to assist veterans find lasting and meaningful employment.

Specifically, under Title 38, the JVSG program provides funding for states to hire Disabled Veterans' Outreach Program Specialists (DVOPS) and Local Veterans' Employment Representatives (LVERs). DVOPS provide intensive services to eligible veterans with significant barriers to employment and LVERs conduct outreach to employers and facilitate employment and training services.

Funding under the current statute is contingent upon the submission of an annual plan by Governors identifying the following:

- the number and types of DVOPS or LVERs;
- their specific roles and responsibilities;
- their geographic location; and
- how the above criteria matches the unique needs of the state's Veteran population.

DOL-VETS is required to accept or reject a Governor's plan in writing before funds are released to a state. If approved, the common model is for the state's workforce agency to administer the JVSG program by passing Federal funds to local workforce boards who provide the approved services to veterans.

Texas adhered to this model prior to 2006. However, out of concern for the under achieving performance of the program in its then current form, Governor Perry and the Texas Legislature took initiative to move the administration of the JVSG program from the workforce agency to the TVC. This move further consolidated critical

veteran services and programs under one agency with the sole focus of supporting the over 1.7 million veterans in Texas.

Under the Texas Model, the JVSG program constitutes the Veteran's Employment Services department which is part of the umbrella of services the TVC provides to Texas veterans and their families. These services includes claims and benefits assistance, veteran education programs, a peer-to-peer networking and counseling program, women veterans outreach, State Strike Force Teams, and a grants program entitled the Fund for Veterans Assistance.

No other state has a full complement of veteran services centralized within the state's veteran affairs agency. This consolidation is key to the success of the Texas Veterans Commission, allowing the agency to concentrate efforts and resources on veterans with a focus not possible when these programs exist as separate components in larger agencies. Since 2008, TVC's JSVG program has been recognized as one of the best in the Nation and received the following awards from Veteran Service Organizations:

- Mark Sanders Award for Exception Service to Disabled Veterans from the National Association of State Workforce Agencies, 2008.
- National Employment Services Office of the Year from the Veterans of Foreign Wars (VFW), 2008.
- National Employment Office of the Year from the American Legion, 2008.
- National DVOP of the Year from the American Legion, and DVOP of the Year from the Disabled American Veterans (DAV), 2008.
- National DVOP of the Year from the DAV, 2009.
- National LVER of the Year, from the DAV, 2009.
- National LVER of the Year, from the DAV, 2013.
- National Employment Office of the Year from the American Legion, 2013.
- National American Legion of the Year from the DAV, 2014.

In the most recent reporting period, Texas' performance led the Nation. The Veterans Employment program assisted 55,864 Texas veterans, with 26,283 of those veterans obtaining employment. As a result of these efforts, 171 veterans obtained employment for every one Veteran Employment Representative. While Texas receives 7% of JVSG total funding nationwide, the state accounts for 18% of the Nation's veterans receiving services and entering into employment.[1]

Despite the success of the Texas Model, DOL-VETS routinely denies other Governors the flexibility to move JVSG funding from state workforce agencies to state departments of veterans affairs (SDVA). For example, Wisconsin's most recent state budget included a provision to move JVSG-funded programs to the SDVA. However, that request was denied by DOL-VETS without providing clear reasoning for its objection to the Wisconsin plan. Instead, DOL-VETS leadership justified their denial by attempting to discredit the Texas program. Other states have expressed interest in a consolidation of veteran services, but express hesitancy to do so in light of DOL-VETS's arbitrary response to the Wisconsin proposal.

We believe that the JVSG program in its current state is unduly inflexible; a one size fits all approach that limits a state's ability to incorporate best practices into their employment program. A state should be able to tailor the intensive services they provide to meet the unique needs of the veterans they serve. An inability to do so can ultimately prevent a veteran from overcoming the unique barriers to sustained employment they face.

The SOLVE Act provides Governors the opportunity to recommend additional Significant Barrier to Employment (SBEs) that hinder a Veteran's ability to find gainful employment in their state. By analyzing local and regional data, states are able to recognize problematic barriers that may not meet the stringent 10 categories currently recognized by DOL-VETS. Allowing a Governor to identify a unique barrier to veteran employment may facilitate valuable communication between states and DOL-VETS and help solve the problem of veteran's unemployment at the macro level.

As part of a state's JVSG Plan, any SBEs recommended by a Governor would still require DOL-VETS approval. If approved, the SBE could be in addition to or in place of those currently used as part of the national standard. Allowing this flexibility would enable the DVOPs to provide one-on-one job coaching and help the specific population overcome the identified barriers through development of employment plans and providing intensive services. This approach is a better alternative over submitting an additional Special Initiative Modification request, which may require DOL to provide additional funding if approved.

