

THE INDEPENDENT BUDGET

Veterans Agenda for the 114th Congress

Policy Recommendations for Congress and the Administration



The Independent Budget for the 114th Congress



PROLOGUE

The contributions made by our veterans to the growth and development of the United States are part of the basic fabric of the nation. In fact, the very foundations of the American way of life were, in large part, hewn by individuals who at some point in their lives served in the United States armed forces. Unlike the environment in which today's voluntary force serves, during our nation's infancy military service was a highly accepted and even expected obligation of citizenship. Then and now the leadership and determination of service members and veterans to set by example and serve as influential frontrunners in all areas of American society—economic, political, social, and moral—we are able to enjoy the stature as the leader of the global community of nations.

Our service members, on behalf of all our citizens, share a long history of shouldering the burden and bearing the sacrifice of defending this country. For this reason, our veterans and military service members have been the beneficiaries of the promises and support of a grateful nation after serving. Veterans "benefits" have been purchased by an individual's sacrifice and therefore should not be diminished by politics or any dereliction of duty by Congress or the Administration. The promises made to our service members, who stepped forward and selflessly raised their right hands as part of a solemn oath to "support and defend the Constitution of the United States against all enemies, foreign and domestic" must be faithfully upheld and fulfilled.

Through this publication, the four *Independent Budget* co-authors—American Veterans, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars—have had the longstanding responsibility of illuminating and consolidating for the Administration, Congress, the Department of Veterans Affairs, Department of Defense, and the American people, the highly specialized benefits, health care, infrastructure, education, employment, training, and memorial concerns and challenges being faced by our service members and veterans, along with consensus recommendations to address these concerns.

INDEPENDENT BUDGET AUTHORS

INDEPENDENT BUDGET AUTHORS

The four coauthoring organizations have worked in collaboration for 29 years to produce *The Independent Budget* to honor veterans and their service to our country. Throughout the year each organization works independently to identify and address legislative and policy issues that affect the organizations' memberships and the broader veterans community.

AMERICAN VETERANS (AMVETS)

Since 1944, American Veterans (AMVETS) has been preserving the freedoms secured by America's armed forces, and providing support for veterans and the active military in procuring their earned entitlements, as well as community service and legislative reform that enhances the quality of life for this nation's citizens and veterans alike. AMVETS is one of the largest Congressionally chartered veterans service organizations in the United States, and includes members from each branch of the military, including the National Guard and Reserves.

DISABLED AMERICAN VETERANS

The Disabled American Veterans (DAV), founded in 1920 and chartered by Congress in 1932, is dedicated to a single purpose—empowering veterans to lead high-quality lives with respect and dignity. This mission is carried forward by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV members also provide voluntary services in communities across the country.

PARALYZED VETERANS OF AMERICA

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

As a partner for life, Paralyzed Veterans also develops training and career services, works to ensure accessibility in public buildings and spaces, provides health and rehabilitation opportunities through sports and recreation, and advocates for veterans and all people with disabilities. With more than 70 offices and 34 chapters, Paralyzed Veterans serves veterans, their families, and their caregivers in all 50 states, the District of Columbia and Puerto Rico.

VETERANS OF FOREIGN WARS OF THE U.S.

The Veterans of Foreign Wars of the U.S. (VFW), founded in 1899 and chartered by Congress in 1936, is the nation’s largest organization of combat veterans and its oldest major veterans service organization. Its 1.5 million members include veterans of past wars and conflicts, as well as those who currently serve in the active, Guard, and Reserve forces. Located in 7,900 VFW Posts worldwide, the VFW and the 600,000 members of its Auxiliaries are dedicated to “honoring the dead by helping the living.” They accomplish this mission by advocating for veterans, service members, and their families on Capitol Hill as well as state governments; through local community and national military service programs; and by operating a nationwide network of service officers who help veterans recoup more than \$1 billion annually in earned compensation and pension.

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

SUPPORTERS

African American Post Traumatic Stress Disorder Association
African American War Veterans of the U.S.A.
Air Force Association
Air Force Sergeants Association
American Coalition Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees (National VA Council)
American Foundation for the Blind
American Military Retirees Association
American Military Society
American Psychiatric Association
American Psychological Association
American Society of Nephrology
American Thoracic Society
American Veteran Alliance
American Veterans for Equal Rights
American WWII Orphans Network
Armed Forces Top Enlisted Association
Association of American Medical Colleges
Association of the United States Navy
Blinded Veterans Association
Combined Korea-US (KORUS) Veterans Association
Commissioned Officers Association of the U.S. Public Health Service
Easter Seals
Fleet Reserve Association
Gold Star Wives of America, Inc.

Jewish War Veterans of the USA
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National Alliance for Eye & Vision Research
National Alliance on Mental Illness
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of State Head Injury Administrators
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Disability Rights Network
National Gulf War Resource Center
Navy Seabee Veterans of America, Inc.
Nurses Organization of Veterans Affairs
P-47 Thunderbolt Pilots Association
The Sergeant Thomas Joseph Sullivan Center
United States Coast Guard Chief Petty Officers Association
US Federation of Korea Veterans Organizations
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Vietnam Veterans of America

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SECTIONS OF THIS YEAR'S *INDEPENDENT BUDGET* WERE WRITTEN BY:

Christina Arenas, Paralyzed Veterans	Ray Kelley, VFW
Adrian Atizado, DAV	Mark Lichter, Paralyzed Veterans
Denny Boller, AMVETS	Gerald Manar, VFW
Carl Blake, Paralyzed Veterans	Lana McKenzie, Paralyzed Veterans
Linda Blauhut, Paralyzed Veterans	Aleks Morosky, VFW
Richard Daley, Paralyzed Veterans	Blake Ortner, Paralyzed Veterans
Peter Dickinson, DAV	Susan Prokop, Paralyzed Veterans
Jim Fischl, Paralyzed Veterans	Paul Varela, DAV
Ryan Gallucci, VFW	Joseph A. Violante, DAV
Sherman Gillums, Paralyzed Veterans	Jennifer A. Zajac, Paralyzed Veterans
Joy Ilem, DAV	Diane Zumatto, AMVETS

ADVISORS:

Heather Ansley, Esq., VetsFirst
John M. Bradley III, DAV Senior Advisor
Frederick Downs, Paralyzed Veterans Prosthetics Consultant
John Driscoll, National Coalition for Homeless Veterans
Gary Ewart, American Thoracic Society
Amy Hogan, DAV Research Assistant
Heather Kelly, PhD, American Psychological Association
Robert Norton, Military Officers Association of America
Grant Olan, American Society of Nephrology
Matthew Shick, Association of American Medical Colleges
Thomas Stripling, National Association of Veterans Research and Education Foundations
Jennifer Zeitzer, Federation of American Societies for Experimental Biology

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INTRODUCTION

The Independent Budget for Fiscal Year 2016 has been revamped in an effort to make it more user-friendly and to make clearer its intent and recommendations. Additional changes include the following:

- New additions will be released biennially at the beginning of each new Congress.
- Priority issues and recommendations will be highlighted at the beginning of each new edition.
- Unlimited additional policy recommendations/issue briefs are released as needed throughout the new two-year cycle.
- Budget recommendations are released as a stand-alone document.
- Recommendations are found at the beginning of each article.
- Articles are presented in summary/issue brief format.

Although the look and feel of *The Independent Budget* is fresh and new, our mandate remains resolute—to ensure that the Department of Veterans Affairs provides—

- competent, compassionate, timely, and consistently high-quality health care to all eligible veterans;
- timely and accurate delivery of all earned benefits to veterans and their eligible dependents and survivors, including—
 - disability compensation,
 - pensions,
 - education,
 - housing assistance, and
 - other necessary supports
- dignified memorial services to all eligible veterans; and
- the preservation of our national cemeteries as shrines to those lost after serving our nation.

In formulating our policy and program recommendations, *The Independent Budget* veterans service organizations (IBVSOs) consider not only the ongoing and evolving needs of our current veterans, but also the needs of the hundreds of thousands of American men and women who in the near future will be applying for and utilizing the benefits they so dearly earned. As leaders in the veterans service organization community, the IBVSOs (American Veterans, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars) have shared their combined expertise in formulating policy recommendations for nearly 30 years for the benefit of those fighting to protect the rights and earned benefits of all American veterans.

This policy document, then, is meant not only to serve as a wide-ranging reference focused on all issues important to veterans, but also to be an educational tool for the use of the Department of Veterans Affairs and all veteran stakeholders, as well as the American people, Congress, and the Administration. The IBVSOs hope that our joint recommendations included within these pages serve as seeds for improving the lives of veterans, as well as providing some hard-earned positive support for the many challenges facing our veterans, including transitioning to civilian life, recovering from injuries, obtaining a living wage from employment, and securing a comfortable retirement.

Critical Issues



Timely Access to High-Quality Health Care

RECOMMENDATIONS:

VA and the Administration should propose budget requests similar to those laid out in the recommendations of *The Independent Budget* and Congress should favorably act on these requests.

Congress should invest significant new funds in VA capital to ensure that facilities remain up-to-date and capable of delivering safe, quality services to all veterans who need them.

VA should ensure that VA facilities understand how to deliver non-VA care through either Patient-Centered Community Care or traditional fee-basis care models and that non-VA Care Coordination teams are properly staffed to make timely outside referrals.

VA should ensure that contract non-VA care provider networks possess the tools and resources to deliver timely care to veterans upon receipt of VA referrals.

The VHA should make public its reports by VA facility, indicating the number of veterans waiting beyond the access-to-care standards.

The VHA must address the recommendations contained in Office of Inspector General audits and other reports on timely access to care.

The OIG should conduct a follow-up evaluation of the VHA outpatient scheduling systems and its procedures, compliance, employee training, monitoring, and oversight.

VA must implement a solution to the information technology limitations of the current appointment scheduling software that will also address interrelated health care delivery functions in VistA to improve efficiency of care delivery, operating, and capital resources.

The VHA should also include VA purchases from the private sector in the timeliness-of-care standards indicators for veterans who receive care.

VA should modernize the VA appointment scheduling system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans.

VA should develop and implement wait-time standards that would trigger non-VA care referrals. These standards should be based on quality-of-care outcomes and the clinical needs of veterans. VA must ensure that these standards are enforced at every facility.

VA should strengthen accountability protocols for all VA employees—not just for senior executives—to ensure that poor-performing employees are held accountable for their actions.

VA should implement comprehensive training for all VA employees that focuses on quality customer service and positive health outcomes.

VA should streamline federal hiring protocols for VA health care professionals to ensure that VA can compete with private industry to hire and retain the best health care providers and do so in a timely manner.

VA should implement and sustain effective whistleblower protections for VA employees who expose improper practices in VA facilities.

BACKGROUND AND JUSTIFICATION:

In April 2014, the disclosure of long and secret waiting lists at the Department of Veterans Affairs Medical Center in Phoenix, Arizona, and the subsequent disclosure of thousands of veterans waiting too long for care around the country, shined the light on a problem that *The Independent Budget* has identified for years. Timely access to high high-quality health care services remains a clear objective that VA has not achieved. Access to health care, along with the cost and quality of that care, is generally considered one of the three major indicators for evaluating the performance of a health care system. Prevalent delays in delivering timely care result in patient dissatisfaction, higher costs, and increased risk for adverse clinical consequences. These facts became evident in Phoenix and other VA centers around the country.

Generally speaking, veterans who receive care from VA in a timely manner are satisfied with that care, but veterans are understandably frustrated by the roadblocks they encounter trying to receive timely appointments. VA health care access has been a subject of rigorous debate for more than a decade. As far back as 2002 more than 310,000 veterans were waiting 6 months or more without appointments for needed medical care. That same year the first *Independent Budget* wrote an article on waiting times for outpatient appointments, in which the IBVSOs urged the Veterans Health Administration (VHA) to “identify and immediately correct the underlying problems that have contributed to intolerable clinic waiting times for routine and specialty care for veterans nationwide.” Unfortunately, the problems exposed around the country last year validated that our warnings had been generally ignored. Access still remains the principle problem facing the VA health care system today. Moreover, the access problem is compounded by insufficient funds, insufficient staffing, and an ineffective scheduling system.

Addressing the Funding Shortfall

We believe many of the access problems facing the VA health care system are the joint responsibility of Congress and the Administration. Although both branches of government are committed to improvements, current and past Administrations have requested wholly insufficient resources to meet the ever-growing demand for health care services and at the same time attempted to fragment the VHA health system framework. Congress bears additional burden for the problem as it continues to appropriate insufficient funding to meet the needs of veterans seeking care. The disclosure by VA late last year that it needs to add as many as 28,000 providers—physicians, nurses, therapists, etc.—to the ranks of the VHA in order to meet growing demand while also accounting for attrition of its workforce clearly reflects the fact that VA has been left wanting for resources to appropriately build its capacity.

For many years, the IBVSOs have advocated for sufficient funding for the VA health care system, and the larger VA. Our thorough analysis of health care utilization in VA evolves a set of full and sufficient budget recommendations to address known current and future utilization of the system. Moreover, our recommendations are not clouded by the politics of fiscal policy. In fact, despite the recommendations of *The Independent Budget for FY 2015* (released in February 2014), Congress enacted an appropriations act for VA that we believe was nearly \$2.0 billion short for VA health care in FY 2015 (based on previous estimates) and approximately \$500 million short for FY 2016. After the disclosures of seriously repressed demand across VA in 2014, we believe the funding shortfall may be significantly greater than what we projected last year.

While the IBVSOs understand that federal agencies have increasing pressure to hold down spending and that Congress has moved toward fiscal restraint in recent years, the health care of veterans outweighs those priorities. We certainly appreciate the fact that Congress provided approximately \$5 billion to expand internal capacity, as well as supported other priorities, in P.L. 113-146, “Veterans Access, Choice and Accountability Act (VACAA).” However, we also recognize that these resources will be released only slowly over an extended period of time while, demand for health care services will continue to grow. To satisfy this increased demand, new and sufficient resources must be found.

Non-VA Purchased Care and Coordinated Care

VA must remain the guarantor of care, wherever that care is provided. VA facilities, therefore, must refer veterans to community providers using a system that requires full coordination and guarantees access and quality.

Under the traditional fee-basis system, VA would issue veterans in need of non-VA care authorization letters or cards. This system allowed the veteran to “shop” for a provider who accepted authorization for VA payment and who could schedule an appointment in a timely manner. Following the appointment, the veteran would be responsible for returning to VA records of the care received, in order to have them included in the veteran’s VA medical record. This traditional system was entirely uncoordinated, failed to guarantee access or quality, and was highly susceptible to improper billing of the veteran and improper payments by VA. At times this system even exposed veterans to unnecessary financial hardship as a result of VA unwillingness to pay for services erroneously billed to the veteran that should have been fee-based, or because of unreasonable delays in VA payment to private providers.

The dangers of uncoordinated care are well documented. An April 2013 an Office of the Inspector General (OIG) report revealed the mismanagement of non-VA care at the Atlanta VA Medical Center in which approximately 4,000 veterans were referred to non-VA mental health providers without an adequate tracking system. The OIG found that this situation led to an average wait time of 92 days, with 21 percent of veterans receiving no care at all, and others never receiving any follow-up from VA. Even VA staff admitted to the OIG that because of the large number of referrals, many veterans had “fallen through the cracks.” The lesson from Atlanta is clear: VA must not be allowed to push large numbers of veterans to outside providers without proper coordination simply to create the appearance that access is being provided.

In order to address the problems of fee-basis care, VA developed a new contract care model, Patient-Centered Community Care (PC3). Under this program, networks of specialty care providers were created to provide care at prenegotiated rates in a well-coordinated manner. VA also recently expanded the PC3 to include non-VA options for primary care. However, the PC3 networks are not yet fully operational nationwide. According to VA, veterans will be referred to PC3 providers if direct care cannot be readily provided because of lack of available specialists, long wait times, or geographic inaccessibility.

In theory, the PC3 program should help solve the access problems that have been plaguing many VA facilities. The program cannot succeed, however, if individual facilities are not open and honest about access-to-care issues and accurate appointment wait-time data, all of which continue to be unreliable. The IBVSOs believe that VA must develop and implement wait-time standards that would trigger PC3 referrals, and enforce those standards at each facility. Rather than an arbitrary number of days, these wait-time standards should be developed based on the type of care being provided and the immediacy of the individual veteran’s need for that care based on a physician’s or other professional provider’s medical opinion.

Although the IBVSOs generally support the PC3, we will be watching its progress closely, and we ask Congress to conduct robust oversight to ensure that the PC3 is being utilized to its full potential. Specifically, we will want to know which facilities are using the PC3 appropriately to reduce actual wait times and which are not. If certain facilities are not making proper referrals because of poor training, lack of standards, or institutional resistance, VA must move swiftly to address those problems. If the PC3 is not being used effectively because of insufficient funding at the local level, we will call on VA and Congress to work together to obtain the resources they need.

The PC3 program is new, and the IBVSOs recognize that the capacity of its networks may not immediately be sufficient to provide timely access for all specialties. In addition, the PC3 is not currently set up across the board to provide primary care. Consequently, some facilities may need to enter into local contracts for specific services. Under no circumstances should veterans be expected to coordinate their own care or be held responsible for record sharing when receiving care outside of VA. We believe that all contracts and agreements should include provisions that ensure the same level of coordination, access, and quality as the PC3 contracts. Any-

thing less than full compliance to these provisions would not only fail to address the access problems many VA facilities are facing, but would also represent a huge step backward in the evolution of non-VA care.

Finally, VA recently implemented a new method through which non-VA care would be coordinated at each facility. VA facilities have now been directed to establish Non-VA Care Coordination (NVCC) teams responsible for determining whether care should be delivered through the newly commissioned Veterans Choice Card, the PC3, other contracts or sharing agreements, or traditional fee-basis models. The NVCC is also designed to ensure that the veteran will not be billed for coordinated non-VA care. The IBVSOs insist that veterans must never be held financially liable for authorized non-VA care. The IBVSOs agree that centralizing the referral, claims, and coordination process has the potential to cut down on red tape for veterans who need non-VA care, but in order to succeed, NVCC teams must be adequately staffed to competently coordinate care, and process timely referrals and payments for care. If the NVCC is poorly staffed, veterans will likely face referral backlogs and persistent billing problems, further exacerbating access issues.

Access Through Choice

To address the problems that the VA health care system experienced, Congress approved on a bipartisan basis P.L. 113-146 to expand purchased care outside of VA. The IBVSOs cannot overemphasize the fact that VA specialized services—spinal cord injury and dysfunction care, amputation care, blind care, polytrauma care, etc.—are unique VA resources that cannot be duplicated and sustained in the private sector. Moreover, establishing a scenario whereby veterans can choose to leave the VA health care system—a reality of the act of Congress—places the entire system at risk. Former VA Secretary Anthony Principi explained recently in the *Wall Street Journal* why the concept of a veterans’ choice card (as provided for in the VACAA) is not a viable long-term solution to the problems facing the VA health care system:

“Vouchers (a concept of “choice”) are not necessary to ensure high-quality health care... While this may have value in areas with long waiting lists, it raises serious questions. The VA system is valuable because it is able to provide specialized health care for the unique medical issues that veterans face, such as prosthetic care, spinal-cord injury and mental-health care. If there is too great a clamor for vouchers to be used in outside hospitals and clinics, the VA system will fail for lack of patients and funds, and the nation would lose a unique health-care asset.”