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[1] Source *DOL NATIONAL Veterans Report–2013 data.*

The SOLVE Act also provides DOL the ability to approve and disapprove sections of a state's plan rather than rejecting the entire plan outright. Currently, DOL is required to provide in writing their decision to accept or reject a JVSG plan in full. This legislation provides additional common sense flexibility to ensure accountability and responsiveness.

Our veterans are unique. Our states are unique. The method in which we support these deserving heroes should be reflective of their individual situation. TVC understands and supports the need for national standards and program oversight to be centralized within DOL-VETS. They are our partners and we welcome their support and expertise. However, the SOLVE Act provides the necessary level of flexibility to tailor a national program to meet the veteran's needs at the local level.

The Texas Veterans Commission fully supports S. 2919 as does The American Legion, Paralyzed Veterans of America, and the National Guard Association of the United States. We remain committed in our efforts to serve those who have sacrificed so much, encourage swift passage of the bills and stand by to address any concerns or questions the Committee may have.

PREPARED STATEMENT OF URGENT CARE ASSOCIATION OF AMERICA

Statement from the

Urgent Care Association of America

May 24, 2016

In its Oct. 30, 2015 plan to improve Veterans access to health care, the Veterans Administration (VA) highlighted the essential need to partner with providers in communities across the country to meet the "steep increase in demand for care" by Veterans.

Urgent care centers are well-positioned to partner with the VA to meet the needs of patients with non-emergent acute health care needs and to alleviate the pressure on a strained primary care provider workforce and overburdened hospital emergency departments without compromising continuity of care.

Urgent care medicine has become an important link in the chain of health care delivery, providing prompt, convenient and quality care for a variety of common illnesses. As the leading national association representing urgent care, the Urgent Care Association of America (UCAOA) defines urgent care as health care provided on a walk-in, no-appointment basis for acute illness or injury that is not life-or limb-threatening, and is either beyond the scope or availability of the typical primary care practice or retail clinic. Patients need access for common illnesses and injuries – from sprains, lacerations and broken bones, to strep throat and sinus infections. Urgent care centers exist so patients can get help when they need it without excessive waiting or overpayment. Most urgent care centers offer on-site laboratory, X-ray, electrocardiogram and durable medical equipment. The centers are staffed by physicians or a physician-led team. By comparison, retail clinics, are located in retail stores, are typically staffed by nurse practitioners and offer care for a more limited range of health conditions. They do not typically offer care by physicians and have no X-ray or minor surgery capabilities.

Urgent care centers reduce the burden on already overcrowded hospital emergency rooms and are being utilized by many major insurances, integrated health systems, and hospitals to improve access to care. Urgent care center walk-in policies, along with extended hours, are convenient for patients, and wait and overall treatment times are significantly less than receiving similar treatment in a hospital emergency department. Urgent care centers also produce savings to the health care system when lower acuity patients are diverted from expensive emergency departments.

According to the VA, in Fiscal Year 2014, approximately 30 percent of the 2.9 million emergency treatment claims filed with VA were denied, amounting to $2.6 billion in billed charges that were the responsibility of the Veteran beneficiaries themselves, or their other health care coverage if applicable. Many of these denials are the result of inconsistent application of the

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"prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care.

Veterans may receive emergency care at a non-VA health care facility at VA expense. A medical emergency is generally defined as a condition of such a nature that a "prudent layperson" would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. What the VA's finding suggests is that Veterans in need of urgent care and who may not be able to access a primary care physician or VA facility in a timely manner are seeking care in the emergency department, many times finding themselves responsible for the cost of that care.

The experience within the VA system is consistent with national findings that Americans report having difficulty obtaining timely access to a doctor when medical care is needed, including same- or next-day doctor appointments, obtaining medical advice from a physician during normal working hours, and getting medical care outside normal business hours (without a visit to an emergency department).[1]

Providing Veterans access to care for acute, non-life-threatening conditions could be fulfilled by the more than 7,200 urgent care centers thorough the United States, yet, the VA is not authorized to reimburse Veterans for urgent care at this time.

The VA has proposed that to increase access to urgent care services in the community, such services should be reimbursed by the VA.

UCAOA believes that not only will access to and coverage of urgent care services help meet the health care needs of Veterans, but that it has the potential to reduce health care costs to the VA system. A study published in *Health Affairs* found that 13.7–27.1 percent of all emergency department visits, for conditions such as minor acute illnesses, strains, and fractures, could take place at urgent care centers and retail clinics at a potential cost savings of approximately $4.4 billion annually.[2]

Some of the services currently being reimbursed by the VA when provided by hospital emergency department in the community could be provided in urgent care centers at a lower cost. Furthermore, when Veterans with acute care needs delay care, the result can be an exacerbation of the condition, which requires greater medical resources. And, utilizing urgent care centers as access points for after hours and overflow care could reduce the costs of readmission rates for hospitalization, home health and would lower administrative costs via delivery of care in the appropriate setting.