These specialized services for veterans do not operate in a vacuum. The viability of VA health care depends upon a fully integrated system where all of the services inherently support each other. Sending veterans into the private health care marketplace supports parts of this principle while undermining others. Contract care is not a viable option for veterans with the most complex and specialized health care needs. Sending those individuals outside of VA places their health at significant risk while abrogating VA of the responsibility to ensure timely delivery of high-quality health care for our nation’s veterans. Leveraging coordinated, purchased care is still a part of the solution to access problems in VA. However, granting easier access to the private sector should not adversely affect the existing health care system or the catastrophically disabled veterans who rely nearly exclusively on VA for their health care.

Appointment Scheduling and Tracking

For years, VA has been tracking appointments with a scheduling system that relies on outdated software that produces unreliable wait-time data. In some cases, employees have manipulated schedules to mask the amount of time veterans waited to receive care. The IBVSOs believe that timely access is impossible unless wait times are accurately captured, recorded, and reported publically. VA must implement an updated appointment scheduling system that accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veteran. All employees must be fully trained and the policy must be adhered to at every VA facility. VA recently issued a request for proposals to acquire a new appointment scheduling system. The IBVSOs are concerned that this procurement either will be rushed and VA will award a contract that results

in a new, but still inadequate, scheduling system, or that the VA chronically troubled procurement system will bog down and procurement may take inordinate time for veterans who cannot afford to wait.

We emphasize that a new scheduling system alone will not solve VA scheduling problems. The VA current method for measuring timeliness is arbitrary and does not reflect the care needs of veterans. Arbitrary wait-time deadlines of 15, 30, or 45 days do not necessarily correlate to quality health care outcomes. A veteran's "desired date" also does not necessarily reflect the clinical needs of a patient. At worst, a desired date is a subjective timeline that has been proven to be highly susceptible to manipulation and misrepresentation. VA must determine reasonable wait times based on the different types of care needs—non-urgent and urgent, primary, and specialty—of individual veterans. If VA must track appointment wait times, they must be measured from the date a veteran contacts VA seeking care, rather than tracking from a subjective desired date.

We appreciate the fact that VA recently published regulations for tracking wait time that require care to be provided within 30 days of the date that an appointment is deemed clinically appropriate by a VA provider, or if no such clinical determination has been made, the date a veteran prefers to be seen. Under this regulation, any conflict between the clinically determined and patient's desired date must be resolved between the provider and patient. The IBVSOs believe extensive monitoring is essential to ensure that this principle is applied consistently and appropriately across the VA system and in all facilities.

Accountability

The medical community readily acknowledges that staff attitudes and proper bedside manner have an undeniable impact on quality, satisfaction, and health care outcomes. An environment in which patients are belittled or degraded does not foster recovery. Civilian hospitals know this and strive to cultivate an environment conducive to healing.

We believe that VA should be held to a higher customer-service standard than civilian hospitals. Poor customer service in VA facilities demands specific actions to address accountability, staff competencies, and staff morale. The IBVSOs have long been concerned about accountability of employees at all levels of VA from the highest executive offices at VA Central Office to the nursing assistants and part-time clerks at VA medical centers. Unfortunately, managers cannot easily sanction poor-performing employees, and VA cannot quickly hire new employees to close gaps.

During a hearing before the Senate Committee on Veterans' Affairs in May 2014, then-VA Secretary Eric Shinseki noted that VA had reprimanded, moved, demoted, retired, or terminated 3,000 VA employees for poor performance. However, when senators pressed the Secretary on exactly how many had been terminated, the Secretary acknowledged that very few were fired but instead were moved, demoted, or forced to retire.

With passage of P.L. 113-146, Congress gave the VA Secretary faster authority to immediately fire executive-level employees for poor performance effective after a brief period to appeal the decision. The IBVSOs note that the ability to take immediate action against senior executives only applies to actions initiated after the bill was signed into law. Despite the constant clamoring for individuals involved in the Phoenix scandal and other VA facilities to be terminated, VA cannot exercise its new authority against senior executives whose poor performance occurred prior to the approval of the law.

Strict firing authority is not a complete solution to accountability. The IBVSOs believe VA should instead offer robust training to employees at all levels to promote quality customer service. All employees who interact with veterans must understand that their primary function is to serve the needs of veterans in a considerate and compassionate manner. Those employees who cannot deal with veterans with compassion must only work in positions in which they do not interact with veterans or should resign from VA.

Additionally, whenever an employee leaves VA, VA acknowledges that six months to a year are required to fill vacant positions—assuming a viable pool of candidates is interested and available. When VA seeks to

replace health care professionals, VA bureaucracy cannot compete with nimble private health care systems. Private health care systems can easily fill vacancies in a matter of days or weeks. While doctors, nurses and nurse practitioners may have noble intentions of working for VA and serving veterans, many will forgo what could be a year-long waiting period and pursue timely employment opportunities elsewhere. For these reasons, the IBVSOs ask Congress to carefully review VA appointment authorities, internal credentialing processes, and common human-resources practices to identify ways to streamline the hiring process. If VA cannot quickly fill its vacancies with top talent, we cannot expect VA to deliver timely, quality care those who need it.

Several VA whistleblowers have stated that transparency was stymied within VA, meaning proper protocols could never be implemented to deal with the real challenges the agency faced in delivering timely care to veterans. When failures are identified, they must be swiftly corrected with better oversight, sufficient funding, and accountability of those responsible for retaliating against whistleblowers and mismanaging VA health care.

The IBVSOs believe that Congress and the American public should resist any suggestion that VA health care be dismantled in favor of an alternative model. The narrative that VA is a failed or flawed system could potentially be more disastrous for veterans who need care than any cover-up already exposed. Such suggestions not only serve to relieve VA of its responsibilities but fail to take into account the contributions that VA makes to veterans, their families, and the medical community as a whole. VA's goal must be to ensure that as many veterans as possible are able to receive quality VA care in a timely manner.

Fixing the VBA Claims-Processing and Appeals Systems

RECOMMENDATIONS:

The VBA must openly and honestly reassess whether the target goal established five years ago—that all claims would be completed within 125 days with 98 percent accuracy by the end of 2015—remains realistic and achievable. If the VBA confirms these goals are not reachable, it must work in a transparent and collaborative manner with Congress and its veterans service organization (VSO) partners to set new goals, revise current strategies, or request new resources.

The VBA must increase the amount and quality of its training programs for both new and onboard employees and managers, must allocate sufficient resources to ensure the best training methods, and must not be constrained by arbitrary travel or meeting restrictions.

The VBA must accelerate the development of the Veterans Benefits Management System (VBMS) to complete remaining core and critical components, including major modules, to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations. The VBA must be provided sufficient resources to expand VBMS with all its core components, as well as provide sufficient resources for VMBS or other compatible information technology solutions required to link the remaining VBA business lines, including the BVA.

The National Work Queue (NWQ) program must be implemented carefully in order to retain to the maximum degree practical the benefits of local processes and relationships in order to attain accurate claims decisions. The NWQ must be implemented in a manner that recognizes and responds to the different organizational structures and needs of VSOs that represent veterans in the claims process. Congress must carefully and continually oversee the NWQ program in order to ensure that the quality and accuracy of claims processing remains the most important consideration for workload management.

Congress should enact legislation to create a Fully Developed Appeals pilot program, modeled after the existing Fully Developed Claims program, one that would allow appellants to receive more timely decisions from the BVA if it agrees to a streamlined appeals process and accept responsibility for assembling new private evidence required to justify their appeals.

Congress should enact legislation requiring the VBA to provide due deference to private medical evidence that is competent, credible, probative, and otherwise adequate for rating purposes.

The VBA must strengthen the Decision Review Officer (DRO) program by refocusing DROs on the de novo review function of their responsibilities, ensuring sufficient numbers of DROs to meet appeals workload in all regional offices, and ensuring that DROs focus on appeals-related work and perform no original ratings work.

Congress should enact legislation to effectively eliminate the “new and material evidence” standard, which generates unnecessary work for the VBA and the BVA but that provides no practical benefit to veterans.

Congress should enact legislation to require that when a claimant submits a nonstandardized form with the intention of disagreeing with a claims decision, the VBA must respond to the claimant with a standardized Notice of Disagreement (NOD) form, including instructions on how and when it must be completed and returned. The VBA must allow the claimant the remainder of the NOD time period, or 60 days, whichever is longer, to return the completed form.

BACKGROUND AND JUSTIFICATION:

In early 2010 with a growing backlog of disability compensation claims and no solution in sight, the Veterans Benefits Administration (VBA) set out to transform and modernize its systems and procedures for processing veterans' claims for benefits. Despite numerous failed attempts to modernize its claims-processing systems over the past 2 decades, the VBA made the critical decision to develop new plans to transform its paper-based systems and replace them with modern information technology systems and business processes. Former VA Secretary Shinseki announced ambitious aspirational goals for transforming the claims system, promising that by 2015, the VBA would decide all claims for disability compensation within 125 days and that they would be completed to a 98 percent accuracy standard.

Today, with less than 12 months remaining in 2015, dramatic transformation of the claims-processing system has occurred and significant progress can be measured towards reaching those goals. For example, the VBA created and implemented a new organizational model for its Regional Offices, developed and then rolled out a new fully developed claims (FDC) process to speed simpler claims, and collaborated with VSOs to create new standardized medical evidence forms, called Disability Benefits Questionnaires, to streamline the rating process. The VBA also designed, tested, and deployed critical new Information Technology (IT) systems, including the Veterans Benefits Management System (VBMS), the Stakeholder Enterprise Portal and e-Benefits, which together have revolutionized the electronic filing of claims.

In 2010, no claims were processed electronically; by the end of 2014, more than 93 percent of VBA 526,000 pending claims were fully electronic and less than 40,000 paper claims remain in the system. There have been more than one billion images scanned into the VBMS associated with veterans' new e-Folders, allowing them to be simultaneously read at all VBA offices, 148 VHA facilities, and by VSOs who represent veterans. In 2015 almost 75 percent of the rating schedule, which covers far more than 90 percent of all rating decisions, will have been coded into "calculators" and embedded in the VBMS to assist Rating Veterans Service Representatives to make rating decisions. Every day thousands of veterans file and track their claims online either through e-Benefits or with a service officer through SEP.

While all these achievements and progress are laudable, an analysis of current claims-processing data and trends raises some questions about whether the aspirational goals Secretary Shinseki first talked about in early 2010 remain achievable by year's end.

Historic Progress but Unrealistic Goals

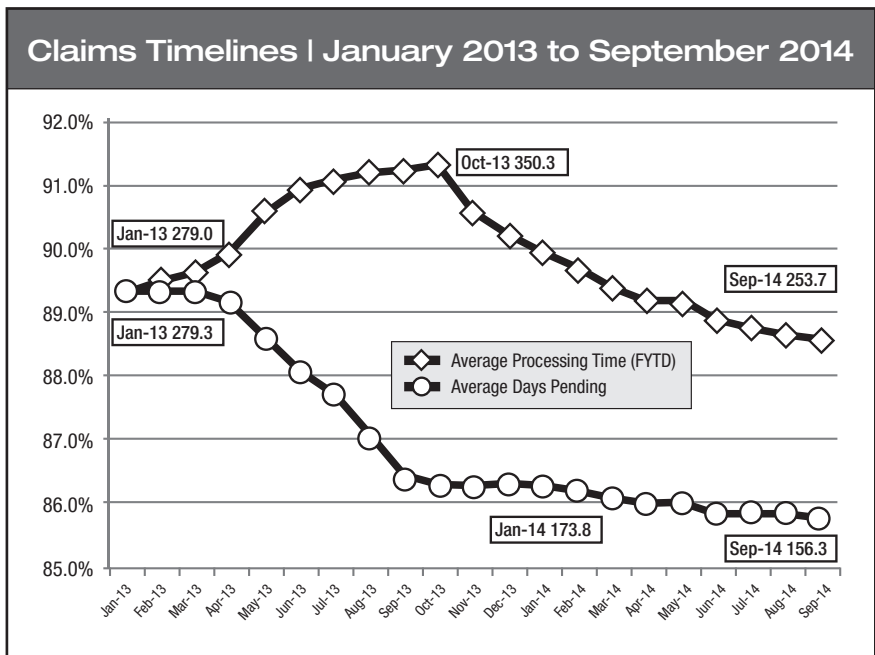
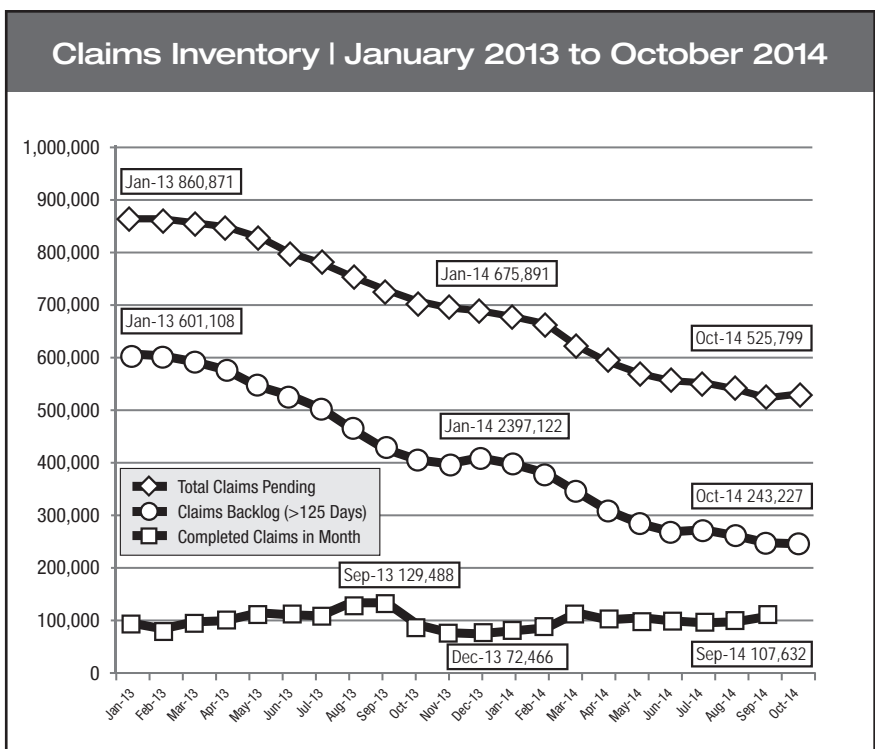
When the VBA initiated its current transformation efforts five years ago, the volume and complexity of claims was rising and did not reach a peak until the beginning of 2013, largely driven by the VA decision to add new presumptions for Agent Orange-related conditions in Vietnam veterans. According to VBA Monday Morning Workload Analysis reports, by January of 2013 the total number of pending claims for disability compensation and pension claims had risen to over 860,000, of which more than 600,000 were older than 125 days, the VBA official metric for the backlog. However, by the end of 2013 the total pending inventory of claims had been reduced by more than 20 percent, and the number in backlog status was cut by over 33 percent. Through September 2014 the total pending inventory of claims dropped an additional 22 percent, and the backlog was reduced by almost 40 percent more. Since the peak in January 2013, the total pending inventory of claims fell from 860,000 to just over 525,000, a reduction of about 40 percent. The total number of claims in backlog status dropped even more dramatically from 600,000 to just over 240,000, a reduction of almost 60 percent.

While both the total pending inventory and the total number of claims in the backlog has steadily declined for almost two years, the number of completed claims per month has remained more or less constant, hovering around 100,000 according to the VBA Aspire Dashboard. The highest work volume occurred in September 2013, when almost 130,000 claims were completed, primarily because of the VA policy of mandatory overtime that month. Overall, the trends shown in the chart above appear to indicate a slowdown in the reduction of

both the total pending inventory and the backlog.

Based on data from the Aspire Dashboard, the timeliness of claims has also improved; however, it remains far from the 2015 goal for all claims to be completed in less than 125 days. In January 2013 the Average Processing Time and the Average Days Pending metrics were both approximately 280 days. Early in 2013, the VBA initiated its 2-year-old claims initiative to complete the oldest part of its inventory, followed shortly thereafter by its one-year old claims push. At that time, the VBA indicated that completing its oldest claims would increase the average processing times with a corresponding reduction in the average days pending measure, a reduction which occurred through most of 2013. Once the older claims initiatives were substantially completed, the average processing times began to rapidly fall, and the average days pending continued to fall, but at a more modest rate. By September 2014 the average days pending dropped to about 250 days and the average processing times to about 150 days.

Both of those numbers reflect “average” times, however, and the VBA’s 2015 target is based on all claims being completed with 125 days requiring an average processing time of 80 to 90 days. As with pending inventory, the trends reflected on the chart above raise questions about whether the target will be met by the end of 2015.



Finally, perhaps the most important metric of a properly functioning claims-processing system is the accuracy of decisions. According to the VBA Aspire website, in January 2013, the VBA claims accuracy based on its Systematic Technical Accuracy Review methodology was 86.4 percent for the most recent 12-month period, and 86.8 percent for the most recent 3-month period. Throughout 2013 the 12-month accuracy rate rose steadily to almost 90 percent by year’s end, while the 3-month accuracy rate climbed as high as 91 percent at one point, before declining back to 90 percent.

Among the reasons for these increases were sharpened focus on training, testing, and quality control, including the creations of Quality Review Teams, the dramatic reduction of VCAA “duty to assist” notification errors

because of the inclusion of this notice directly on application forms, and the elimination of other errors because of automation within the VBMS for certain processing steps. Based on the trend line in the chart above, the accuracy rate appears to be leveled off, raising questions about when the VBA will reach its 98 percent goal.

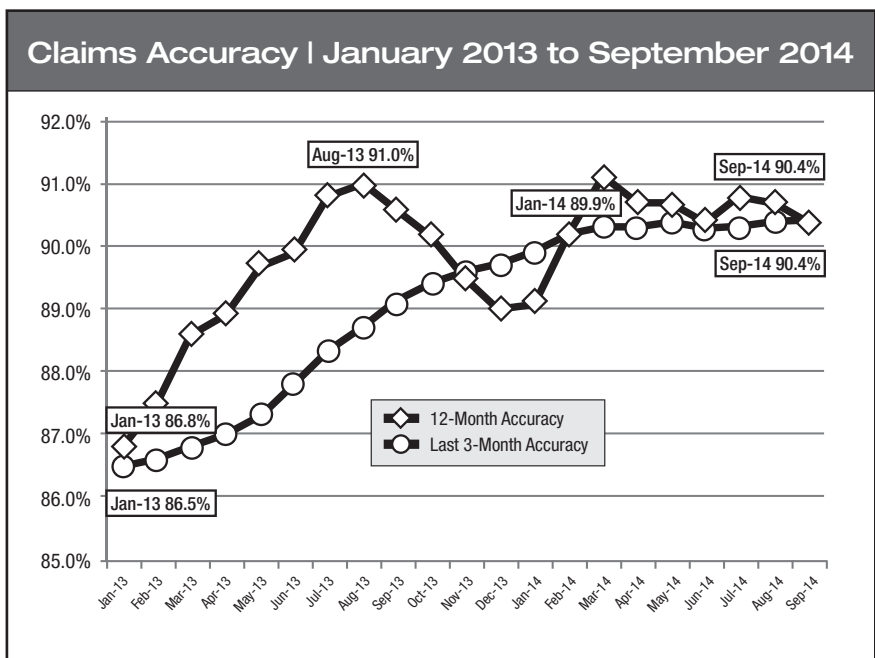
Overall, the VBA has made significant progress toward reaching the 2015 goals set by former Secretary Shinseki in 2010; however, with less than a year remaining to reach those “aspirational goals,” now is an appropriate time for the VBA to reassess whether those goals are still appropriate and achievable. If the

VBA concludes they are not, it is imperative that new, more realistic goals are set not just for this year but for the next several years. If targets need to be adjusted, strategies revised, or new resources provided, the VBA must work openly and cooperatively with both Congress and VSO stakeholders to justify these changes.