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[1] Public Views on U.S. Health System Organization: A Call for New Directions; Commonwealth Fund Pub 1158 Volume 11. http://www.commonwealthfund.org/~/media/files/publications/data-brief/2008/aug/public-views-on-u-s--health-system-organization--a-call-for-new-directions/how_publicviewsushltsysorg_1158_db-pdf.pdf

[2] Weinick R, Burns R, Mehrotra A. Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics; Health Aff September 2010 vol. 29 no. 9 1630-1636. http://content.healthaffairs.org/content/29/9/1630.full

According to a report issued by the Massachusetts Health Policy Commission in 2015[3], a high share of emergency department visits in the state stem from limited access to care after normal operating hours of the doctor's office. The report also found that the presence of a retail or urgent care clinic nearby reduced use of emergency departments by 30 percent.[4]

UCAOA believes it is important for all Veterans to have a regular source of health care. UCAOA agrees with the VA that access to urgent care in the community should be used as appropriate and not as a substitute for a patient's medical home. Co-management with the patient's dedicated primary care provider is a central tenet of urgent care delivery. According to UCAOA's 2014 Benchmarking Study, 93 percent of respondents indicated they have a mechanism in place to align patients with a medical home when they do not have one. Additionally, when the patient does have a primary care provider, 88 percent of respondents indicated there was communication from the urgent care center to the primary care provider, and approximately 72 percent indicated they had the ability to communicate electronically.

UCAOA supports the use of tools, including financial incentives, that encourage Veterans to utilize their primary care providers for most care, but to seek services at urgent care centers when necessary, including when a primary care provider is unavailable.

The UCAOA represents more than 6,000 individual members working at more than 2,000 urgent care centers throughout the United States. Urgent care centers play a dominant and important integrative role in health care communities across the country and are uniquely positioned to resolve the significant health care access issues facing our nation's Veterans and, in the process, generate cost savings. **The members of the UCAOA strongly urge Congress to take action to allow our Veterans to join the millions of Americans who are afforded access to the quality, cost-effective health care provided at urgent care centers.**

[3] 2015 Cost Trends Report; Massachusetts Health Policy Commission.

[4] 2015 Cost Trends Report; Massachusetts Health Policy Commission. Residents shown all live within 5 miles of an emergency department. Residents who do not live within 5 miles of an emergency department are excluded from 30 percent reduction figure.

LETTER FROM THE VETERANS AND MILITARY LAW SECTION, FEDERAL BAR ASSOCIATION

Dear Senators Isakson and Blumenthal: The Veterans and Military Law Section (V&MLS) of the Federal Bar Association is pleased to submit comments on the proposed legislation regarding amendment of the claims appeals process within the Veterans Benefit Administration. The opinions herein asserted are those of the Veterans and Military Law Section and not necessarily those of the entire Federal Bar Association.

As a general matter, review of this proposed legislation clearly demonstrates that the Secretary desires a more traditional adjudicatory process. However, if that is the legislative intent, then there must be a concomitant acceptance of the traditional role of paid counsel within that system. The claims system within the Department of Veterans Affairs is the only system within the Executive branch of government in which the right to paid representation is precluded until the initial record is complete. This legislation is indicative of an increasingly adversarial process in which it is critical that there should accrue to the veteran/claimant a corresponding increased right to representation qualified to litigate in the adversarial environment created by this legislation.

There are general issues which significantly affect the process as well, all of which may not be subject to address in this legislation, but of which the Committee should, in the opinion of V&MLS be aware, as they significantly affect the quality and the efficiency of the claim and appeal process, i.e. the environment within which this legislation will operate.

1. *Jurisdiction of the CAVC and the Federal Circuit:* The CAVC is the only Article I court without the judicial authority to provide the litigants before it with a final resolution in any case that comes before it. The only relief it may grant an appellant is to either reverse/remand or affirm, and even with grounds in the record for reversal, remand is the only possible ultimate resolution at the Court. While historically this may have been politically justifiable at the inception of the Court, that justification no longer exists. Granting the CAVC the judicial authority to issue dispositive rulings that terminate the potential for repeated remands of appeals on the same issues would have an ameliorative effect on backlogs. Similarly the restriction of the Federal Circuit's jurisdiction to regulatory and legislative interpretation is an artificial limitation on the traditional jurisdiction of a U.S. Circuit Court of Appeal and in a sense limits the recourse of the veteran population to a full and fair hearing of the issues raised.