Building a Culture of Quality and Accountability

Vital lessons on the dangers of unrealistic or unachievable goals can be learned from the recent VA health care scheduling scandals. The VHA employed a metric that health care medical appointments for veterans should be scheduled within 14 days of the “desired date, a goal that was widely viewed by VHA employees, veterans, and veterans advocates as unrealistic in lieu of the VHA’s capacity to provide care at that time. Constrained by an insufficient number of clinical professionals and inadequate treatment space, most VHA employees did not expect to meet this metric. Yet the metric remained the standard by which employees and their facilities would be measured and held accountable. Faced with an unachievable goal, some employees made the unfortunate decision to manipulate data and cover up true waiting lists rather than be held accountable for failure to meet this metric. Following revelations about the scheduling and waiting list violations, VA quickly removed this unrealistic metric, a decision that gained the full support of Congress, while working to develop more realistic metrics for waiting times designed to improve performance and responsibly hold employees accountable.

The critical question that VA and Congress must resolve is whether the aspirational goals established five years ago by the prior Secretary continue to positively drive the VBA performance in the right direction or whether VA should reassess and potentially revise some of the target goals now, rather than take the risk that unreachable goals again might distort reporting. VA must provide complete and accurate data and answers to these critical questions. For its part, Congress must work together with VA in an open, transparent, nonpolitical, and nonpartisan manner to ensure that VBA claims and backlog goals are driving productive change and progress to improve outcomes for veterans, not just to meet metrics.



Transparency and Partnership with VSO Stakeholders

A renewed commitment to full transparency and partnership with VSOs is another critical factor ensuring reforms in the VBA claims process. At the outset of the transformation efforts, the VBA worked very closely with VSO stakeholders in both the planning and execution phases. This cooperation, collaboration, and partnership resulted in a number of successful initiatives, including the VBMS, FDC, and Disability Benefits Questionnaires. However, VBA openness and outreach to VSOs has noticeably diminished in the past few years. Clearly, the drive to reach the 2015 goals has increased both the pressure on and the workload facing the VBA, resulting in a tendency to focus inward rather than outward.

However, the VBA would be making a mistake if does not continue to fully engage with its VSO stakeholders in the design and execution of new and existing transformation initiatives. VSOs have tremendous experience and expertise in claims processing, and through our service programs, the IBVSOs are active partners inside the VBA regional offices. Our service officers not only help veterans get quicker, more accurate decisions on their claims for benefits, they also reduce the VBA workload and serve as another layer of quality control. As the VBA works toward completing the claims transformation, it remains essential that it pro-actively engage and collaborate with VSO stakeholders and increase the level of transparency about their activities.

Information Technology Modernization and Improvement

The most critical and dramatic elements of the VBA claims-processing transformation have been the new IT systems—the VBMS, e-Benefits and SEP—built over the past five years. These three systems have led the way in moving claims processing from an outdated, paper-based system to a modern, automated digital system. Despite some early challenges, the VBMS program has proven to be an effective platform for processing claims in a digital environment. The challenge now is to fully integrate all phases of the claims-processing system, all VSOs, and the other VBA business lines into a single, unified digital-work environment.

Because of budget constraints, current planning at the VBA calls for some critical elements of the claims process, including major new modules to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations, to be slowly phased in over the next several years. Similarly, plans to expand the VBMS or other compatible IT solutions to all remaining VBA business lines and the Board of Veterans' Appeals (BVA) are being stretched into future years because of budget considerations. Congress must provide sufficient resources to the VBA to allow the critical elements of the VBMS just described to be accelerated. The VBA must also place greater emphasis on creating new and adjusted current elements of the VBMS to better integrate VSO service officers and to resolve lingering issues in the Stakeholder Enterprise Portal, both of which are essential to maximizing the benefits provided by veterans service organization service officers.

Business Process Changes

The National Work Queue

In the first quarter of 2015, the VBA is scheduled to begin operation of the National Work Queue (NWQ) program, a paperless workload-management initiative designed to improve the VBA claims-processing productive capacity. The NWQ builds on the work-flow and management capabilities provided by the VBMS allowing veteran's e-Folders containing all of their personal information, data, and records to be instantly transferred to any regional office (RO) and incorporated into the work queue of any employee. The NWQ is intended to provide the VBA with the ability to redistribute workload to ROs based on parameters such as the amount of pending workload and the number, experience, and type of employees working at each RO. The NWQ can also separate and allocate workload based on any parameters or priorities established by the VBA. In effect, the NWQ acts as the nexus between VBA business processes and IT systems, playing the role of “traffic cop” for claims processing.

During the first phase of the NWQ deployment, the primary filter for determining where a veteran's claim will be processed will be the veteran's place of residence, as is the case under the current organizational model. However, if the veteran's local RO is under-resourced or overburdened with work, the NWQ will assign that claim to another RO, brokering it in a much more efficient, timely, and accountable way than exists today. The NWQ will also have the ability to assign development of a claim to one RO but the rating work to a different RO if that referral results in a more timely decision. The NWQ could potentially divide claims by issue, assigning some of the development and rating work to multiple ROs, about which the IBVSOs would have concerns; the VBA, however, has indicated it does not have plans to divide claims in this manner.

The NWQ can provide the VBA with significant technological capabilities to reorder and redistribute workload. The VBA, however, must ensure that the NWQ remains a tool to enhance sound business processes rather than determine which business processes the VBA will use. The goal must always be to improve veterans' outcomes and protect their rights in the claims process. Furthermore, while modern information technologies are changing the nature of communication and social interaction, the VBA should retain, to the extent practical, the benefits of having VSO service officers working locally inside ROs where they help the VBA achieve quicker and more accurate decisions for veterans.

Standardized Forms for Claims and Appeals

On September 25, 2014, VA issued a Final Rule for Standard Claims and Appeals Forms, requiring that all claims and appeals for benefits must be filed on standard forms issued by the VBA, including informal claims. Under the new rule, if a claimant files a written claim or appeal using anything other than a standard form, the VBA will not recognize that filing as a claim or an appeal but will generally send the claimant the appropriate standardized form with instructions on how and when the form must be completed. This new standard form rule includes the filing of an informal claim. A claimant can only preserve an effective date for a claim by filing an informal claim on the standard form, even if the claimant makes perfectly clear in his or her written filing that he or she intends to file a formal claim in the future.

Similarly, claimants who intend to appeal a claims decision can only use the new standard Notice of Disagreement form; any other written communication will not be accepted as a Notice of Disagreement (NOD). The VBA will not be required to respond to such filings by sending claimants the standard NOD form. If a claimant files an incomplete standardized NOD form, the VBA will send the claimant a standard form with instructions on how and when he or she must complete that filing. However, the VBA will provide no extension of time to allow a claimant who submits an incomplete NOD form near the end of the NOD's one-year time period to allow him or her to complete and return the standard form.

The IBVSOs understand the need to use standard forms whenever possible in order to create a more efficient claims-processing system to benefit all claimants, but this rule allows no reasonable exceptions or extensions to accommodate the small number of claimants who would require such accommodation. Considering the fact that claimants often have physical and mental limitations from service-connected disabilities that may hinder their ability to fulfill these new requirements, the IBVSOs believe that this rule should be amended to allow limited commonsense exceptions and extensions.

For the purpose of establishing the effective date for a claim, the VBA must accept both standard and nonstandard communications that clearly indicate the intent to file a claim for benefits at the earliest possible effective date. Also, when a claimant sends any written communication to the VBA indicating his or her disagreement with a claims decision, the VBA must send that claimant the standard NOD form with instructions on how and when it must be completed. The VBA must also allow the veteran either the remainder of the one-year NOD period or 60 days, whichever is longer, to complete and return the standard NOD form.

Private Medical Evidence

The VBA must also expand the use and acceptance of private medical evidence in order to eliminate the time and resources required to administer medical examinations. Accepting private medical evidence would also increase the number of FDCs filed. Unfortunately, some ROs and employees resist giving private medical evidence the same weight as VA medical evidence. In order to further support efforts to encourage the use of private medical evidence, Congress should amend 38 U.S.C § 5103A(d)(1) to provide that, when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not require a duplicative and redundant VA medical examination.

Appeals Reform

While the claims backlog has fallen significantly, as indicated above, the backlog of pending appeals has grown in recent years. Despite the fact that the BVA completed more than 55,000 appeals decisions in FY 2014, an increase of 10 percent over the highest previous total, the number of appeals at various stages working their way through the VBA toward the Board now tops 330,000, not counting the approximately 60,000 already pending before the Board.

Claims Decision Letters

The format and content of claims decision letter can influence the number of appeals filed. Veterans forced to wait up to a year or longer to get an initial decision are less likely to have complete confidence in that decision, particularly when the decision is a denial, than if their claim were decided within a reasonable timeframe. As *The Independent Budget* has noted in recent years, the current format of claims-decision letters, which evolved from the Simplified Notification Letter program, often contains insufficient information to allow veterans and their representatives to fully understand the rationale for the rating decisions or the evidence considered. Without sufficient confidence in rating decisions, veterans and their advocates are more likely to pursue appeals options. The VBA must continue to work with VSOs to improve claims-decision letters.

Decision Review Officer Program

An essential VBA program that can help lower the appeals workload is the Decision Review Officer (DRO) post-determination review process, which can resolve otherwise appellate-bound disputes at the local level. A DRO has “de novo” authority, meaning he or she is empowered to review a claimant’s entire appeal file, with no deference given to the rating board decision. When warranted, a DRO can issue a new, independent decision that obviates further appeal. The IBVSOs strongly support the DRO program.

For years, the IBVSOs have voiced concerns that the number of DROs is insufficient for the amount of DRO work that is generated in regional offices. Further, the assignment of original claims-processing work to DROs at numerous regional offices is merely shifting the weight of the backlog from one area (claims) to another (appeals.) Over the past year the VBA leadership has made some efforts to limit the use of DROs in performing original claims-processing work; however, we continue to observe DROs at many ROs working on original claims. The IBVSOs believe it is imperative that every regional office assign an adequate number of DROs, and that DROs focus solely on appeals work; if additional personnel are needed, the VBA must request new resources, not repurpose DROs.

Fully Developed Appeals Pilot Program

In order to seek new solutions that could improve the appeals process for veterans, the IBVSOs, other VSO stakeholders, the VBA, and the BVA have informally discussed a proposal to create a “fully developed appeals” (FDA) program modeled after the FDC program. The premise of the FDA program is that the appellant would assume responsibility for gathering any new private evidence necessary to support the appeal and would agree to eliminate some steps and work currently performed by the VBA and the BVA; in return, the veteran would receive a significantly quicker appeals decision by the BVA.

At the time of the NOD election, the veteran would submit any evidence and argument he or she wants considered in appeal, and would certify that he or she has been fully informed about the FDA program and that the appeal would go directly to the BVA on a newly created FDA docket. There would be no SOC created or issued, no Form 9 to complete and file, no local RO hearings or reviews, no Board hearings, no SSOCs, and no Form 8 certification process. According to the BVA, the elimination of these steps alone could save two to three years of processing at the RO compared to a traditional appeals process.

The FDA program should be created as a statutorily authorized pilot program in order to allow Congress and stakeholders to oversee details of the program's design, implementation, and operation. While the FDA proposal is not the magic bullet that will eliminate the backlog of pending appeals, it creates another option that could save some veterans up to a thousand days waiting for their appeals to go to the Board while also reducing the workload in both the VBA and the BVA. As discussed above, the IBVSOs continue to strongly support the DRO process; the FDA program is neither a substitute nor replacement for it. Instead, it will provide another voluntary option that each individual veteran and representative, if any, could consider as they make decisions about the most effective and timely way to resolve their appeals.

New and Material Evidence Standard

Current statute (38 U.S.C. § 5108) requires that in order for a decided claim to be reopened and reconsidered, "new and material evidence" must be presented by the claimant or secured by the VBA. This standard was intended to prevent the VBA from re-opening and re-adjudicating claims based on existing evidence that was the basis for the original rating decision. However, the statute today provides no actual benefit since almost anything submitted by the claimant can arguably be considered both new and material. Further, even if the VBA does invoke the new and material standard, claimants can appeal that ruling to the Board and request a hearing, which in itself could be considered "new and material evidence."

The practical effect of the new-and-material evidence standard has been that rather than reducing the workload on the VBA by dissuading additional unnecessary submissions by claimants, the current statute has resulted in additional work by the Board without any appreciable reduction of workload for VBA. While the standard may have been intended to be a filter barring submission of irrelevant evidence, it does not effectively serve that purpose and should be repealed or reformed.

Resource, Budget and Technology Needs

Finally, in order to address BVA's pending and future workload, Congress must provide additional resources to enable the Board to hire sufficient personnel. Furthermore, BVA's need to modernize IT systems will require that additional resources be provided to the VA IT program and that those resources be allocated to BVA's IT needs. The Administration must request, Congress must provide, and VA must properly allocate sufficient resources to meet all of VBA's personnel and infrastructure needs, which includes both physical and IT infrastructure. While specific recommendations on FTEE levels, funding increases, and IT requirements are contained in the *IB's* budget report for Fiscal Year 2016, without new resources no amount of reform or reorganization will allow the BVA to meet its rising workload within a reasonable timeframe.

Over the next year VA must work collaboratively with both Congress and VSO stakeholders to openly and honestly review its budgets, goals, and plans for claims processing and appeals, and if necessary, revise these processes appropriately. The VBA must continue to refine its new business processes as well as accelerate development of new IT systems and components to support the new work. And in order to truly fix its claims processing and appeals systems, the VBA must develop a new work culture focused on quality and accountability.

Maintaining and Rebuilding VA Critical Infrastructure

The Department of Veterans Affairs opened its first National Home on November 1, 1866. World War I veterans returned from Europe with complications from shell shock and mustard gas exposure and the United States was ill-prepared to care for these unique conditions. In 1918 the need to care for veterans had grown so quickly that Congress authorized rapid expansion of veterans' hospitals. Because of this lack of planning, the Bureau of War Risk Insurance and Public Health Service had to rent space in existing hospitals and hotels to ensure care was provided to our returning veterans. By 1930, 54 veterans hospitals were built to provide direct care for the unique needs of veterans.

Today VA operates 152 hospitals, more than almost 900 community-based outpatient clinics, and 161 extended-care and domiciliary facilities. Unfortunately, many of these facilities are aging and struggling to meet the needs of today's veterans. In 2004, VA capacity was at 80 percent. Today it is 119 percent, while the conditions of the facilities hover just under 80 percent. Over the past few years, the VA budget request and the Congress's VA construction appropriation has fallen far short of the actual need. VA facilities are where enrolled veterans receive health care, and the facilities are just as important as the physicians and staff who deliver that care. A VA budget that does not adequately fund facility maintenance and construction will continue to negatively impact the quality and timeliness of veterans' health care.

In its FY 2012 budget submission, VA introduced the Strategic Capital Investment Planning (SCIP) process. SCIP provides an in-depth analysis of VA infrastructure, identifying gaps in access, utilization, and safety, and details the cost to close these gaps.

The vastness of the VA capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately \$45 billion. Although VA has reduced the number of critical infrastructure gaps, more than 4,000 gaps remain that will cost between \$56 and \$68 billion to close, including \$12 billion in activation costs.¹

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

The IBVSOs understand that some projects move through the planning and contracting stages quicker than others, but to allow safety gaps to sit for seven years, such as the one in West Los Angeles, with no clear strategy to correct them, not only impedes access for veterans but potentially puts them in harm's way. Another key element that appears to be missing from the gap analysis criteria is a comprehensive assessment of the existing contracts and sharing agreements resources that exist outside of VA.

Without a comprehensive understanding of the health care resources that exist within and outside of VA, the Department would encounter difficulty making sound decisions on capital investments and to right-size its inventory of facilities for the near, mid, and long term vista.

These issues were among the findings in a report that the Government Accountability Office issued on January 31, 2011, titled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*. Funding to close infrastructure gaps continues to be insufficient and arbitrary. VA must begin requesting fund-

¹Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 1-4, 9.2-7.

ing that will close all safety, condition, access, and utilization gaps, and at the same time present a five- and ten-year plan that will systematically describe when and how VA plans to close each gap. In developing these five- and ten-year plans, VA must work from a budget proposal that is designed to maintain VA facilities for the buildings expected life-cycle as well as to eliminate existing gaps in safety, access, and utilization.

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

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

VA is increasingly lagging in closing current NRM safety, condition, utilization, and access gaps, and continues to fall behind on preventing future gaps from occurring. Just to maintain what VA has in its infrastructure portfolio, the VA NRM account must be funded at \$1.35 billion per year, based on IBVSOs' estimate of PRV. NRM is currently being funded at \$462 million per year. Along with the PRV-calculated funding baseline, additional funding needs to be invested to prevent the \$22 billion NRM backlog² from growing even larger.

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

To close all major and minor construction safety, condition, access and utilization gaps, VA will need to invest approximately \$23 billion. Nearly \$5 billion is needed to close seismic deficiencies alone. Studies have identified 12 major construction seismic correction projects and 9 of those projects are partially funded. These projects cannot wait any longer. As VA develops its five- and ten-year plans, it must make closing these gaps a priority with the goal to have seismic deficiencies closed within five years.

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

²Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 9.3-14

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

Over the life cycle of a medical facility, utilization and services often change because of a shifting demographic of patients and new technologies that alter the way health care is delivered. VA must invest in medical center-based, architectural master planning so these changes can be better anticipated and funding can be made available as the need arises, not years later. Congress must appropriate an additional \$15 million to allow VA to fund 10-year comprehensive facility master plans.

VA must do a better job of engaging local community partners to increase access and better utilize resources. Each facility master plan should include an analysis of services provided and services needed. When it makes sense, VA must leverage those partnerships to improve care and better allocate resources.

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

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

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

RECOMMENDATIONS:

Congress should pass legislation to correct the inequity in access to the VA program of comprehensive assistance for family caregivers.

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

Congress should pass legislation to allow primary caregivers to earn income credits for caregiving a disabled veteran to safeguard their own income security.