2. *Qualifications of Board hearing examiners:* The abysmal performance of the "Veterans Law Judges" as reflected in the 2015 Annual Report from the CAVC demands at a minimum the identification and decertification of those whose decisions are consistently overturned by the Court. The more prudent approach, in order to deconstruct the existing culture at the Board is to require that all hearing examiners at the Board meet Title V Administrative Law Judge standards of qualification. The statistics cited below for the reversal/remand rate for those Board decisions that are appealed to the Court are not unique at all to 2015. They have been in those ranges since at least 2002. While transition to Title V ALJs may require considerable initial expense, the reduction in necessary remands and improvement in quality and consistency of decisions will reduce the number of remands and the number of trips around the "hamster wheel" by the individual veteran, his/her survivor or dependent. This will ultimately more than pay for the transition.

3. *Training Issues:* There is no transparency regarding the sources or resources utilized by the Agency to train its rating personnel. Nor is there any discussion of the minimal qualifications for employment as a rater or as a trainee. It is the position of V&MLS that at a minimum applicants for these positions should be required to have an Associate Arts degree from a community college with required courses in biology, physiology and preferred health care related subjects. Most preferred would be a 4 year college degree with courses similarly relevant to the nature of subject matter of claims and health care within the VA environment.

The most egregious deficiencies are in the training of Board personnel. The 2015 Annual Report issued by the CAVC shows that of the 4,030 dispositions of appeals made by the CAVC in 2015, only 445 (11%) were affirmances of Board decisions. 77% (rounded from 76.6%) of the dispositions of appeals were reversed or remanded on at least one ground. There is no excuse for this level of performance on the part of any government entity supported by the American taxpayer. There were 2873 EAJA petitions granted by the Court during this time; a rate of 50% of the remands & reversals, indicating that the Agency was substantially in error at least 50% of the time. This is indicative of substantial deficiencies in the education of Board personnel. Congress has never addressed this issue. It is time to do so.

4. *Leadership Issues:* Disposition statistics of this nature are indicative of first, an insular culture with a mindset resistant to the developing CAVC case law by which its decisionmaking processes by law are to be governed. Who or what is providing the instructional leadership and how is the curriculum developed? Second it is clear that the administrative leadership is non-existent. There has been an "acting" Board chairperson for far too long. It is time to insist that a qualified Board Chairman be appointed and confirmed and given the authority to decline to recertify those hearing examiners (euphemistically characterized as "Veterans Law Judges") whose decisions result in excessive remands and reversals at the CAVC. Too many appeals are at the Court for the second, third and fourth time as a result of the failure of the hearing examiners to follow clear instructions given by the Court.

DISCUSSION OF PROPOSED LEGISLATION

Definitions: The initial proposals to redefine the process by modernizing the definitions under Sect. 101 of Title 38 seeks to remove any barriers perceived to exist to the adjudication of claims through reassignment from the Regional Office with geographical jurisdiction over the veteran's claim to "specialty offices" often far removed from the veteran. While there may be some value in doing that in the instances regarding subject matter, codification provides too much incentive to remove the matter from any reach by a veteran requesting a review within the Agency of Original Jurisdiction (AOJ).

Similarly , removing the word "material" in lieu of "relevant" in the consideration of a readjudicated or "supplemental" claim requires the claimant to "prove" the claim through the evidence submitted, a legal standard to which the veteran may not be held. Similarly, replacing the terms "re-opened claim" and "increase in benefits" with "supplemental claim" alters the landscape by cluttering the process with collateral litigation. The definition proposed does not discriminate the objection to the initial rating benefit granted from a later claim for increase in benefits. What is clear is that the bar for re-opening a previously denied or insufficiently adjudicated claim would be much higher, and if filed within a year of the original decision, no notification would be required. These provisions contribute to the Agency's increasing view of the claims system as an adversarial environment.

As matters stand, the claimant veteran, widow or dependent may only retain counsel prior to the promulgation of a rating decision on a pro bono basis. The basis for this limitation was the premise that the benefits claims system is non-adversarial. The national VSOs were deemed more than capable of assisting the veteran in pursuit of compensation. Since the passage of the VJRA there has been a gradual shift in the nature of the claims system from non-adversarial to a system increasingly governed by an escalating body of decisional law which is entirely inconsistent with the concept of non-adversarial. The proposals in this Bill advance the adversarial elements further than ever before. It is, in the opinion of the V&MLS time to revisit the denial of paid representation at the initiation of the claim.

Duty to Assist: "(c) Section 5103A(f)" underscores the raising of the evidentiary bar to re-adjudication of disallowed claims to a standard that requires that new evidence "prove" the claim rather than be simply "material."

Any doubt as to the shift to an adversarial environment is removed with the proposed addition of Sect. 5103B removing the obligation of the duty to assist from any stage above the initial rating decision. It would, under the provisions of (a), (b) and (c) of this amendment exist only within the original rating process and after the issuance of a "notice" of the rating decision apply neither to any "higher review within the AOJ" nor to any obligation on the part of the Board. Further, the correction of a duty to assist error during a "higher level review" within the AOJ [(1)] is dependent upon the "identification" of said error by the reviewer. There is no duty imposed upon the reviewer to search for or identify a violation of the duty to assist. Remand for correction is required if the claim cannot be granted in full.

Identification of a duty to assist error at the Board [(2)], if the failure occurred prior to the "notice" of the original rating decision, triggers remand for correction if the claim cannot be granted in full. This provision also includes a provision that allows the Board to order an advisory medical opinion as part of the correction. Flaws in the original rating decision are in most instances the result of reliance on an inadequate medical exam, followed by failure to obtain critical records and failure to appropriately consider lay evidence. Current litigation and Agency investigations indicate that this aspect of the claims system is far more troubled than was previously considered with the revelation that an estimated 25,000 veterans may have had improperly conducted exams for TBIs by unqualified examiners. V&MLS is concerned that it is essential that opportunity for paid representation and the opportunity to present additional evidence with or subsequent to the NOD is essential

to improving the cost effectiveness of the system, enhancing the perception of fairness.

Ancillary to this concern is that of the lack of any discovery in either the initial AOJ rating process or in the review process. Credentials of examining personnel and often the identities of examiners and rating personnel are barred from discovery procedures available in similar proceedings in other agencies that are in those jurisdictions considered elementary administrative due process. Transparency in this aspect of the system would conserve agency resources In the long run and diminish the lengthy appeals and litigation surrounding the issue of adequacy of examinations.

The Duty to Assist is a cornerstone concept of Veterans Law. It is the creature of a paternalistic, veterans-first adjudicatory philosophy inherent in the claims system. It is the concept upon which the entire structure of that system rests. It is also the rationale by which paid representation has been limited to the appellate stages of the claims process. The imposition of the Duty to Assist at every stage of the claims process from the initial processing of the claim through the hearing and the consideration before the Board is also the cornerstone of nearly every decision by the CAVC. The limitation of the duty to assist as proposed by this legislation poses a significant impediment to administrative due process on the part of the impaired or pro se veteran before the Agency at any stage of the proceedings. V&MLS strongly opposes any limitation of the duty to assist requirement anywhere in either initial claim or the review of denial of the claim.

Sect. 5104A: V&MLS has no issue with this provision. Any favorable finding should be, as a matter of the law of the case binding on further adjudicatory action.

Sect. 5104B: The provision, under (b) of this Section requires that a request for review by the AOJ be specific as to which office of the AOJ is requested. This requires more precise language. It appears to allow for review by a different set of eyes in another office, i.e. more independent review. If this is the case, V&MLS is not opposed, and continues to urge that the duty to assist be continued, especially for the impaired or pro se claimant.

(a) V&MLS does not disagree with the concept of permitting a request for higher level review within the AOJ. This appears to retain the process of the Decision Review Officer. When this process was allowed to function as it was designed to function it was/is beneficial to efficiency of time and resources and eliminated the need for appeals to the Board by resolving the issues at the AOJ. V&MLS approves of this provision.

(b) V&MLS approves of retaining the one year time allocation for filing a Notice of Disagreement (NOD). However, V&MLS has significant reservations about prescribing overly restrictive provisions governing the form such disagreement must take. The forms "prescribed by the Secretary" are, in their current versions, very narrowly worded and spaced. They are clearly designed to limit the scope of the disagreement and are antithetical to allowing the veteran/claimant any freedom of expression. They are also contrary to existing case law regarding the definition of a NOD. V&MLS urges the Committee to provide guidelines for content of the NOD but to phrase it in the permissive "should" rather than exclusionary mandatory language and to require that the "form prescribed by the Secretary" include sufficient space for addressing the claimant's concerns.

(c) V&MLS urges language added to this provision that requires that copies of Notices under this provision be supplied to both the claimant and any representative, either VSO or counsel. V&MLS recommends that all communication relating notices of decisions or decisions be sent by certified mail. V&MLS further urges the Committee to provide for pre-decisional consultation with any representative of record for the purpose of resolving evidentiary and legal issues that may have arisen in the course of investigating and developing the claim. The purpose for this is to avoid unnecessary higher level review and permitting early resolution of issues presented. V&MLS notes that "previewing" decisional action is common procedure between rating personnel and VSOs who are often co-located in ROs. This should be standard procedure for all representatives, as it is conducive to filling in evidentiary gaps, clarification and administrative best practices.