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

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

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

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

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

BACKGROUND AND JUSTIFICATION:

Family caregivers supporting severely wounded, injured, and ill veterans require considerable strength to tend to the needs of family and home, assist their veterans with everyday activities, take their veterans to appointments, or just be there in their veterans' times of need. Caregiving takes endurance, commitment, love, and patience. With proper support, many severely injured or ill veterans can benefit from residing at home instead of being institutionalized. Support from family caregivers plays a crucial role helping to reduce health care utilization and health care costs and in improving veterans' psychosocial well-being. Being a caregiver, however, carries a significant cost.

Studies show improving family caregivers' well-being and sustaining them as caregivers requires a multifaceted approach—including training, health care coverage, and support services—to reduce the burden caregiving may create and to bolster their ability to serve as caregivers more effectively.

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law No. 111-163, requires VA to create caregiver support programs to serve three types of family caregivers:

1. Primary caregivers who are the main source of support for veterans severely injured on or after September 11, 2001;
2. Secondary caregivers who generally serve as a back-up to the primary caregiver, and;
3. General caregivers who are the main source of support for all other severely ill and injured veterans enrolled in the VA healthcare system.

The law's multifaceted approach of support from VA includes:

- General caregiver support includes caregiver education and training, use of telehealth technologies, restricted counseling and mental health services, and respite care.
- Secondary family caregiver support includes all general caregiver supports, monitoring veterans' quality of life, instruction and training specific to a veteran's needs, paid travel expenses while accompanying veterans to appointments, information and assistance to address the routine, emergency, and specialized caregiving needs and individual and group therapy, counseling and peer support groups.
- Primary family caregivers support includes all general caregivers and secondary family caregivers supports, a monthly caregiver stipend, at least 30 days a year of respite care, and CHAMPVA healthcare coverage if the veterans have no other coverage.

Almost 12,000 primary caregivers were receiving needed supports and services from this VA program at the end of 2013. Also in 2013, VA launched an evidence-based six-week online workshop designed to reduce caregiver stress and increase family caregiver well-being. The VA family caregiver website (www.caregiver.va.gov) received over 1,300 hits a day on average, and the caregiver support line (1-855-260-3274) received over 92,000 calls during the year.

The Law's Inequity for Caregivers and Veterans

Family caregivers of veterans suffering from severe illnesses (such as amyotrophic lateral sclerosis, multiple sclerosis, or Alzheimer's disease) provide enormous amounts of care and support to them. However, they are excluded from primary caregiver supports, even if the veteran served in combat in Iraq, Afghanistan, or in World War II or Vietnam.

While Title I of P. L. 111-163 created a program to address the adverse impact of caregiving, the law also turned a blind eye to family caregivers of severely ill veterans, and did so without regard to how heavy a burden they shoulder.

Program Leadership and Operations

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

Currently, only one person is acting as both the director and deputy director of the Caregiver Support Program. The program and the caregivers of severely injured veterans, therefore, are not being effectively represented in higher organizational policy discussions. Moreover, unlike other clinical programs under the VHA's current organizational structure, its Caregiver Support Program Office has no corresponding Clinical Operations office with which to work collaboratively to support field operations.

Ostensibly, having a program director, deputy director, and Caregiver Support clinical operations office would make developing and deploying a more robust and integrated IT system for the caregiver program a high priority. Filling these positions also would capture comprehensive workload data to support effective oversight and management.

Without reasonable support and reliable data, the IBVSOs are concerned about the VA's ability to properly analyze and project the amount of resources needed to address the backlog of pending applications and continue supporting the growing caregiver population and their veterans. While the Administration's FY 2015 budget request appeared reasonable when it was submitted last year, a flat-line FY 2016 advance appropriations request for the Caregiver Support Program is not adequate.

Enhancements Needed in Other Caregiver Supports

The IBVSOs have heard consistent criticism from primary caregivers on certain aspects of the Caregiver Support Program. Many primary caregivers comment on differences between this program and the Department of Defense's Special Compensation for Assistance with Activities of Daily Living in terms of eligibility and caregiver training.

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

In addition, family caregivers applying for comprehensive supports under this program have voiced frustration over the lack of transparency of the application process and details about the program. Notably, there is no publicly available directive, handbook, or manual to educate caregivers about what to expect.

Creating and implementing a policy to better serve caregivers of severely injured veterans should depend on representative data that can be used to determine validity, reliability, and statistical significance. The IBVSOs note that in an earlier version of the caregiver bill, Congress would have authorized VA and the Department of Defense to contract for a national survey of family caregivers of seriously disabled veterans and service members and to submit a report to Congress. The final bill failed to include this language. VA estimates the survey would cost approximately \$2 million over a four-year period.

VA's In-Home and Community-Based Services for Supporting Caregivers

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

VA, OIG, and GAO reports from early 2000 to as recently as late 2013 repeatedly have documented that some VA medical facilities employed local restrictions to limit access to these services. In September 2013, the OIG reported some VA medical facilities depress waiting time data and used various methods and strategies to restrict access to homemaker/home health aide, respite, and skilled care services—in-home services often employed to support family caregivers.

Future Income Security for Primary Caregivers

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

Under the VA comprehensive caregiver support program, primary caregivers—predominantly spouses, and some parents, relatives, and friends—receive a tax-free stipend based on the amount of hourly assistance these veterans receive. About 6,000 of these caregivers were assigned to “Tier 3” (the highest level, providing a maximum of 40 hours of caregiving per week) for their stipend payments.

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

Because of the relative youth of many of these seriously injured veterans, their primary caregivers are facing a long-time horizon of supporting their veterans. Because of its tax-free nature, primary caregivers cannot claim stipend payments as income, and stipends are not considered wages or earnings creditable for the purposes of Social Security, placing their future income security at risk. Congress needs to address this inequity to obviate future poverty in these caregivers as they approach their elder years, or in the event they, too, become disabled.

Ensuring That Women Veterans Gain Timely Access to High-Quality Care and Benefits

Federal agencies need culture change and should reevaluate programs and services for women veterans to ensure they are meeting the unique needs of women service members and transitioning women veterans.

RECOMMENDATIONS:

VA and the DOD should aggressively pursue culture and organizational change to ensure that women are respected and valued.

The DOD, VA, and other federal partners should collaborate to develop and maintain an up-to-date central directory and mobile applications for federal programs and services that are available to women service members and veterans who are transitioning from military to nonmilitary life.

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

The DOD, VA, and local communities should work together to establish peer support networks for women. VA should establish child-care services as a permanent program to support health care, vocational rehabilitation, education, and supported employment services.

VA should build upon the local community partnerships and outreach established for other programs, such as those for homeless veterans, to establish support networks for women veterans in accessing health care, employment, financial counseling, and housing.

The DOD and VA should increase engagement and treatment of family members in post-deployment health care and the transition programs for service members and veterans.

VA needs to improve access to gender-specific health care for women veterans by requiring every VA Medical Center to hire a part-time or full-time gynecologist.

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

The DOD should eliminate rape, sexual assault, and sexual harassment in every part of its organization and take action to establish a culture that does not tolerate sexual assault and sexual harassment.

The DOD should allocate the resources needed to fully implement its Sexual Assault Prevention and Response Office's Strategic Plan. The DOD should conduct program evaluations and prospective scientific studies to monitor the success of its plan to prevent military sexual trauma, change the military culture, assess program progress and outcomes, and adjust actions as needed.

The DOD should improve policies and programs that provide family support to the spouses and children of women veterans.

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

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

VA should address the needs of women veterans in education by piloting programs such as education and career counseling, virtual peer support for women students, and child-care services. VA should establish comprehensive guidelines that schools can use to assess and improve their services and programs for student veterans. Special attention should be given to the needs of women veterans on campus. Schools who adopt these guidelines should be rated on the GI Bill Comparison Tool. VA should market its Education Counseling services on the Veterans Benefits Administration website and emphasize them during the Transition Assistance Program (TAP) process. Alternative options such as live chat and email should also be made available and marketed.

VA should enhance its monitoring and reporting on educational institutions to include consistent standards for granting credit for military-training and education-credit transfer; support for veteran students with identified disabilities, educational outcomes, and barriers; and availability of career counseling and job-placement success.

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

The DOD should transfer contact information and data on all TAP participants to VA and the Department of Labor, who should be responsible to provide gender-sensitive follow up with all service members 6 to 12 months after separation to offer additional support and services.

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

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

The DOL should work more closely with state certification organizations to translate military training and certification to private-sector equivalency. VA and the DOD should establish a grant program to accelerate these efforts.

Congress should reauthorize and fully fund the Supportive Services for Veteran Families program to promote positive transitions for women veterans during the anticipated downsizing of the armed forces.

VA and the Department of Housing and Urban Development should invest in additional safe transitional and supportive beds designated for women veterans.

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

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

BACKGROUND AND JUSTIFICATION:

Women are a rapidly growing and important component of the U.S. military services, yet their contributions have been under-recognized, even by the women themselves. Today women constitute approximately 20 percent of new recruits, 14.5 percent of the 1.4 million active-duty component, and 18 percent of the 850,000 members of the reserve components. Over 300,000 women have served in Afghanistan and Iraq. While the number of male veterans is expected to decline by 2020, the number of women veterans is expected to grow to 11 percent of the total veteran population.

Over the past decade of war, women have served in forward, exposed positions in unprecedented numbers. They are assigned to female engagement and reconstruction teams, military police units, transportation teams, as helicopter and jet fighter pilots, and in a variety of other positions that put them in combat, resulting in exposure to trauma, injury, and myriad environmental threats associated with modern warfare.

Despite a government that provides an array of benefits to assist veterans with transition and readjustment following military service, serious gaps are evident for women in every aspect of existing federal programs. These gaps impede their successful transitions to civilian life. Today, women lack consistent access to a full range of gender-sensitive benefits and services, and the federal government has not ensured that the staffs of each agency are exemplifying and promoting culture that supports women veterans. The vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a focus on developing programs for men who are prominent in both numbers and public consciousness. Resources for implementation and evaluation of programs that address culture and climate for women are long overdue, but the IBVSOs believe they are achievable.

Because of their role in the military and society, women veterans confront unique transition challenges. The challenges of readjustment to post-military life affect women differently than men and should receive attention from their local communities and the federal government at a level that is at least comparable to that received by men. One of the most persistent problems is a military and veterans' culture that is not perceived by women as welcoming and does not afford them equal consideration. The VA Women Veterans' Task Force noted the "need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran's wife, mother, or daughter."

Similar to their male counterparts, wartime deployments expose women to harsh living conditions. This environment impacts overall health and wellness, and women's health concerns must be considered and addressed in order for them to be effective and fully functioning members of military units. To accomplish this goal, in December 2011 the Army Surgeon General directed the establishment of a Women's Health Task Force team to assess the health care needs of Army women. The task force reported a lack of education and information on birth control, menstrual cycles, and feminine hygiene. The physical effect of poor-fitting uniforms and protective gear, barriers to seeking gender-specific care during deployment, the psychosocial impact of deployment on new mothers, reintegration with spouses and children, and sexual harassment and assault were also highlighted by the task force as key issues. The Armed Services Committees of the House and Senate should review these recommendations and should assume a strong oversight responsibility and agenda to see that all service branches make progress in resolving these important challenges, which IBVSOs believe are universal across the services, National Guard, and reserve components.

Many women who return from deployments are made stronger by their experiences, but some have difficulty in their transitions and are not fully supported by existing federal programs. Research demonstrates that women veterans returning from deployments in Iraq and Afghanistan experience higher rates of under-employment and unemployment than male peers, experience disturbingly high rates of homelessness—at least twice as high as women nonveterans, have high rates of sexual assault during military service, and reveal a lack of safe housing, especially for women with minor children.

Women continue to report access to child-care services as a barrier to needed health care services based on the success of the VA's child-care pilot program. The IBVSOs believe VA should establish child-care services as a permanent program to support health care, vocational rehabilitation, education, and supported employment services.

Women experience deployment and reintegration differently than do men. According to a special report issued by DAV in 2014, women are believed to focus more on disruption of interpersonal relationships, they report experiencing less social support once they return home, and they do not find services or commanders prepared to support women and their families after deployment. Compared to men, women are less likely overall to be married, and if married more likely to be married to a fellow service member, more likely to be a single parent, more likely to be divorced, and more likely to be unemployed after military service.

Women veterans have been underserved for far too long by the federal, state, and local programs. While VA deserves praise for its efforts to improve women's health programs, for its outreach to women, and for establishing comprehensive primary care programs for women veterans at all VA facilities, very serious gaps still occur in some VA clinics and specialty services. For example one third of VA medical centers do not employ a gynecologist. Holistic, evidence-based programs for women's health, mental health, and rehabilitation programs must be expanded to address the full continuum of care needed by all veterans, including women veterans.

Where Do Gaps Exist?

Health Care Services

Numerous reports have indicated that women veterans suffer from a high burden of post-traumatic stress disorder (PTSD), depression, and other comorbid conditions; yet, VA has experienced difficulty in establishing gender-specific group counseling, residential treatment, and specialty inpatient programs to serve women. The IBVSOs recognize the difficulty in building a critical volume of women to maintain these specialized programs in every location; therefore, we recommend that VA and DOD work collaboratively on pilot programs to address these issues, such as "tele-group" therapy, VA-DOD joint programs, and expanding regional centers of excellence. These agencies should jointly explore "warm handoffs" and other new approaches to transitioning care from the DOD to VA.

Sexual assault and rape are crimes. The recent dramatic increase in reported military sexual trauma is an illustration of problems and solutions that require radical change in the culture of our armed forces. In order to successfully eliminate rape, other forms of sexual assault, and sexual harassment in the forces, the DOD must address organizational, culture, and preventive solutions. Although VA has excellent evidence-based treatments for military sexual trauma (MST) survivors, VA still lags in providing the number of qualified providers with specific training and expertise in treating the consequences of MST and helping veterans recover.

The DOD has neither adequately supported nor adjusted its programs to meet the needs of deployed women and their families. For example, husbands of deployed women service members do not receive the same level of family support services available to women spouses because programs are not designed to meet men's concerns, needs, and schedules, or are not viewed as welcoming to men's participation. Current transition programs and treatments for relationship building, family reintegration, prevention of intimate partner violence, and support for family functioning are based on civilian programs and lack evidence of effectiveness in military and veteran populations. Improved transition support programs designed for prevention, treatment, and support for women and their families are needed.

While the VA women veterans' mental health retreat program has been a resounding success in reducing stress, improving coping skills, and improving women's sense of psychological well-being, it is only a small pilot effort and has served a limited number of women. However, in its report to Congress, VA noted that 85 percent

of participants showed improvements in psychological well-being, 81 percent showed significant reduction in stress symptoms, and 82 percent showed an improvement in positive coping skills. These kinds of outcomes warrant permanent reauthorization of the program by Congress, and justify a study of long-term outcomes in women who participate in these retreats.

In order to understand the experience of women in the military and veterans, data needs to be routinely collected, analyzed and reported by gender and minority status. The IBVSOs recommend improved data collection on women and minorities for health care, disability compensation, justice involvement, education, transition assistance, sexual trauma, employment, and housing programs. Congress, policy makers, program directors, and researchers need this information in order to monitor and enhance services for women veterans.

Education

The Post-9/11 GI Bill represents the largest expansion of educational support to military and veterans in our post-World War II experience, and this Congressional authority provides excellent educational benefits. However, there is a paucity of information available on the education subsidies and support received by women veterans or on the outcomes of the use of the Post-9/11 GI Bill benefits and services by women. More information is needed for program planning, policy-makers, and researchers to ensure this program is meeting women's needs after service.

Transition Assistance Program

There are no comprehensive studies that evaluate the effectiveness of the Transition Assistance Program (TAP) program. The hallmark of adult learning is that adults seek out and absorb information when they perceive that they need it, not necessarily when it is available. Some transitioning service members may not be primed to absorb TAP training during their pre-separation periods but would be more receptive once they are actively seeking help and assistance following their discharges several months later.

Employment

The need for assistance will become even more pressing as the DOD executes its downsizing plan. Those who expected full military careers will be suddenly thrust, with little warning, into ill-prepared civilian communities and job markets as new veterans. The Department of Labor (DOL) has provided women veterans with many customized programs, communications, and supports. Despite these efforts the unemployment and under-employment rates for women veterans are higher than those for men. The planned military downsizing is likely to exacerbate this problem. Additional efforts are needed to reverse these trends.

Housing

VA's efforts to eliminate veterans' homelessness have been impressive and are showing significant success. However, women veterans still have higher rates of homelessness than their nonveteran counterparts, and housing support for women veterans needs to be enhanced, particularly for women with dependent children.

Disability Compensation

The burden of illness and injury in post-9/11 veterans is high and nearly half have applied to VA for disability compensation. VA confirmed that disability evaluation ratings for MST-related PTSD claims were lower for women veterans and took action to educate and retrain staff on proper adjudication of these claims. VA needs to do more to assure that women are receiving fair and equitable adjudication of all their disability compensation claims.

SUMMARY

Women veterans deserve an integrated approach to address their transition needs, and the IBVSOs expect to observe and support an overhaul of the culture, values, and services of the federal systems that should be supporting them in a successful transition home.

The following recommendations cover the broad range of transition needs of women veterans in culture change, health care, disability compensation, family and community support, education, transition assistance, employment, housing, and in efforts to treat the devastating effects of MST and prevent sexual assault. The IBVSOs urge Congress, federal, and state agencies and community partners to re-evaluate existing programs and services and make necessary changes to ensure they are tailored to meet the needs of all veterans, including women. Congress should provide the necessary resources to meet this goal and should furnish continuing oversight of programs and services to ensure the unique transition needs of women veterans are being fully met.

Benefit Programs



Support Effective VBA Reform Initiatives

RECOMMENDATION:

The Veterans Benefits Administration and Congress must carefully monitor both workload and productivity in the VBA Compensation Service so that resource levels can be adjusted annually to reflect changes affecting benefit and appellate processing. This data-driven model is essential to determining current and future claim and appellate demands that will be placed upon VA.

BACKGROUND AND JUSTIFICATION:

In recent years the Veterans Benefits Administration has seen a significant staffing increase because Congress recognized that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, and therefore Congress provided additional resources to do so. More than 5,000 full-time employee equivalents (FTEEs) were added to the VBA ranks between 2008 and 2012 with most of the newly hired personnel being allocated to the Compensation Service.

Various initiatives provided the VBA with an added benefit. One such initiative was the “stimulus” legislation, where the VBA hired several thousand employees for a temporary two-year term, and at the end of those two years, many of those hired on a temporary basis transitioned into permanent positions. The VBA received an additional gain in claims-processing power by having a generous pool of fully trained, qualified candidates to choose from as replacements for full-time VBA employees who will be lost by attrition over the next few years. This gain in personnel would help mitigate any slowdown in claims processing as a new fully trained group hired under the stimulus legislation would be available to immediately replace tenured employees who might leave.

The VBA is still in a major state of flux with the recent implementation of the new organizational model and the Veterans Benefits Management System, (VBMS), which the VBA hopes will address many of its current processing deficiencies. *The Independent Budget* veterans service organizations (IBVSOs) believe the VBA and Congress should consider a multifaceted approach toward achieving sustainable and meaningful progress relative to claims processing that includes a mix of technology and personnel. A one-or-the-other approach would inhibit true claims-processing reform.

The VBA is currently undergoing major transformation in order to migrate to a paperless processing system. While this transformation is taking place, the VBA and Congress must continue to closely monitor the Compensation Service’s actual and projected workload and the measurable and documented increases in productivity resulting from the new organizational model and the VBMS.

The VBA and Congress must also regularly track personnel changes, such as attrition, in order to ensure that staffing is sufficient. Furthermore, the VBA must develop a better, more consistent, and data-driven method of determining future staffing requirements to more accurately predict not only current, but future demands of veterans seeking benefits from VA.

Expedite Administration of the Specially Adapted Housing Grant for Eligible Terminally Ill Veterans

RECOMMENDATIONS:

Congress should pass appropriate legislation to provide VA with the authority to implement emergency procedures to bypass existing regulations when life-threatening situations are involved.

VA should be required to expedite the approval of the Specially Adapted Housing process and be authorized to exercise judgment at the local level in cases where the failure to act would pose a significant risk to the life or health of a veteran.

BACKGROUND AND JUSTIFICATION:

Veterans who suffer from amyotrophic lateral sclerosis (ALS) often do not survive to benefit from the improvements that a specially adapted housing (SAH) grant could have furnished for them. It is not uncommon for unneeded adaptations to be forced on veterans as a condition of project approval, only to be removed by them after the work is completed. These extra adaptations are a needless waste of time and money. The root of this problem is the myriad and complex network of regulatory requirements that guide the SAH program. While the required renovations must be as compliant as possible, there must be a balanced focus on the immediate needs of the veteran. Safety issues must be weighed and balanced to ensure that concerns, such as potential evacuation in case of fire, do not prevent immediate modifications that would be critical in preventing more imminent dangers such as falling. The Department of Veterans Affairs must encourage employees at the local level to request waivers when appropriate and to streamline the overall waiver process.

Veterans with ALS and other terminal illnesses who satisfy eligibility requirements dealing with medical feasibility, property suitability, and financial feasibility can be granted conditional approval that would authorize them to incur certain preconstruction costs for home adaptation. While there is a procedural framework in place for this to happen, there are risks involved for the clients that opt for these provisions.

Also, in some cases, VA can provide direct reimbursement for work that has been completed, but nuances in the law can too easily thwart these options. Every veteran and every situation is unique, and these variances require legislation to be crafted in such a way as to facilitate favorable outcomes for the most severely disabled veterans who may face life-threatening emergencies in the absence of prompt modifications to their living environment.

Numerous administrative hurdles must be overcome in the application of the SAH decision process. The minimum property requirements (MPR) focus on safety and sanitation. Some MPR's address how these two items can best be achieved. More progress, however, is needed when dealing with unique situations, such as veterans with terminal illness.

Reduce Premiums for Service-Disabled Veterans Insurance

RECOMMENDATION:

Congress should enact legislation that authorizes the Department of Veterans Affairs to revise its premium schedule for Service-Disabled Veterans Insurance based on current mortality tables.

BACKGROUND AND JUSTIFICATION:

Improved life expectancy and new mortality tables should be used to reduce premiums for Service-Disabled Veterans Insurance. Congress created the Service-Disabled Veterans Insurance (SDVI) program for veterans who faced difficulty obtaining commercial life insurance due to their service-connected disabilities. At the program's onset in 1951, its rates were based on contemporaneous mortality tables and remained competitive with commercial insurance.

Since that time, reductions in commercial mortality rates reflected improved life expectancy as illustrated by updated mortality tables. The Department of Veterans Affairs, however, remains bound to outdated mortality tables. The use of outdated tables results in rates and premiums that are no longer competitive with commercial insurance offerings. This is a deviation from the intended benefit of providing SDVI to veterans with service-incurred disabilities who cannot obtain commercial life insurance due to their disability.

This inequity is compounded by the fact that eligible veterans must pay for supplemental coverage and may not have premiums waived for any reason. Even though *The Independent Budget* veterans service organizations recognize the efforts of Congress authorizing an increase from \$20,000 to \$30,000 in the supplemental amount available with the passage of P.L. 111-275, the "Veterans Benefits Act of 2010," we believe Congressional intent will not be met under the current rate schedule because many service-disabled veterans cannot afford VA premiums.



Provide a Supplement for Auto Grants to Eligible Veterans

RECOMMENDATION:

VA should provide supplementary automobile grants to eligible veterans in amounts equaling the difference between the amount previously spent and the current grant maximum in effect at the time of vehicle replacement.

BACKGROUND AND JUSTIFICATION:

The cost of replacing modified vehicles purchased through the VA automobile grant presents a financial hardship for veterans who must bear the full replacement cost once the adapted vehicle has exceeded its useful life. The Department of Veterans Affairs provides a one-time financial assistance grant of \$20,144 to eligible veterans toward the purchase of a new or used automobile to accommodate a veteran or service member with certain disabilities that resulted from a condition incurred or aggravated during active military service. Unfortunately, veterans who have exhausted the grant are left to replace modified vehicles that have surpassed their useful life at their own expense, often at a higher cost than the first adapted vehicle.

VA has previously acknowledged the impact that higher cost-of-living had on the intrinsic value of another critical, one-time VA benefit. P.L. 109-233 authorized up to three usages of the Specially Adapted Housing (SAH) grant. P.L. 110-289 provided for annual increases in the maximum grant amount to keep pace with the residential cost-of-construction index. When the maximum grant amounts are increased, veterans or service members who have not used the assistance available to them up to the allowable three times may be entitled to a grant equal to the increase in the grant maximum amount at that time. This increase also means a veteran who previously used the grant is entitled to additional SAH benefits—the current rate of maximum entitlement minus what was previously used. The intent of this one-time grant, which allows for prorated supplementary funding as it increases, was to provide veterans with a means to overcome service-incurred disabilities in the home. The same calculus should be applied to the automobile grant.

The Department of Transportation reports the average useful life of a vehicle is 12 years, or about 128,500 miles. On average, the cost to replace modified vehicles ranges from \$40,000 to \$65,000 when the vehicle is new and \$21,000 to \$35,000 when the vehicle is used. These substantial costs, compounded by inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches its expected useful life.

Provide Supplemental Grant for Adaptation of a New Home

RECOMMENDATION:

Congress should establish a supplementary housing grant that covers the cost of new home adaptations for eligible veterans who have already used their initial grants.

BACKGROUND AND JUSTIFICATION:

Grants should be established for special adaptation to homes that veterans purchase to replace initial specially adapted homes. Adapted housing grants for eligible service-connected disabled veterans literally open doors to independence. Prevailing societal and structural barriers to access outside the home become easier to confront once the limitations brought by a veteran's disability are mitigated by living circumstances that promote confidence and freedom of movement.

VA adapted-housing grants currently given to eligible veterans are provided on a one-time basis. Homeowners, however, sell their homes for any number of reasons both foreseeable and unforeseeable (e.g., change in the size of families, relocation for career or health reasons, etc.). Once the housing grant is used, veterans with service-incurred disabilities who own specially adapted homes must bear the full cost of continued accessible living should they move or modify a home.

Those same veterans should not be forced to choose between surrendering their independence by moving into an inaccessible home or staying in a home simply because they cannot afford the cost of modifying a new home that would both mitigate their service-incurred disability and better suit their life circumstances.

Exclude the Value of Life Insurance Policies as Countable Income

RECOMMENDATION:

Congress should enact legislation that exempts the cash value of VA life insurance policies and all directly resulting dividends and proceeds from consideration in determining a veteran's entitlement to health care under Medicaid.

BACKGROUND AND JUSTIFICATION:

Life insurance provides the surviving spouses and dependents of veterans with a means of maintaining financial stability after a sponsor's death. In some cases, however, veterans are forced to surrender their VA life insurance policies and apply the cash value of the surrendered policy toward the cost of nursing home care as a precondition of Medicaid coverage. When this occurs, these policies become nothing more than a funding vehicle for the veteran's care prior to death masquerading as a form of protection for survivors. As a result, the government is paying for a veteran's care in lieu of paying proceeds to survivors, instead of fulfilling both obligations.

Eliminate Rounding Down of Veterans' and Survivors' Benefit Payments

RECOMMENDATION:

Congress should not return to a policy of rounding down veterans' and survivors' benefits payments.

BACKGROUND AND JUSTIFICATION:

In 1990, Congress, in an omnibus reconciliation act, mandated veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress has continued to extend it every few years. Each year's cost-of-living adjustment (COLA) is calculated on the rounded-down amount of the previous year's payments. While not significant in the short run, the cumulative effect over time results in a significant loss to beneficiaries.

The effect of rounding down monthly COLA increases has eroded approximately \$10 per month for every veteran or survivor. For example, a veteran totally disabled from service-connected disabilities would have received \$1,823 per month in 1994 today will be paid at \$2,848 per month. Had that veteran received the full COLA each year for the past two decades, he or she would receive about \$120 extra this year, and Benefit Programs cumulatively over two decades would have received almost \$2,000 more.

The cumulative effect of this provision of the law levies a tax on disabled veterans and their survivors, costing them money each year, and when multiplied by the number of disabled veterans and Dependency and Indemnity Compensation recipients, millions of dollars are siphoned from these deserving individuals annually.

The Independent Budget veterans service organizations note and greatly appreciate that the most recent COLAs were not rounded down and encourages Congress to make this change in policy permanent.

Relax Standards to Establish Service Connection Based on Military Sexual Trauma

RECOMMENDATION:

Revise Section 3.304(f)(3) to allow that a veterans lay testimony alone may establish military sexual trauma (the stressor) when a mental health professional confirms the claimed stressor is adequate to support a diagnosis of post-traumatic stress disorder related to that stressor.

BACKGROUND AND JUSTIFICATION:

Evidentiary standards for establishing a service connected disability resulting from military sexual trauma should be relaxed. One in five female veterans and one in 100 male veterans have reported to VA they experienced military sexual trauma (MST) while on active duty. A recent study examined MST in men and women deployed in the wars in Iraq and Afghanistan. Twelve and a half (12.5) percent of men and 42 percent of women reported experiencing MST.

According to the Department of Defense Sexual Assault Prevention and Response Office, 86.5 percent of sexual assaults go unreported, meaning that official documentation of most assaults may not exist. Sexual assault is one of the most devastating crimes against a person. Long after physical injuries heal, psychological wounds can persist.

For decades VA treated claims for service connection for mental health problems resulting from MST in the same way it treated all claimed conditions—the burden was on the claimant to prove the condition was related to service. Without validation from medical or police records, claims were routinely denied. More than a decade ago VA relaxed its policy of requiring medical or police reports to show that MST occurred.

Nevertheless, thousands of claims for service connection for post-traumatic stress disorder (PTSD) resulting from MST have been denied since 2002 because claimants were unable to produce evidence that assaults occurred. From 2008 to 2012 grant rates for PTSD resulting from MST were 17 to 30 points behind grant rates for PTSD resulting from other causes. Unfortunately victims of MST often do not report such trauma to medical or police authorities, which results in a disproportionate burden placed on veterans to produce evidence of MST. Full disclosure of incidents occurring during service tend to be reported years after the event(s), making it exceedingly difficult to obtain service connection for PTSD and other mental health challenges.

The Independent Budget veterans service organizations conclude that current VA regulations and policies with regard to MST lead to a high level of denials of claims for PTSD. Given the high incidence of veterans experiencing sexual trauma while on active duty, the IBVSOs believe it reasonable for VA to grant veterans the same reduced evidentiary burden as provided title 38, United States Code, § 3.304(f)(3).

Establish More Equitable Rules for Service Connection of Hearing Loss and Tinnitus

RECOMMENDATION:

Congress should enact a presumption of service-connected disability for combat veterans and veterans whose military duties exposed them to high levels of noise and who subsequently suffer from tinnitus or hearing loss.

BACKGROUND AND JUSTIFICATION:

Many veterans exposed to acoustic trauma and increased noise exposure during service are now suffering from hearing loss or tinnitus and are unable to prove service-connection because of inadequate in-service testing procedures, lax examination practices, or poor record-keeping. The presumption requested herein would resolve this long-standing injustice. The Institute of Medicine issued a report in September 2005 titled *Noise and Military Service: Implications for Hearing Loss and Tinnitus*, where it found that patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel and are common among combat, combat arms, combat support, and combat service support veterans.

These veterans are typically exposed to prolonged, frequent, and exceptionally loud noises from such sources as gunfire, tanks, artillery, explosive devices, aircraft, and other equipment used in the performance of their military occupations. Exposure to acoustic trauma is a well-known cause of hearing loss and tinnitus. Yet many combat veterans are not able to document their in-service acoustic trauma nor can they prove their hearing loss or tinnitus is because of military service.

World War II veterans are particularly at a disadvantage because hearing testing by spoken voice and whispered voice was universally insufficient to detect all but the most severe hearing loss. Audiometric testing in service was insufficient, and testing records are lacking for a variety of reasons. Additionally, the hearing-test baseline of today's active duty service-members is "re-normed." This skews the test making the results appear better than they actually are.

Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control. Congress should do the same for veterans exposed to acoustic trauma and routine noise exposure, including combat veterans, and by instructing VA to develop a list of military occupations that are known to expose service members to noise.

VA should be required to presume noise exposure for anyone who worked in military occupations and grant service connection for those who now experience documented hearing loss or tinnitus after separation from service. Furthermore, this presumption should be expanded to anyone who is shown to have been in combat.

Establish More Equitable Rules for Hearing Aid Compensation

RECOMMENDATION:

VA should amend its Schedule for Rating Disabilities to provide a minimum 10 percent disability rating for any hearing loss medically requiring a hearing aid.

BACKGROUND AND JUSTIFICATION:

Currently, the VA Schedule for Rating Disabilities (VASRD) does not provide a compensable rating for hearing loss at the established levels severe enough to require hearing aids. A disability severe enough to require use of a prosthetic device should be compensable.

Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device.

For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb. Additionally, a review of 38, C.F.R. § 1(4), the VASRD, shows that all disabilities, whose treatment warrants an appliance, device, implant, or prosthetic, receives a compensable rating with the exception of a hearing loss with hearing aids.

Assigning a compensable rating for medically directed hearing aids would be consistent with minimum ratings otherwise provided throughout the rating schedule. Such a change would be equitable and fair.

Protect Standards for Service Connection

RECOMMENDATION:

Congress should reject proposals from any source that would change the definition of service connection for veterans' disabilities and death. Standards for determining service connection should remain grounded in the existing law, which recognizes the 24-hour nature of military service.

BACKGROUND AND JUSTIFICATION:

Disability compensation is paid to a veteran who is disabled as the result of an injury or disease (including aggravation of a condition existing prior to service) while in active service if the injury or the disease was incurred or aggravated in line of duty. Compensation may also be paid to National Guard and reserve service members who suffer disabilities resulting from injuries while undergoing training.

Periodically a committee, commission, government agency, or member of Congress proposes that military service should be treated as if it were a day job: if a service member happens to get sick or injured while working

a shift, he or she may be eligible, after discharge, for medical treatment and, perhaps, compensation from the Department of Veterans Affairs. Conversely, if a service member is injured before or after “work,” or becomes ill from a disease that isn’t obviously related to military service, he or she would not be eligible for service connection. Furthermore, medical care after service would be the responsibility of the veteran alone.

The military does not distinguish between “on duty” and “off duty.” A service member on active duty is always at the disposal of military authority and is essentially on call 24 hours a day, 365 days a year. A soldier on leave can be ordered back to base to be deployed that same day. A ship returning from a 6-month tour in the Persian Gulf can be turned around in mid-ocean to undertake a new mission that will keep its crew away from home for additional weeks or months. The ground crews that prepared planes in support of missions in Iraq, Afghanistan, and Libya worked anytime they were needed, day or night. Service members are there when needed, every day, and more often put at risk of injury, disease, or death in defense of all Americans.

Congress created the Veterans’ Disability Benefits Commission (VDBC) to carry out a study of “the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service....” After more than 30 months of hearings, study, analysis, and debate, the VDBC unanimously endorsed the current standard for determining service connection. Current law requires only that an injury or disease be incurred coincident with active military service. This law has no requirement that a veteran prove a causal connection between military service and a disability for which service connection is sought.



Compensation for Quality of Life and Non-Economic Loss

RECOMMENDATIONS:

Congress should amend title 38, United States Code, to clarify that disability compensation, in addition to providing compensation to service-connected disabled veterans for their average loss of earnings capacity, must also include compensation for non-economic loss and diminished quality of life.

Congress and VA should determine the most practical and equitable manner in which to provide compensation for non-economic loss and loss of quality of life and move expeditiously to implement this updated disability compensation element.

BACKGROUND AND JUSTIFICATION:

Under the current VA disability compensation system, the purpose of the compensation is to make up for “average impairments of earning capacity,” whereas the operational basis of the compensation is usually based on medical impairment. Neither of these models generally incorporates non-economic loss or diminished quality of life into final disability ratings, although special monthly compensation does address these needs in some limited cases.

In 2007 the Institute of Medicine (IOM) published a report, *A 21st Century System for Evaluating Veterans for Disability Benefits*, recommending that the current VA disability compensation system be expanded to include compensation for non-work disability (also referred to as “non-economic loss”) and loss of quality of life.

The IOM report stated, “In practice, Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating Schedule and other ways. Modern concepts of disability include work disability, non-work disability, and quality of life...[and that] [t]his is an unduly restrictive rationale for the program and is inconsistent with current models of disability.”

The Congressionally mandated Veterans’ Disability Benefits Commission (VDBC) spent more than two years examining how the Rating Schedule might be modernized and updated, and reflecting the recommendations of the IOM, the VDBC in its final report issued in 2007 recommended:

“The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life.”

The IOM report, the VDBC, and the Dole-Shalala Commission (President’s Commission on Care for America’s Returning Wounded Warriors) all agreed that the current benefits system should be reformed to include non-economic loss and diminished quality of life as factors in compensation.

Support Survivor Benefits Reform

RECOMMENDATIONS:

Congress should authorize Dependency and Indemnity Compensation (DIC) eligibility increases for all survivors, equal to that of other federal programs. The amount of increase should be 55 percent of VA disability compensation for a 100 percent disabled veteran.

Congress should repeal the inequitable offset between DIC and Survivor Benefit Plan because no duplication occurs between these two separate and distinct benefits.

Congress should enact legislation to enable survivors to retain DIC upon remarriage at age 55 for all eligible surviving spouses.

BACKGROUND AND JUSTIFICATION:

Increase DIC rates

The current rate of compensation paid to the survivors of deceased members is inadequate and inequitable when measured against other federal programs. Under current law, DIC is paid to an eligible surviving spouse if the military service member died while on active duty or the veteran’s death resulted from a service-related injury or disease.

DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved ones. All surviving spouses who rely solely on DIC, regardless of the status of their sponsors at the time of death, face the same financial hardships. Therefore, The Independent Budget veterans service organizations (IBVSOs) believe that the rate of DIC should be increased from 43 percent to 55 percent of a 100 percent disabled veteran’s compensation for all eligible surviving spouses.