(d) *Evidentiary Record:* The added Section 5104B also seeks to close the evidentiary record at the issuance of the initial rating decision. While there are provisions in later elements of this Bill for the submission of further evidence at the Board level, to the average pro se veteran, this shuts the door to submission of further evidence. Under this modification of existing law, either a VSO or an attorney retained subsequent to the Notice of Disagreement would be ethically bound to seek by motion to modify the notice of disagreement to provide for utilizing the "hearing option" track at the Board in order to fill in the evidentiary gaps left by either inadequate representation or by the omissions of the pro se veteran.

The unrepresented veteran who fails to ask for the "hearing option " docket in the notice of disagreement and fails to comprehend the consequences of failing to do so loses any opportunity to submit additional evidence in this forum short of filing a supplemental claim, in which the evidentiary bar is much higher. Entry into the appellate stage by either paid or lay representation, under this provision, would require a motion to amend the notice of disagreement to request a "hearing option" docket or higher AOJ review in order to fill in the evidentiary gaps or argue evidence that is relevant but otherwise not of record.

V&MLS categorically disagrees with this provision as it constitutes as a denial of procedural due process and is utterly contrary to the concept of a "veteran-centric VA," unless provision is made for notice of this limitation prominently articulated within the body of the rating decision. Such notice should also advise the claimant that selection of the "hearing option" docket in an appeal to the Board will permit the submission of further evidence.

The fact remains that the combined effect of limitation of submission of further evidence, limitation of the duty to assist and raising the evidentiary bar for supplemental claims/readjudication leaves very little that is non-adversarial within the system. While amending Sect. 5904 to allow the veteran paid representation subsequent to the notice of decision by the AOJ is somewhat ameliorative it fails to permit the veteran access to paid representation in order to better ensure that the AOJ adequately develops the record from the beginning. It should be noted that doing so accords the veteran the Sixth Amendment right to representation by counsel enjoyed by every claimant before every other Administrative agency.

(e) V&MLS agrees that any review by any entity within the Agency at any level should be DE NOVO

Sect. 5104(b): The enumeration of required contents of any notice of denial of benefits is certainly useful, but the language of this amendment appears to codify that which has previously appeared as "Statement of the Case." Limitations should be included which preclude the utilization of endless "explanations" which yield no aids to comprehension and serve only to obfuscate the obvious. The inclusion of the requirement that the content state simply and precisely the basis for the decision in terms readily understood by an unrepresented claimant. V&MLS would then be supportive of this provision.

Proposed Sect. 5104(b) requires, within the enumeration of elements of a denial, (if applicable), identification of criteria that must be satisfied in order to grant (the benefit sought). Yet, any higher review must be done on the basis of evidence considered in the initial development. This is utterly inconsistent and will engender substantial numbers of "supplemental" claims. It makes no sense to require the Agency to advise the claimant of what evidence is missing and at the same time preclude the introduction during the Higher Review of evidence that will satisfy the missing elements. This is not an issue of legal sufficiency or insufficiency; it is a matter of common sense.

Sect. 5108, Supplemental Claims: This amendment of Sect. 5108 replaces "reopened claims" with "supplemental claims:" Under this provision "new and relevant" evidence is required for the adjudication of a supplemental claim. This once again raises the adjudicatory bar much further than does the language of the existing provision. Whereas "material" requires only that the evidence tend to influence the trier of fact because of its logical connection to the issue, "relevant" would raise the bar to evidence that relates to or bears directly on point or fact in issue; proves or has tendency to prove a pertinent theory in the case. This is a technical, legal requirement imposed on a process that is required to be veteran-centric. This language is a trap for the pro se claimant, inviting a quick denial. V&MLS urges the Committee to recognize that this is once again a further shift to an adversarial process in which paid representation should be a recognized right accruing to the claimant.

Sect. 5109 is given a new subsection under which the Board may remand a claim to the AOJ for procurement of an advisory medical opinion to correct an error by the AOJ to satisfy its duties under 5103A *when* the error occurred prior the AOJ decision on appeal. This adds an unnecessary step to the review process—requiring the matter to be remanded yet again. Nor does it specify whether this applies to errors on the part of a "higher-level reviewing authority" within the AOJ. As a significant number of duty to assist errors are incident to inadequacies of medical exams, this should be clarified.

Sect. 5904, Amendment: The proposed amendment of (c)1 and (c)2 appears to move the point at which paid representation becomes available to the veteran to the point of the issuance of the decision on the initial claim by the AOJ; "notice of the Agency of Original Jurisdiction's initial decision under Section 5104 of this Title."

Under the existing statutory provisions paid representation is not available to a veteran/claimant until the point at which the Notice of Disagreement is filed.