Eliminate DIC and SBP Offsets

The current requirement that amounts of an annuity under the DOD SBP be reduced on account of and by an amount equal to DIC is inequitable. This offset is inequitable because no duplication of benefits is involved. A veteran disabled in military service is compensated for the effects of service-connected disability. When a veteran dies of service-connected causes or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the Department of Veterans Affairs.

Career members of the armed forces earn entitlement to retired pay after 20 or more years of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay after his or her death, unlike many retirement plans in the private sector. Under the SBP, deductions are made from military pay to purchase a survivor's annuity. This benefit is not gratuitous but is purchased by a retiree.

Upon a retiree's death, the SBP annuity is paid monthly to eligible beneficiaries. If the veteran died from other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was a result of military service or after the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose the SBP annuity in its entirety.

Remarriage

No eligible survivors should be penalized for remarriage. Equity with beneficiaries of other federal programs should govern Congressional action for this deserving group; therefore Congress should lower the age required for remarriage for survivors of veterans who have died on active duty or from service-connected disabilities. Current law allows retention of DIC upon remarriage at age 57 or older for eligible survivors of veterans who die on active duty or of a service-connected injury or illness.

Although *The Independent Budget* veterans service organizations appreciate the action Congress took to allow restoration of this rightful benefit, the current age threshold of 57 years remains arbitrary. Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. This change in eligibility would also bring DIC in line with Survivor Benefit Plan rules that allow retention with remarriage at the age of 55.



Establish More Equitable Rules for Veterans Exposed to Agent Orange on the Korean Demilitarized Zone

RECOMMENDATIONS:

Extend the presumptive service-connection end-date to May 7, 1975, for Korea veterans who served on the Demilitarized Zone (DMZ) to mirror the end date for Vietnam veterans. Currently, the Korean DMZ presumptive end date is August 1971.

The delineating dates for presumptive service connection because of exposure to herbicides (Agent Orange) in Korea should be established in the same manner as they are for Vietnam veterans—if a veteran served in Korea, north of the Imjim River at any time after Agent Orange was applied, then presumptive service-connection should be granted for the conditions identified in title 38, Code of Federal Regulations § 3.309(e).

BACKGROUND AND JUSTIFICATION:

For **Vietnam veterans**, the current law states that if service in Vietnam is verified as defined in 38 C.F.R. § 3.307(a)(6), service-connection for any of the presumptive conditions contained in 38 C.F.R. § 3.309(e) will be granted.

For **Korean DMZ veterans**, presumptive service-connection is granted if a veteran served on the Korean DMZ between April 1968 and August 1971. This is verified by assignment to one of the units that rotated to the Korean DMZ. Hostile fire-pay was granted for these period(s) of DMZ assignment.

Usage

- **Vietnam**, Agent Orange was used in Vietnam between January 1961 and October 1971.
- **Korean DMZ**, Agent Orange was used on the Korean DMZ from April 1968 through July 1969.

Presumptive periods

- **Vietnam**, January 9, 1962, and ending on May 7, 1975 – four years after last application.
- **Korean DMZ**, April 1968 and ends on August 31, 1971 – two years after last application.

Department of Defense records confirm that herbicides were used extensively in sections of the Korean DMZ. Research has shown that the dioxin in Agent Orange has a half life of one to three years in surface soil, and *up to 12 years* in interior soil. The toxicity of dioxin is such that it is capable of killing newborn mammals and fish at levels as small as 5 parts per trillion (or one 1 ounce in 6 million tons). Dioxin's toxic properties are enhanced by the fact that it can enter the body through the skin, the lungs, or through the mouth.

The dioxin on the Korean DMZ did not lose its efficacy on 31 August 1971. It continued to be absorbed into the bodies of the troops who were operating north of the Imjim River and affected the health of those veterans just as it did to Vietnam veterans.

Expand the Definition of Wartime Service for Nonservice-Connected Disability Pension

RECOMMENDATION:

Congress should change the law to authorize eligibility to nonservice-connected VA pension for veterans who have received hostile-fire pay; who served in combat environments, regardless of whether or not a period of war is defined by VA regulations; or were awarded the Armed Forces Expeditionary Medal, Purple Heart, Combat Infantry Badge, or similar decoration for participation in military operations that fall outside officially designated periods of war.

BACKGROUND AND JUSTIFICATION:

Pension is payable to a veteran who is 65 years of age or older or who is permanently and totally disabled as a result of nonservice-connected disabilities, who served at least one day of active duty during a period of war, and has a qualifying low income.

Although Congress has the sole authority to make declarations of war, the President, as Commander in Chief, may send U.S. forces into hostile situations at any time. While some of these incidents occur during defined periods of war (e.g., Somalia, 1992–95), many other military actions take place during periods of “peace” (e.g., Granada, 1983; Lebanon, 1982–87; Panama, 1989). Even the Mayaguez Incident, May 12-15, 1975, falls outside the official dates of the Vietnam War, which ended May 7, 1975.

The sole service criterion for eligibility to pension, at least one day of service during a period of war, too narrowly defines military activity in the last century. Expeditionary medals, combat badges, and the like can better serve the purpose of defining combat or warlike conditions when Congress fails to declare war and when the President neglects to proclaim a period of war for veterans benefits purposes.

Congress should amend the law so that the receipt of hostile-fire pay, award of an expeditionary medal, campaign medal, combat-action ribbon, or similar military decoration would qualify an individual for VA pension benefits. This action would ensure that veterans who were placed in hostile situations would become eligible for pension should they become totally disabled due to nonservice-connected disabilities.

Judicial Review



Require Enforcement of the Benefit-of-the-Doubt Rule

RECOMMENDATION:

Congress should amend 38 U.S.C. § 7261(a), by adding a new section, (a)(5), that states: “In conducting a review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision.” Congress should require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under § 7261(b)(1), when applicable.

BACKGROUND AND JUSTIFICATION:

To achieve the law’s intent that the Court of Appeals for Veterans Claims (CAVC) enforces the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the CAVC’s scope of review. Congress should reaffirm its intent concerning changes made to the Veterans Benefits Act of 2002 38 U.S.C. § 7261, by indicating that it was and still is intended for the CAVC to provide a more searching review of the Board of Veteran’s Appeals (BVA) findings of fact and in doing so ensure that the CAVC enforces a VA claimant’s statutory right to a benefit of the doubt.

Congress amended the law with the enactment of the Veterans Benefits Improvement Act to expressly require the CAVC to consider whether a finding of fact is consistent with the benefit-of-the-doubt rule. However, this intended effect of § 401 of the act has not been used in subsequent CAVC decisions. Prior to the Veterans Benefits Improvement Act, CAVC case law provided that it was authorized to reverse a BVA finding of fact when the only permissible view of the evidence of record was contrary to that found by the BVA, and that a BVA finding of fact must be affirmed where there was a plausible basis in the record for the BVA’s determination.

As a result of Veterans Benefits Improvement Act (§ 401 amendments to § 7261(a)(4)), the CAVC is now directed to “hold unlawful and set aside or reverse” any “finding of material fact adverse to the claimant...if the finding is clearly erroneous.” Furthermore, Congress added entirely new language to § 7261(b)(1) that mandates the CAVC review the record of proceedings before the Secretary and the BVA pursuant to § 7252(b) of title 38 and to “take due account of the Secretary’s application of § 5107(b) of this title....”

The Committees expected CAVC to reverse clearly erroneous findings when appropriate rather than remand the case. Subsection (b) (of § 7261) maintained language from the Senate bill that would require the Court to examine the record of proceedings before the Secretary and the BVA and the special emphasis during the judicial process on the benefit-of-the-doubt provisions of § 5107(b) as it makes findings of fact in reviewing BVA decisions. The combination of those changes was intended to provide for more searching appellate review of BVA decisions, and thus gave full force to the benefit-of-the-doubt provision.

Therefore, to clarify the less deferential level of review that the Court should employ, *The Independent Budget* veterans service organizations believe Congress should amend § 7261(a) by adding a new section, (a)(5), that states, “In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision.”

Congress should also require the CAVC to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under title 38 U.S.C. § 7261(b)(1) when applicable.

Enhancements Needed for the Court of Appeals for Veterans Claims

RECOMMENDATIONS:

Congress should provide all necessary funding to construct a courthouse and justice center in a location of honor and dignity--a location befitting the authority and prestige of the Court of Appeals for Veterans Claims (CAVC).

Congress should enact legislation as described herein to preserve the limited resources of the CAVC and reduce the Court's backlog.

Congress should enact legislation that would permanently increase the number of judge appointments to the CAVC from seven to nine.

BACKGROUND AND JUSTIFICATION:

The Court's Backlog

Congress is aware that the number of cases appealed to the CAVC has increased significantly over the past several years. Nearly half of those cases are consistently remanded to the BVA. The CAVC has attempted to increase its efficiency and preserve judicial resources through a mediation process, under Rule 33 of the Court's Rules of Practice and Procedure, to encourage parties to resolve issues before a court briefing is required. Despite this change to CAVC rules, VA general counsel routinely fails to admit error or agree to remand at this early stage, yet later seeks remand, thus utilizing more of the Court's resources and defeating the purpose of the practice. In this instance, VA usually commits to defend the BVA's decision at the early stage in the process.

Subsequently, when VA general counsel reviews the appellant's brief, general counsel often changes its position, admits to error, and agrees to or requests a remand. Likewise, the Department of Veterans Affairs agrees to settle many cases in which the CAVC requests oral argument, suggesting acknowledgment of an indefensible VA error through the Court's proceedings. VA failure to admit error, to agree to remand, or to settle cases at an earlier stage of the Court's proceedings, does not assist the CAVC or the veteran.

This failure merely adds to the Court's backlog; therefore, Congress should enact legislation to help preserve CAVC resources. Such an act would be codified in a note to § 7264; for example, the new section could state that under 38 U.S.C. § 7264(a), the Court shall prescribe amendments to Rule 33 of the Court's Rules of Practice and Procedure. These amendments would also contain language stipulating that if no agreement to remand has been reached before or during the Rule 33 conference, the Department, within seven days after the Rule 33 conference, shall file a pleading with the Court and the appellant describing the bases upon which the Department remains opposed to remand. If VA later determined that a remand was necessary, it may only seek remand by joint agreement with the appellant. No time would be counted against the appellant where stays or extensions are necessary when the Department seeks a remand after the end of seven days after the Rule 33 conference.

Furthermore, if the Department sought a remand after the end of seven days after the Rule 33 conference, the Department would waive any objection to and may not oppose any subsequent filing by appellant for Equal Access to Justice Act fees and costs under 28 U.S.C. § 2412. The Court would have the authority to impose appropriate sanctions, including financial sanctions, against the Department for failure to comply with these prescribed rules.

Permanently Increase the Number of Judges to Nine

The CAVC's caseload averages roughly 4,600 cases per year. As a result, the CAVC has had one of the highest, if not the highest, caseloads per active judge of any federal appellate court in the country. In response, the CAVC was authorized in 2008, as part of the Veterans Benefits Improvement Act to expand, at least temporarily, to nine judges, as of January 2010.

The authorization to increase the number of CAVC judges was set to expire at the end of 2012 if the positions were not filled within that time frame, fortunately for the CAVC, the two available vacancies were filled prior to the expiration date. The CAVC now stands at nine judges, due to this temporary authorization, an increase justified due the growing number of appeals handled by the CAVC.

Congress must enact legislation to permit an increase in judge appointments to keep pace with an increasing caseload. If these two temporarily authorized appointments become vacant, the CAVC is not authorized to replace them. The statute mandates no more than seven judges, which would adversely impact the CAVC's ability to make timely decisions because the remaining judges would be left to absorb the current and incoming workload.

A Dedicated CAVC Building

Finally, the United States Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs, and in a location befitting its authority, status, and function as an appellate court of the United States. During the 26 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not reside in its own courthouse.

The CAVC should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Congress allocated \$7 million in FY 2008 for preliminary work on site acquisition, site evaluation, preplanning for construction, architectural work, and associated other studies and evaluations; no further funding has been provided. The issue of providing a fitting and proper court facility must move forward.

Repeal the Tax Imposed on Military Retirees Rated Less Than 50 Percent Disabled

RECOMMENDATION:

Congress should enact legislation to repeal the inequitable practice requiring military longevity retirees pay be offset/taxed by an amount equal to the disability compensation awarded to veterans rated less than 50 percent.

BACKGROUND AND JUSTIFICATION:

All military retirees should be permitted to receive military longevity retired pay and VA disability compensation concurrently, also known as Concurrent Retirement Disability Pay. *The Independent Budget* veterans' s believe the time has come to finally remove the current prohibition imposed upon those longevity retirees rated less than 50 percent disabled.

Many veterans retired from the armed forces based on length of service must forfeit a portion of their retired pay, earned through faithful performance of military duties, as a condition of receiving VA compensation for service-connected disabilities when they are rated less than 50 percent disabled. This policy is inequitable—military retired pay is earned by virtue of a veteran's career of service, usually more than 20 years of honorable and faithful service performed on behalf of our nation.

VA compensation is paid solely because of disability resulting from military service, regardless of the length of service. Most nondisabled military retirees pursue second careers after serving in order to supplement their income, thereby justly enjoying a full reward for completion of a military career with the added reward of full civilian income. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. A longevity-retired disabled veteran should not suffer a financial penalty for choosing a military career over a civilian career, especially when, in all likelihood, a civilian career would have involved fewer sacrifices and quite likely greater financial rewards. In order to place all disabled longevity military retirees on equal footing with nondisabled military retirees, no offset should occur between full military retired pay and VA disability compensation. To the extent that military retired pay is offset by VA disability compensation, the disabled military retiree is treated less fairly than a nondisabled military retiree.

Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA disability compensation and full civilian retired pay—including retirement from any federal civil service position. A veteran who honorably served and retired after 20 or more years who suffers from service-connected disabilities should not be penalized for becoming disabled in service to America.

While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent disabled who retire from the armed forces on length of service may not receive disability compensation from VA in addition to full military retired pay.

Medical Care



INTRODUCTION

The Veterans Health Administration (VHA) is among the largest direct providers of health care services in the nation. The VHA provides the most extensive training environment for health professionals and is the nation's most clinically focused setting for medical and prosthetic research. Additionally, the VHA is the nation's primary backup to the Department of Defense in time of war or domestic emergency.

Unfortunately, the VHA came under serious scrutiny in 2014 when it was reported that facilities around the country had extensive waiting lists and that veterans were not receiving high-quality health care in a timely manner. These problems were exacerbated by the fact that VHA staff was apparently intentionally covering up this information in order to make performance look better than it actually was. These problems served to validate concerns that *The Independent Budget* veterans service organizations (IBVSOs) have raised for many years. We have long known that access and lack of capacity presented a serious and chronic problem in the VHA, yet most of those concerns were never properly addressed.

Despite these problems, it remains true that providing primary care and specialized health services is an integral component of Department of Veterans Affairs core mission and responsibility to veterans. Across the nation, VA has served as a model health care provider and has led the way in various areas of biomedical research, specialized services, and health care technology. The unique VA system of care is one of the nation's only health care systems that provides developed expertise across a broad continuum of care. Currently, the VHA provides specialized health care services that include program specific centers for care in the areas of spinal cord injury/disease, blind rehabilitation, traumatic brain injury, prosthetic services, mental health, and war-related polytraumatic injuries. Such quality and expertise on veterans' health care cannot be adequately duplicated in the private sector, and in many cases, simply does not exist. The effort to further expand contracted care in the community as a result of the widespread problems that were identified in 2014 will only serve to degrade these critical services.

In fiscal years 2015 and 2016, VA anticipates enrolling more than 9 million veterans. Meanwhile, the number of unique users of the VA health care system is now approaching 7 million, and the VHA will provide the means for approximately 100 million outpatient visits. Additionally, with passage of Public Law 113-146, the VHA will likely see a significant increase in veterans accessing the system in order to take advantage of the opportunity to receive care from private sources outside of the VA health care system. In order to meet these demands, VA will continue to need significant resources. Moreover, a concerted effort is going to become necessary to build appropriate capacity within the VA health care system to meet demand that continues to rise.

Ultimately, the policy proposals the IBVSOs present and the funding recommendations we make are intended to enhance and strengthen the VA health care system. We, along with Congress and the Administration, have the responsibility to defend and improve a system that faces this set of challenges. Clearly, numerous problems must be confronted and resolved as exemplified by the scrutiny being applied by Congress and with various ongoing investigations. However, the resolution of these challenges should not become a justification to abandon a system that serves so many and serves them well. For all of the criticism that the VA health care system receives, much of it deserved, VA continues to outperform, in quality of care, safety, and patient satisfaction, every other health care system in America. For this reason the co-authors of *The Independent Budget* believe VA to be a vital national asset for veterans, to be protected and enhanced, not dismantled.

Health Care Programs and Access

VA Must Provide Timely Access to Mental Health Services and Sustain a Comprehensive Mental Health Program for All Veterans

RECOMMENDATIONS:

The Independent Budget veterans service organizations (IBVSOs) urge Congress to ensure that ample resources are provided for VA mental health programs, including comprehensive treatment for serious mental illness and sexual trauma, Veterans Readjustment Services peer-to-peer programs, promotion of evidence-based treatments for post-traumatic stress disorder, and specialty substance-use disorder services to provide effective mental health care for all veterans needing such services.

VA should improve timely access for veterans in crisis and those seeking VA primary mental health care and specialized programs while concentrating on targeted outreach, anti-stigma, early intervention, and routine screening for all post-deployed veterans as a critical building block to an effective mental health and suicide prevention effort. Also, VA should ensure that veterans with war-related mental health issues have access to VA specialized mental health services from providers who have the cultural competency and expertise to understand and treat the unique needs of the veterans population.

The IBVSOs support continued mental health research to close gaps in care and develop best practices in screening, diagnosis, and treatment for veterans' post-deployment readjustment challenges.

BACKGROUND AND JUSTIFICATION:

Over the past decade the VA Office of Mental Health Services has evolved a comprehensive set of mental health services while seeing a significant increase in the number of veterans receiving services. VA provided specialty mental health services to 1.4 million veterans in FY 2013. VA has integrated mental health into primary care settings. From FY 2008 to March 2014, VA provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 veterans.

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

VA has increased staffing of new mental health providers following a 2012 Office of Inspector General (OIG) report on the Veterans Health Administration, *Review of Veterans' Access to Mental Health Care* (<http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf>), and made efforts to improve wait times for access to mental health services and address numerous known barriers to care. However, it is still unclear to *The Independent Budget* veterans service organizations if veterans are receiving the types of services they need—and when they need them. Veterans indicate they desire a variety of new services, such as web-based life coach and skill-building tools, comprehensive, intensive evidence-based therapies, and nonmedical/nontraditional therapies, such as complementary and alternative medicine options (yoga, meditation, acupuncture, Tai Chi, and other exercise therapies).

While veterans who served in Iraq and Afghanistan make up only a small percentage of the VA patient population, they are requiring a significant proportion of VA specialized mental health services. Since the wars began in 2002, over 2.7 million service members have deployed, and some deployed multiple times. Of this group, more than 1.8 million are now fully eligible veterans. Of those who have become eligible for VA health care, almost 1.1 million have obtained care; more than 56 percent of them have been given a mental health diagnosis, prominently including post-traumatic stress disorder (PTSD), depressive disorders, and alcohol dependence syndrome.

Experts estimate that about 11–20 percent of Iraq and Afghanistan veterans, as many as 10 percent of Gulf War veterans, and about 30 percent of Vietnam veterans have experienced PTSD at one time or another in their lives. PTSD is associated with other mental health conditions, substance-use disorders, unemployment, and homelessness.

Post-Traumatic Stress Disorder and Substance-Use Disorder

RECOMMENDATIONS:

VA and the DOD must ensure that veterans and service members receive proper, nonstigmatizing mental health screening, especially following combat deployments and treatment referrals for those who screen positive.

VA should improve and increase early intervention efforts with a focus on the prevention of substance-use disorders (SUDs) in the veterans population—in particular in recent combat veterans.

VA should provide training, evaluate provider skills, and monitor treatment outcomes of veterans who receive treatment for SUD from patient-aligned care teams.

VA should conduct health services research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder (PTSD) and SUD in combat veterans, and increase funding and accountability for evidence-based treatment programs.

VA should conduct an assessment of providers trained in evidence-based mental health treatments, including services for PTSD; identify shortfalls by sites of care; and allocate resources to provide universal access to evidence-based care.

VA should continue pilot programs to remove barriers to care, and improve continuity of care and retention of veterans in evidence-based PTSD treatment programs. Pilot programs should be established to address the special needs of women veterans and among racial and ethnic minorities.

VA must provide mental health services that meet the needs of veterans who have catastrophic injuries or disabilities with a focus on adapting to life after severe injury or disability. Mental health professionals should receive cultural competency training and education specific to the needs of this special population of veterans.

VA should provide accessible space within VA medical centers for catastrophically injured or disabled veterans seeking inpatient mental health care.

BACKGROUND AND JUSTIFICATION:

The long duration of the wars in Iraq and Afghanistan has taken a toll on the mental health of U.S. military troops. Combat stress and often severely disabling combat-related mental health readjustment challenges are prevalent among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans. Unique aspects of their deployments, including the frequency and intensity of exposure to combat, guerrilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with the risk of chronic PTSD.

Newly returning veterans' post-deployment mental health challenges have resulted in a surge in need for and use of VA specialized PTSD mental health services. Applying lessons learned from earlier wars, VA mounted earnest efforts at early identification and treatment of behavioral health problems in OEF/OIF/OND veterans by instituting system-wide mental health screening, expanding mental health staffing, integrating mental health and primary health care, adding new counseling and clinical sites, and conducting wide-scale training on evidence-based psychotherapies. Despite these efforts, critical gaps remain in certain locations and VA continues to struggle in providing immediate access for veterans in crisis. The mental health toll of these wars is likely to increase over time for those do not receive needed services, who remain at risk for developing chronic mental health conditions.

VA is the largest integrated health care system in the country that provides specialized mental health treatment for PTSD. In FY 2013, over 530,000 veterans (including over 140,000 OEF/OIF/OND veterans) received treatment for PTSD in VA medical centers and clinics, up from just over 500,000 veterans (including over 100,000 OEF/OIF/OND veterans) in FY 2011. Each medical center within VA employs PTSD specialists, and there are nearly 200 specialized PTSD treatment programs throughout the VA system in a variety of settings, including inpatient, residential and outpatient programs. The number of veterans receiving specialized mental health treatment from VA continues to rise each year, from over 900,000 in FY 2006 to more than 1.4 million in FY 2013.

VA state-of-the-art care for veterans with PTSD is delivered by more than 5,200 VA mental health providers who have received training in Prolonged Exposure and/or Cognitive Processing Therapy. These two techniques are the most effective known therapies for PTSD. Medication treatments also are offered and may be especially helpful for specific symptoms of PTSD. The Enhanced Brief Treatment PTSD Unit (EBTPU) is a unique VA program that provides evidence-based treatment to groups of six veterans struggling with combat-related PTSD. The EBTPU model is a four-week inpatient program that accepts referrals nationwide. Outcomes of the EBTPU have shown sustained reductions in PTSD symptoms and high levels of veteran satisfaction.

VA operates a National Center for PTSD (NCPTSD) that provides research, consultation, and education to clinicians, veterans, family members, and researchers. The national PTSD Mentoring Program, which works with every specialty PTSD program across the system, is designed to promote evidence-based practice within VA. NCPTSD's award-winning PTSD website (www.ptsd.va.gov) provides research-based educational materials for veterans and families, as well as for the providers who care for them. VA also works on outreach through social media, online video galleries, and national campaigns to raise awareness about PTSD, its causes, and proven treatments.

Co-occurring conditions with PTSD are a common phenomenon, and according to VA, treatment for them must take place concurrently. VA notes that more than 2 in 10 veterans with PTSD also experience SUD and that war veterans with PTSD and alcohol problems tend to be binge drinkers, which may be a coping mechanism in response to combat-related trauma. Almost one out of every three veterans seeking treatment for SUD also exhibits PTSD; for OEF/OIF/OND veterans, about one in ten seen in VA programs is challenged with alcohol or drug use.

VA has SUD-PTSD specialists in each facility who are promoting integrated care for veterans with these co-occurring conditions and has provided direct services to over 19,000 of these veterans in FY 2013 (including over 6,000 OEF/OIF/OND veterans). In collaboration with the Mental Illness Research Education and Clinical Centers and the NCPTSD, a SUD-QUERI Workgroup is seeking to implement evidence-based psychotherapy, develop and evaluate web-based training interventions for PTSD and SUD, and develop automated

telephone screening for those with these co-occurring conditions. Furthermore, the SUD-QUERI Pain Workgroup addresses pain and pain-medication misuse in SUD specialty care.

According to DOD personnel, PTSD is estimated to affect 11 to 20 percent of OEF/OIF/OND service members after deployment. Data from a number of sources have shown rising rates of PTSD associated with multiple deployments, and service members with PTSD exhibit more problems with post-deployment readjustment, including marital instability, divorce, family problems, homelessness, and higher unemployment rates. The VA cumulative analysis of health care utilization data among OEF/OIF/OND veterans shows that as of June 30, 2014, a total of 337,285 veterans were diagnosed with PTSD and 183,642 were classified with either alcohol-dependence syndrome, nondependent abuse of drugs, or drug dependence. These data do not include those diagnosed with alcohol abuse.

Dr. Charles W. Hoge, a leading DOD researcher on the mental health toll on military service personnel from the conflicts in Afghanistan and Iraq, observes that VA is still not reaching large numbers of returning veterans, and that high percentages drop out of treatment. As Hoge has written, "...veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out...with only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."

The IBVSOs agree with Dr. Hoge's view that VA must develop a strategy of expanding the reach of treatment to include greater engagement of veterans, understanding the reasons for veterans' negative perceptions of mental health care, and "meeting veterans where they are."

VA acknowledges that it should focus on ways to enhance access to its SUD programs, with a particular emphasis on the needs of OEF/OIF/OND populations and notes the best resolution for SUD problems comes from early intervention. The IBVSOs also need to reduce the stigma associated with seeking care for SUD.

The GAO March 2010 report *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans* noted that the three main challenges VA faces in providing care for veterans with substance-use disorder are accessing services, meeting specific treatment needs, and assessing the effectiveness of treatments. VA states that it has begun a number of national efforts to address these challenges, including increasing veterans' access to its services, promoting the use of evidence-based treatments, assessing services, and monitoring treatment effectiveness.

In summary, while VA has a comprehensive continuum of services across the system to improve engagement in evidence-based care for an ever-increasing number of veterans with mental health and substance use disorders, the implementation of evidence-based practices is still ongoing.



Traumatic Brain Injury

RECOMMENDATIONS:

VA and the DOD should coordinate efforts to better address the consequences of mild-to-moderate traumatic brain injury (TBI) and other concussive injuries. The Departments should work to refine screening and treatment protocols and improve coordination of care and support services for injured service members, veterans and their families affected by TBI. A comprehensive program of care including therapeutic residential facilities should be made available for all generations of veterans who suffer the effects of devastating brain injuries.

The VA Under Secretary for Health and the DOD Assistant Secretary for Health Affairs should establish a joint clinical registry to promote research, prevention, and treatment of TBI and provide Congress with an annual report on coordination efforts and progress in caring for veterans with all forms of TBI.

TBI research and treatment protocols undertaken by VA and the DOD for the current generation of brain injured veterans should also include older veterans of past military conflicts who suffered similar injuries that went undetected, undiagnosed, and untreated.

Congress should make permanent the statutory authority for VA to contract for assisted living facilities for the care of veterans with severe TBI.

VA should screen 100 percent of Iraq and Afghanistan veterans for TBI, and should conduct comprehensive evaluations of all who screen positive.

BACKGROUND AND JUSTIFICATION:

TBI is a complex injury to the brain structure and is becoming common among war veterans. It has been called the “signature injury” of modern combat and it is estimated that at least 20 percent of U.S. troops who were wounded in Iraq and Afghanistan have been affected by TBI. TBI is also a significant cause of disability outside of military settings, most often as a result of physical assault, falls, vehicular accidents, and sports injuries. According to the Defense and Veterans Brain Injury Center, more than 300,000 cases of TBI were recorded among service members from 2000 to March 2014.

VA reports that all OEF/OIF/OND veterans who receive VA health care are screened for possible TBI, yet it should be noted that VA is currently reporting that about 95 percent of these veterans are successfully screened and about 75 percent of those who screen positive undergo comprehensive evaluation. From April 13, 2007, through December 31, 2013, VA screened over 804,000 veterans; more than 151,000 screened positive for possible TBI and were referred for comprehensive TBI evaluations by specialty teams. Over 65,000 of these screened veterans were diagnosed with sustained mild-to-moderate TBI (mTBI) and received follow-on care.

To treat veterans with TBI, regardless of whether it is combat-related or not, the VHA provides comprehensive health care and support services and utilizes its nationwide resources through the extant Polytrauma System of Care model. Through this system, VA continues to evolve the evaluation, treatment, and understanding of TBI. For example, it has been developing and implementing best clinical practices for TBI, collaborating with strategic partners, including community rehabilitation providers and academic affiliates, providing education and training in TBI-related care and rehabilitation, conducting research, and translating findings into improved clinical care. In FY 2013, VA invested \$231 million in care for veterans with TBI; of this amount, \$49 million was for the care of OEF/OIF/OND veterans.

Veterans with a TBI diagnosis are generally more intense users of health care services. According to VA, a veteran with a TBI diagnosis may need 20 outpatient appointments annually, compared with 7 appointments for veterans without a TBI diagnosis. Many of these additional appointments are in mental health, rehabilitation, and polytrauma clinics, but also they make significantly more primary care and other appointments. Inpatient hospital stays are also more common in this population, at 13 percent versus 4 percent of other veteran enrollees.

In 2009 with Congressional authorization, VA launched a five-year “Assisted Living Pilot Program for Veterans with Traumatic Brain Injury” (AL-TBI), an effort that was implemented through contracts with private-sector, accredited residential-living programs, accompanied by VA case management. The AL-TBI pilot program was recently extended by law until October 6, 2017. This crucial program needs a permanent, or a more extended period of Congressional authorization.

VA is also developing an intensive team approach to institute system-wide cultural changes based on the Patient Aligned Care Team model, which intends to integrate standardized best-patient-care practices across the VA system. VA plans to offer interdisciplinary patient-centered care to deal with all aspects of TBI treatment, rehabilitation, and recovery and is currently instituting evidence-based treatments for this injury. The IBVSOs recommend that VA continue to collect data and encourage ongoing research to confirm the effectiveness of this treatment approach. The greatest challenge will be to change the culture in VA so health care teams can achieve the co-treatment approach, which VA is confident is the best approach for positive outcomes in caring for veterans with TBI.

VA research related to TBI is diversified. Key goals of VA researchers working in this field are to shed light on brain changes in TBI, improve screening methods and refine tools for diagnosing the condition, and develop drugs to treat brain injury or limit its severity when it first occurs. Researchers are also designing improved methods to assess the effectiveness of treatments, learning the best ways to help family members cope with the effects of TBI, and to better support their injured loved ones.

Although we are pleased with the progress VA has made in developing new programs and services to address the needs of TBI patients, a number of challenges lie ahead. The IBVSOs urge development of programs and support services to better assist these veterans and their families to manage the tumultuous challenges that accompany brain injury, often attended by other severe physical injuries.



Military Sexual Trauma

RECOMMENDATIONS:

Congress should continue military sexual trauma (MST)-related oversight and hearings with the goal of improving VA/DOD collaboration and improving policies and practices for MST-related care and disability compensation.

The Veterans Benefits Administration (VBA) should employ the clinical and counseling expertise of sexual trauma experts within Veterans Health Administration (VHA), or other specialized providers, during the disability-compensation examination phase.

The VBA should continue to train staff and review MST-related claims to ensure that established directives for claim adjudication are being followed.

The VBA should establish a designated point-of-contact for veterans to have questions answered about correspondence from the VBA regarding their MST-related claims.

The VBA should outreach to all veterans who have filed an MST-related disability-compensation claim or undergone a compensation examination to determine how the process can be improved or less traumatic for sexual-assault survivors.

The VBA should identify and map all personal trauma claims, with a focus on MST, by gender to determine the number of claims submitted annually, award and denial rates, and conditions most frequently diagnosed. This information should be available to the public reported annually.

The DOD and VA need to improve collaboration and develop an appropriate resolution to requesting and sharing MST-related records when authorized by the service member or veteran.

The VHA should adjust its authorization policy for Beneficiary Travel for veterans referred for MST-related mental health treatment at specialized inpatient/residential programs outside of facilities where they are enrolled.

BACKGROUND AND JUSTIFICATION:

The continued prevalence of sexual assault in the military services continues to grow has been the subject of numerous military reports, Congressional hearings, documentaries, and media stories. Many service members who experience sexual trauma do not disclose it to anyone until many years after the fact, but frequently experience lingering or chronic physical, emotional, or psychological symptoms following the trauma.

The IBVSOs strongly believe that survivors of MST deserve proper recognition, treatment, assistance in developing their claims, and compensation for any residual conditions related to the assault. Because of the unique circumstances surrounding MST, these cases need and deserve special attention.

The DOD Sexual Assault Prevention and Response Office (SAPRO) serves as the single point of oversight for these policies, provides guidance to all service branches, and facilitates resolution of common issues that arise in the military services and joint commands. SAPRO's primary objective is to promote prevention through training and education programs, encourage increased reporting of incidents, improve response capabilities, enhance system accountability, and ensure treatment and support for survivors of sexual assault.

The latest annual SAPRO assessment for FY 2013 shows a 50 percent increase in reporting from last fiscal year with 5,061 reports of sexual assault involving 4,113 service members. Approximately 10 percent of the reports were for sexual assaults that occurred prior to a member's military service. Of the 5,061 reports, 3,768 were filed as Unrestricted Reports and 1,293 remained Restricted. The DOD estimates that 86.5 percent of sexual assaults go unreported; therefore, the number of cases is likely closer to 34,200 service members having experienced unwanted sexual contact in FY 2013, up from the estimated 26,000 in FY 2012.

The term military sexual trauma (MST) is a term VA uses to refer to experiences of sexual assault or repeated, threatening sexual harassment occurring during military service. All patients enrolled in the VA health care system are screened for MST, and in FY 2013, 24.3 percent of women (77,681) and 1.3 percent of men (57,856) seen in VHA reported having a history of MST.

All veterans who screen positive are offered a referral for free MST-related treatment that is separate from the disability compensation process through VBA. In FY 2013, 93,439 veterans received MST-related care at the VHA, up from 85,474 in FY 2012. VA has identified transitioning service members and newly discharged veterans as high priority groups for outreach and is collaborating with the SAPRO and other national VA program offices to ensure that veterans are aware of MST-related services available through the VHA and that MST-specific content is part of mandatory out-processing completed by all service members.

Although the VHA is providing excellent care to veterans with assault histories, in December 2012, the VA Office of Inspector General (OIG) released a health care inspection report which concluded that women veterans are often admitted to specialized MST programs outside their Veterans Integrated Service Network (VISN). Obtaining authorization for reimbursement of travel expenses is a frequent problem for both patients and staff. The OIG noted the current Beneficiary Travel directive is not aligned with the VA MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

Another challenge for veterans with MST-related conditions occurs during the VBA disability compensation process. Survivors often take many years to even acknowledge that a trauma occurred, and sharing details, even with advocates and care providers, can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to repeat their experiences to disability compensation examiners. Therefore, the IBVSOs encourage the VBA to employ the clinical and counseling expertise of sexual trauma experts within the VHA or other specialized providers during the compensation examination phase.

MST coordinators are available at every VA medical center to assist veterans in accessing MST services that include outpatient mental health assessments and evaluations, group and individual therapy, and specialty services to target problems such as PTSD, substance use, depression, and homelessness. Many community-based Vet Centers also have trained sexual trauma counselors. Residential rehabilitation and treatment programs exist to help veterans who need more intense treatment, some of which have specialized MST tracks.

We are pleased with the progress that the DOD and VA have made to date; however, both departments must fully commit to improving their Integrated Mental Health Strategy to ensure service members and veterans get the proper screening, treatment, and compensation for conditions resulting from military sexual trauma. A streamlined and integrated approach is necessary to ensure that service members and veterans receive every opportunity to recover their good health and mental well-being following MST. If IBVSOs are to fully support service members and veterans in their recovery, the development of systems that take into account the unique circumstances that surround sexual assault in the military are essential. Most importantly, the DOD must make the necessary changes to prevent sexual assault in the military services and properly manage care coordination for the survivor when an assault does occur.



The DOD and VA Should Intensify Their Suicide Prevention Efforts

RECOMMENDATIONS:

Congress should ensure sufficient resources are made available for VA inpatient and outpatient mental health programs, including Vet Centers, the use of evidence-based treatments for post-traumatic stress disorder and substance-use disorder to achieve readjustment of war veterans and continued effective mental health care for enrolled veterans.

VA and the DOD should improve their collaboration and focus on implementation of the DOD/VA Integrated Mental Health Strategy, to address suicide risk and prevention and improve mental health outreach efforts to service members and veterans.

Both the DOD and VA should continue anti-stigma campaigns, and identify and deploy the best, evidence-based treatment strategies for this population. Easy access to mental health services in primary care is essential to addressing and overcoming stigma frequently associated with seeking mental health care within DOD and VA programs.

VA should continue its support for the VA “Make the Connection” campaign that includes coaching into care, tips for family members, as well as the Veterans Crisis Hotline and chat service—all a part of the VA comprehensive suicide-prevention strategy.

VA must increase options for veteran- and family-centered mental health programs, including family therapy and marriage counseling because relationship problems are often noted as a core reason for suicidal ideation. These programs should be made available at all VA health care facilities.

BACKGROUND AND JUSTIFICATION:

Suicide is a special concern in the active military, reserve component, and veteran populations—especially among war veterans and recently separated veterans. Although only 1 percent of Americans serve in the mili-

tary today, veterans represent 21 percent of suicides in the United States. Despite increased outreach initiatives, focused on reducing stigma, and a number of targeted suicide prevention efforts within VA and the DOD, only marginal improvements have been observed.