Given the existing political climate, the ban on the availability to the veteran of paid representation at the initial submission of a claim may be unlikely to be lifted. However, it should be noted that Congress has, within the last decade, recognized the advisability of allowing paid representation before the Agency. Merely providing an opportunity for paid representation prior to submission of the notice of disagreement is a benefit without practical application; there is no mechanism for repairing a deficient record prior to filing the Notice of Disagreement before the door to submission of additional evidence is closed. The pro se veteran, especially an impaired pro se veteran is out in the cold. In view of the proposed significant restriction of the opportunities for introduction of additional evidence, it is critical that these provisions be as broad as possible. V&MLS supports this provision with significant reservations as stated above.

Sect. 7105, Amendments: V&MLS is supportive of the proposed amendment (b)(1), establishing the time for the filing of the notice of disagreement within one year of the mailing of the notice of the Agency of Original Jurisdiction's decision.

The proposed amendment of (b)(2) establishes legal, technical requirements of allegation of specific errors of law or fact to be inscribed on the Secretary's specific form. Once again, the process shifts further toward an adversarial process in which the unrepresented claimant is presumed to have an unrealistic level of knowledge or expertise. While the opportunities for representation are broadened, the fact is that significant numbers of claimants/appellants before the Board and the Court are unrepresented (27% of appellants at the Court were pro se at filing the NOA in 2015). It is critical to the veteran-centric intent of the claims process that there are provisions for liberal interpretation of what constitutes conformity with the requirement of this provision as proposed. V&MLS urges careful attention to language in this provision as proposed and implementing regulations to avoid adverse impact on the pro se claimant.

V&MLS is supportive of the proposed amendment (b)(3) in that it establishes a three track option for appealing the decisions of the Agency of Original Jurisdiction to the Board. We do, however, suggest that the language more clearly identify the tracks by enumeration.

V&MLS is similarly supportive of the proposed language of Sect. 7105(c), maintaining the jurisdictional finality of Agency of Original Jurisdiction decisions that remain unappealed after one year.

The provisions of 7105(d) as amended eliminate the Statement of the Case and the laborious process it entailed. V&MLS agrees with this provision with the proviso that in order to maintain the veteran-centric character of the claims process that the language also provide that submissions by pro se claimants be read liberally for allegations of error of law and fact. The unschooled or impaired pro se claimant must not be penalized by technical legalistic requirements he/she is incapable of meeting.

Sect. 7106: V&MLS supports the deletion of Sect. 7106.

Sect. 7107: V&MLS supports the amendment of Sect. 7107(a), (b) and (c) as proposed. V&MLS does, however, urge that sub-section (f) be amended to require that the Board screen those cases in which the claimant is pro se for adequacy of the record and undertake such further development as may be necessary to satisfy the duty to assist. In this regard V&MLS re-iterates our strong disagreement with the elimination of the duty to assist after the initial rating decision.

Sect. 7113: V&MLS supports the provisions of this Section with the caveat that the due process requirements of the duty to assist be afforded the pro se appellant, particularly if review of the record demonstrates that the appellant is impaired. This additional provision is consistent with V&MLS position regarding the proposed restrictions on duty to assist, submission of evidence and the impact of these measures on the pro se and impaired claimant.

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REVISION OF EVIDENTIARY THRESHOLD FOR MEDICAL EXAMINATIONS AND OPINIONS.

V&MLS strongly opposes this proposal. It constitutes an effort to overturn the longstanding precedential decision of the Court of Appeals for Veterans Claims in *McLendon* v. *Nicholson, 22 Vet. App 79 (2004).* This decision rested on the determination by CAVC that VA's failure to order a C&P exam was arbitrary and capricious and a violation of the Duty to Assist. It was determined by the Court that the provisions of Sect. 5103(d) established a very low threshold for the requirement for medical examinations. In writing this decision, Judge Kasold iterated several examples of the linkage that this provision is designed to establish information, (*inter*

alia—exposure to artillery fire indicative later development of hearing loss) that assists in informing the rater of another piece of the nexus picture to ensure that the rater has all of the information necessary to reach an informed and fair decision.

The language of the proposed revision imposes on the claimant the requirement of "objective evidence." This raises the evidentiary bar to the level of proof, rather than "indication." It appears that the proponent of this provision would require that the three elements articulated in (A) be met in order to reach the point that a C&P exam is required. Judge Kasold emphasized in the opinion that "Although the claimant may and should assist in processing a claim, it is the Secretary who has the affirmative, statutory duty to assist the veteran in making his case (Cit. omitted). It is the Secretary who is required to provide the medical examination when the first three elements of section 5103(d)(2) are satisfied, and the evidence of record otherwise lacks a competent medical opinion regarding the likelihood of medical nexus between the in-service event and a current disability. The Board is not competent to provide that opinion." *McLendon, supra, at 86* V&MLS cannot support this provision. Given the pending legislation before this Committee which proposes elimination of the duty to assist beyond the original decision by the AOJ, this is an unacceptable attempt to shift the burden entirely onto the claimant.

It should also be noted that implementation of a treating physician rule, wherein the VA treating physician (as well as the private physician when appropriate) are consulted on issues of nexus would improve the quality of medical evaluations and go a long way in relieving the stress of physician availability in VHA. The rationale that treating physicians will have too much sympathy for the patient to provide an unbiased opinion is specious at best as well as demeaning to the professional integrity of the treating physician. At a time when VHA is suffering from an acute shortage of medical personnel the continued duplication of effort in this regard is a waste of taxpayer dollars.

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S. 2487: V&MLS supports this Bill with one qualification. We respectfully request that a provision be added in which VA is required to coordinate with Indian Health Service (IHS) to develop culturally competent suicide prevention programs for Indian women veterans. There are at this time no culturally competent mental health programs for Indian veterans at all. Indian women veterans, particularly those with MST/PTSD are at a very high risk because of the cultural consequences of their experiences. This bill needs to address that issue.

S. 2679: V&MLS supports this Bill without reservation. The results of toxic exposure in Vietnam have yet to be fully counted. The generational effects have been largely ignored or swept under the rug of bureaucratic accountability. The children of the Vietnam veterans are now those in SW Asia; exposed to the toxins of the burn pits, burning oil fields, unidentified ordinance; we cannot afford to repeat the errors of yesterwar. This legislation is badly needed. We urge Congress to establish this Center for Excellence and monitor its progress annually.

S. 2888: V&MLS supports this Bill without reservation. The residuals of long-term exposure to contaminated water at Camp LeJeune are, again, not fully measured. Of particular concern are the families who lived on-post and raised children there. We urge that this legislation include substantial outreach to those veterans and families in order to study and address the down-range effects of this extensive contamination. It should be considered as well that many military families from outside Camp LeJeune accessed base medical, commissary and exchange facilities. This is commendable legislation that is needed to provide oversight and guidance to ensure VA's address of these issues within VBA.

S. 2919; S. 2896; S. 2883; S. 2520; S. 2049: V&MLS is supportive of all of these measures as each provides for an area in which either VA has demonstrated a need for guidance or the circumstances of service have resulted in a separate need, as is demonstrated with the introduction of S. 2919.

Respectfully submitted,

THE VETERANS & MILITARY LAW SECTION,
FEDERAL BAR ASSOCIATION

Addendum:

May 25, 2016

Hon. John Hardy Isaakson
Chair
Senate Committee on Veterans Affairs

Hon./ Richard Blumenthal
Ranking Member
Senate Committee on Veterans Affairs

Dear Senators Isaakson and Blumenthal:

The Veterans & Military Law Section (V&MLS) of the Federal Bar Association is pleased to submit further comments on the proposed legislation addressed in yesterday's hearing. These comments were inadvertently omitted from the comments submitted on May 18, 2016. The opinions herein asserted are those of the Veterans & Military Law Section and not necessarily those of the entire Federal Bar Association.

Revision of Evidentiary Threshold for Medical Examinations and Opinions.

V&MLS strongly opposes this proposal. It constitutes an effort to overturn the longstanding precedential decision of the Court of Appeals for Veterans Claims in *McLendon v Nicholson, 22 Vet. App 79 (2004).* This decision rested on the determination by CAVC that VA's failure to order a C&P exam was arbitrary and capricious and a violation of the Duty to Assist. It was determined by the Court that the provisions of Sect. 5103(d) established a very low threshold for the requirement for medical examinations. In writing this decision, Judge Kasold iterated several examples of the linkage that this provision is designed to establish information, (*inter alia* – exposure to artillery fire indicative later development of hearing loss) that assists in informing the rater of another piece of the nexus picture to ensure that the rater has all of the information necessary to reach an informed and fair decision.

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S. 2919; S. 2896; S. 2883; S. 2520; S. 2049:

V&MLS is supportive of all of these measures as each provides for an area in which either VA has demonstrated a need for guidance or the circumstances of service have resulted in a separate need, as is demonstrated with the introduction of S. 2919.

Federal Bar Association

Veterans & Military Law Section

V&MLS further supports the expansion and transition of the Choice Act to a permanent entity within VHA. The difficulty of travel to VA VHA facilities for many aging and severely impaired veterans would be greatly alleviated by this measure. We do note that the reports of failure of administration which has led to payment issues for private providers still requires considerable Congressional oversight. We applaud the Committee's efforts in this regard.

Thank you for your invitation to submit written testimony. We hope to provide information and perspective on further issues as they arise. V&MLS has a strong commitment to our active duty military service members and to our veterans.

Respectfully submitted,
The Veterans & Military Law Section
Federal Bar Association

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