VA reports that each day 22 veterans commit suicide—over 8,000 suicides per year. Additionally, the veterans' crisis line (1-800-273-TALK) has made approximately 39,000 rescues of potentially suicidal veterans since its inception in 2007.

Veterans over the age of 50 who were in care in the VA health care system made up about 78 percent of the number of veterans who have committed suicide. VA data show that suicide rates among veterans who use VA health care have increased by nearly 40 percent among male veterans under 30 and by more than 70 percent among male veterans ages 18–24, and that suicide rates for women veterans grew by 11 percent between 2009 and 2011. VA data show that, overall, male veterans between the ages of 18 to 24 and female veterans in general were more likely to commit suicide.

Rural Veterans' Health Care: An Important VA Priority

RECOMMENDATIONS:

The Independent Budget Veterans Service Organizations (IBVSOs) recommend that Congress increase funding for the Office of Rural Health (ORH) by the same percentage increase Congress approves for the VA Medical Services appropriation, or, alternatively, to index ORH annual funding increases using the appropriate CPI adjustment for rural inflation, or another appropriate benchmark.

The IBVSOs recommend that Congress change the annual appropriation to the ORH either by making it a “no-year” account or by allowing VA to spend these rural health care funds from one year to the end of the next (“2-year funds”). Such a change will improve decision-making on how best to maximize rural veterans' access to care, and will remove the pressure to obligate all funds by a date certain or risk losing them.

The IBVSOs recommend that the ORH be authorized by Congress to grant funds, or be given direct contracting authority, or both, to establish formal relationships with private health care provider groups, clinics, hospitals, and other facilities in remote and rural areas that exhibit the ability and interest in treating rural veterans.

The IBVSOs recommend that the ORH be organizationally elevated in the Veterans Health Administration Central Office, preferably at the Deputy Under Secretary for Health level.

BACKGROUND AND JUSTIFICATION:

The IBVSOs believe that after serving our nation, veterans should not experience neglect of their health care needs by the Department of Veterans Affairs because they live in rural or remote areas far from major VA health care facilities. Also, VA must ensure that the distance veterans are required to travel, as well as other rural hardships they face, be considered in VA policies in determining the appropriate location and setting for providing direct VA health care services and the benefits they have earned by their service to the nation.

At \$250 million annually in discretionary funds, the appropriated funding for the Office of Rural Health (ORH) has become a stagnant account and is losing its purchasing power over time. Congress and the Administration need to address this challenge by increasing the account, by adjusting its baseline for future bud-

gets and by ensuring through oversight that this funding is not being spent for purposes outside the existing mandate in rural health. For example, the IBVSOs understand that efforts may be under way to shift funding responsibility for conducting a rural pilot program authorized by section 503 of P.L. 111-163 from outside to inside the ORH. If permitted, this new funding requirement would further reduce availability of funds within the ORH to conduct its mission.

Funding by the ORH must be internally obligated by VA medical centers and expended through deployment of direct VA health care services to rural and highly rural veterans, and all funding must be obligated within the fiscal year for which it is appropriated by Congress. In some years because of delays in contracting, recruiting of staff and other human resources obstacles, and entanglements affecting acquisition of necessary information technology, VA facilities have been unable to obligate these funds before the end of the fiscal year, and they have lapsed, creating greater challenges for the ORH in addressing its responsibilities.

The ORH has no authority to grant funds to non-VA organizations for rural veterans' direct care. The lack of a granting authority can become in fact a denial of care for some veterans in remote communities, who often reside far from any VA facility and live in numbers too sparse to justify VA establishment of a direct-care presence.

Given the lofty goals VA has articulated in rural health, the IBVSOs remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning, rather than within the operational arm of the VA health care system, closer to decision makers in the VHA executive management. Nearly half the members of our armed forces deployed to Iraq and Afghanistan live in rural areas, and, according to the VA Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/urban differences within some Veterans Integrated Service Networks and U.S. Census regions are substantial." Needing to traverse multiple layers of the VHA bureaucratic structure frustrates, delays, and has even canceled worthy initiatives desired or established by the ORH. The IBVSOs continue to believe that rural veterans' interests would be best served if the ORH were elevated to a more appropriate level in the VA Central Office organizational structure at the Deputy Under Secretary for Health level.

Other Matters

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated by Congress for this purpose. Furthermore, increases in rural health care funding must not cause reduction in funding to highly specialized urban and suburban VA medical programs. In each of the past six fiscal years, Congress has provided VA with \$250 million to fund rural health initiatives; this dedicated funding stream certainly should be continued, but adjusted as recommended above by the IBVSOs for FY 2016 and subsequent years.

The Veterans Health Administration, in collaboration with the ORH, should seek and coordinate the implementation of novel methods and means of communication, including use of the Internet, mobile applications, and other forms of telecommunication and telemetry. These new communication methods can connect rural and highly rural veterans to VA health care services, providers, technologies, and therapies, including greater access to their electronic health records, prescription medications, and primary and specialty appointments.

Congress and VA should increase the travel reimbursement allowance commensurate with the actual cost of contemporary automobile travel, and VA should continue to work to develop a transportation strategy in rural and highly rural cases that takes into account alternatives, including greater use of telehealth coordination with available providers, and VA mobile services when cost-justified.

VA should ensure that mandated outreach efforts in rural areas by other VA offices as required by Public Law 109-461 should be more closely coordinated with the ORH, to promote consistency in VA approaches to the needs of rural veterans. The ORH, however, should not become the source of funding for such broad outreach activities.

VA should establish additional mobile Vet Centers where needed to provide outreach and readjustment counseling for veterans in rural and highly rural areas, based on analysis and cost effectiveness of current mobile services deployed by the Readjustment Counseling Service. VA should report the findings of its analysis to the Veterans Rural Health Advisory Committee and to Congress.

Given VA affiliations with schools of health professions, the ORH, in coordination with the VHA Office of Academic Affiliations and other federal offices involved in health professions education and rural health care, should develop a specific initiative or initiatives aimed at expanding access to care by rural and remote veterans and more broadly to all of rural America.

VA should move forward to implement regulations associated with section 401 of Public Law 111-163, which authorizes active duty service members and National Guard and reserve component veterans of Iraq and Afghanistan be counseled in VA Vet Centers for readjustment problems.

Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities, the ORH and its satellite Veterans Rural Health Resource Centers should sponsor and establish demonstration projects with available providers of mental health and other health care services for rural veterans, taking care to observe and protect the VA role as the coordinator of care. Such projects should be briefed to the Rural Veterans Health Advisory Committee to obtain that committee's advice. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to *The Independent Budget* veterans service organizations and the Congressional Committees on Veterans' Affairs.

At selected VA community-based outpatient clinics (even some that may be located in urban areas), VA should establish a staff function of "rural outreach worker" serving to coordinate potentially fragmented care. These clinics also would collaborate with rural and highly rural non-VA providers to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available, or to VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

Congress should adequately monitor the VA efforts to implement its new and revised rural health strategic plan, Strategic Plan Refresh, Fiscal Years 2015–19.

Inappropriate Billing

RECOMMENDATIONS:

Congress should enact legislation that exempts veterans who are service-connected with permanent and total disability ratings from first-party or third-party billing for treatment of any condition.

Veterans Health Administration should establish policies and monitor compliance to prevent veterans from being billed for service-connected conditions and secondary conditions that are related to the service-connected condition.

The VHA should establish and enforce a national policy describing the required action(s) a VA facility must take when a veteran identifies an inappropriate billing episode. Resolution(s) must then be reported to a central database for oversight purposes.

The VHA and the Veterans Benefits Administration must improve the eligibility data interface to ensure that information available to the VHA is accurate, up to date, and accessible to staff responsible for billing and revenue.

The VHA must establish performance measures for copayment accuracy rates and periodically assess the accuracy and completeness of its copayment charges.

BACKGROUND AND JUSTIFICATION:

The Department of Veterans Affairs was granted the authority to collect payments from health insurers of veterans who receive VA care for nonservice-connected conditions, as well as other revenues such as veterans' copayments and deductibles, and manage these collections through the Medical Care Collections Fund. These funds are then to be used to augment spending for VA medical care and services and for paying departmental expenses associated with the collections program. In recent years, as IBVSOs have seen significant increases in both medical care collections estimates as well as the actual funds collected, we have received an increasing number of reports from veterans who are being inappropriately billed by the VHA for their care.

Reports continue to surface within our organizations of veterans with service-connected amputations being billed for the treatment of pain associated with amputation and of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers, two of the most common secondary conditions associated with spinal cord injury. Inappropriate billing for such secondary conditions forces service-connected veterans to seek re-adjudication of claims for original service-connected ratings. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Moreover, inappropriate billing is not a problem being experienced only by service-connected disabled veterans but by nonservice-connected disabled veterans as well. The IBVSOs continue to receive reports of nonservice-connected disabled veterans receiving inappropriate bills, most commonly being billed multiple times for the same treatment episode or have difficulty getting their insurance companies to reimburse for treatment provided by VA. In addition, nonservice-connected veterans experience inappropriate charges for copayments.

Training the Next Generation of Physicians to Care for Veterans

RECOMMENDATIONS:

VA should support training additional physicians at VA medical centers—including the Veterans Access, Choice and Accountability Act funding for indirect costs as requested by the VA Office of Academic Affiliations—and reduce barriers to expanding existing programs.

Any congressional legislation to lift the 1997 Medicare cap on Medicare Graduate Medical Education should include an amendment that provides priority for teaching hospitals that are affiliated with VA medical centers.

VA should improve contracting with academic affiliates for veterans' health services to help reduce VA backlogs.

BACKGROUND AND JUSTIFICATION:

Recent VA physician shortages have turned the Department of Veterans Affairs into the proverbial “canary in the coal mine.” While the exact VA need has yet to be determined, the Association of American Medical Colleges estimates that the United States is facing a shortage of 130,600 physicians by 2025, split evenly between primary care providers and specialists. The most vulnerable populations in underserved areas, including the Veterans Health Administration, will be the first to feel the impact of physician shortages. Congress and VA have taken an important first step to addressing these shortages with the Veterans Access, Choice and Accountability Act mandated GME enhancement initiative to add 1,500 residency positions over the next five years.

Nearly all (99 percent) VA residency programs are sponsored by an affiliated medical school or teaching hospital. While programs and specialties at VA medical centers vary considerably, on average medical residents rotating through VA spend approximately three months of a residency year at VA. To successfully expand VA GME, VA estimates that affiliated medical schools and teaching hospitals would need to add two to three positions for every VA position to meet all program requirements.

The primary barrier to increasing residency training at medical schools and teaching hospitals is the cap on Medicare GME financial support, which was established in 1997. The 113th Congress had three Medicare GME expansion bills (H.R. 1180, H.R. 1201, and S. 577) pending approval. These bills could be slightly revised to incentivize VA partnerships by including preferences for those affiliated with VA medical centers.

Other barriers to expanding VA GME residencies include VA contracting mechanisms, VA onboarding procedures, faculty workforce shortages, program accreditation requirements, resident duty hours, proximity to academic affiliates, and additional affiliate costs. VA has launched an internal taskforce on contracting with academic affiliates; however, initial reports indicate that outside stakeholders will not be permitted to participate. Because contracting necessarily is a two-party discussion, appropriate representation from outside VA is essential to help ensure timely care for veterans and to train the physicians who will provide that care in the future.

Improve Oversight and Quality of Care at Community-Based Outpatient Clinics

RECOMMENDATIONS:

VA must improve oversight of all community-based outpatient clinics (CBOCs) at the national, regional, and local levels.

All CBOCs must consistently deliver the highest standard of care with no disparities of quality between them and other VA facilities.

VA must continue to improve access to specialty care at CBOCs, particularly women's health services.

BACKGROUND AND JUSTIFICATION:

The Department of Veterans Affairs currently operates almost 900 CBOCs nationwide. These clinics, whether staffed by VA employees or through contracted staffing, are intended to make VA outpatient care more accessible. They also reduce the risk of readmission into a VA inpatient setting by properly utilizing outpatient preventative care. CBOCs play an immensely important role, and many veterans, especially those who live far from VA medical centers, rely on CBOCs for the majority of the care they receive from VA.

CBOCs are required to deliver the same quality of care as other VA facilities. The VA Office of Inspector General (OIG), however, continues to provide evidence that this is not always the case. The most recent annual evaluation data highlight specific areas of inadequacy over the entire CBOCs network, particularly in the area of women's health services, which half of all CBOCs still do not provide. The OIG also continues to find a large degree of variance in quality between CBOCs. The IBVSOs believe that this variance is largely because of the decentralized structure of the Department, making it difficult for VA to ensure that individual VA Medical Centers are exercising proper oversight over the CBOCs under their control.

The 2012 OIG Evaluation of Major Management Challenges confirmed that VA lacks the means to properly evaluate the CBOCs performance at the national, regional, and local levels. This lack of oversight starts with the delegation of management to VA medical facilities. These parent facilities are divided into 21 networks, known as Veterans Integrated Service Networks (VISNs). Because VISNs have historically not conducted regular, consistent oversight of the CBOCs, compliance with policies and procedures varies, often because of a lack of enforcement or awareness. In response, VA stated in its 2012 Performance and Accountability Report (PAR) that for the first time, data used for monitoring clinical care at CBOCs would be included in VISN quality performance reviews. Parent VISNs were to be evaluated based on the CBOCs clinical-care quality, a change that VA stated would promote accountability and improve care with an estimated resolution timeframe of 2014.

The most recent PAR released in December of 2013, however, made no mention of whether those steps have improved or helped to standardize CBOC quality. As a result, the IBVSOs have no indication that these issues of concern have been fully resolved, or what level of progress has been made. Accordingly, the IBVSOs ask Congress to continue to conduct oversight to ensure that CBOCs are providing care at the highest standard without significant quality variance across VA.

Non-VA Emergency Care

RECOMMENDATIONS:

Congress should enact legislation to make non-VA emergency care benefits less burdensome on veterans and VA.

Congress should conduct oversight on the VA emergency care program to ensure VA is complying with current law.

VA must survey veterans' knowledge of non-VA emergency care benefits to tailor its education efforts.

BACKGROUND AND JUSTIFICATION:

In order for VA to pay for emergency services provided to veterans by non-VA providers, the law prescribes atypical and differing criteria that must be met. This difference in criteria has led to some non-VA emergency care claims being inaccurately and improperly processed.

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

Research suggests that patient concerns about costs can keep them from going to the emergency room. A 2010 study in the *Journal of the American Medical Association* found that insured patients without financial concerns were more likely to seek emergency care within two hours, but almost half of uninsured patients or patients with financial concerns waited six hours or more to seek care.

The laws prescribing VA coverage of non-VA emergency care services places an extraordinary burden on veterans requiring that they be educated on convoluted and burdensome administrative criteria not typically found in private health-insurance plans. Current law governing health insurance plans prohibits higher copayments or co-insurance for emergency care from out-of-network hospitals. Also, health insurance plans cannot require prior approval before getting emergency room services from out-of-network hospitals.

Homeland Security/Funding for the Fourth Mission

RECOMMENDATIONS:

Congress should provide the funds necessary in the Veterans Health Administration FY 2016 appropriation to fund the VA fourth mission.

Because the fourth mission is increasingly important to our national interests, VA should request appropriate funding separately from the medical services appropriation.

BACKGROUND AND JUSTIFICATION:

The Department of Veterans Affairs has four critical health care missions, the first of which is to provide health care to veterans. Its second mission is to educate and train health care professionals. The third mission is to conduct medical research, and its fourth is to serve civilians—both domestic and foreign—in times of national emergency. Whether precipitated by a natural disaster, a terrorist act, or a public health contagion, the federal preparedness plan for national emergencies, known as the National Response Framework, involves multiple agencies. VA is the second-largest department in the federal government, with medical facilities in cities and communities all across the nation. The Department is uniquely situated to provide emergency medical assistance across the country and plays an indispensable role in our national emergency preparedness strategy.

Multiple laws authorize the VA Fourth Mission. The VA role in homeland security and response to domestic emergencies was established by P.L. 107-188, “Public Health Security and Bioterrorism Preparedness Response Act of 2002,” and the subsequently created National Disaster Medical System (NDMS) that combines federal and nonfederal resources into a unified response. The NDMS, an interagency partnership among the Department of Health and Human Services, the Department of Homeland Security, the Department of Defense, and VA, was instituted in a 2005 memorandum of agreement between the agencies. In addition, P.L. 107-188 required VA to coordinate with the Department of Health and Human Services to maintain a stockpile of drugs, vaccines, medical devices, and other biological products and emergency supplies. In response to this mandate, VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those stockpiles are large, able to supply medications to 2,000 casualties for two days, and 53 stockpiles can supply 1,000 casualties for two days. Additionally, VA serves as the principal medical care backup for the DOD during and immediately following a period of war or a period of national emergency.

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

The Independent Budget veterans service organizations believe that the Administration must request and Congress must appropriate sufficient funds in order for VA to meet these responsibilities in FY 2016. Additionally, we continue believe that these funds should be provided outside the medical services appropriation. VA has invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not received any designated funding for the fourth mission. Homeland security funding within VA is taken from the medical services appropriation. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided resources will continue to be diverted from VA direct health care programs.

Specialized Services

Continuation of Centralized Prosthetic Funding

RECOMMENDATIONS:

VA must continue to nationally centralize and protect all funding for prosthetics and sensory aids.

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all enrolled veterans, including the latest advances in technology so that funding shortfalls do not compromise other programs.

The VHA senior leadership should continue to hold field managers accountable for ensuring that data are properly entered into the National Prosthetics Patient Database and any other relevant database.

BACKGROUND AND JUSTIFICATION:

The protection of Prosthetic and Sensory Aids Service (PSAS) funding by a centralized budget has had a major positive impact on meeting the specialized needs of disabled veterans. Prior to the implementation of centralized funding, many VA medical centers reduced overall budgets by cutting spending for prosthetics. Such actions delayed provision of wheelchairs, artificial limbs, and other prosthetic devices. Once centralized funding was enacted, the

Prosthetic Item	Total Cost Spent in FY 2014	Projected Expenditure in FY 15
Wheelchair/accessories	\$201,205,372	\$214,108,198
Artificial legs	\$77,965,221	\$83,226,344
Artificial arms/terminal dev	\$7,017,673	\$7,846,645
Orthosis/orthotics	\$76,502,068	\$84,114,643
Shoes/orthotics	\$74,363,094	\$80,944,844
Sensori-neuro aids	\$380,166,313	\$401,734,930
Restorations	\$6,006,084	\$6,547,115
Oxygen and respiratory	\$171,388,208	\$188,424,734
Medical equipment	\$312,650,394	\$332,103,483
All other supplies & equip	\$47,369,198	\$50,155,177
Home dialysis program	\$2,992,163	\$3,096,326
HISA	\$27,074,174	\$29,136,053
Surgical implants	\$533,338,329	\$561,152,023
Biological implants	\$87,087,248	\$92,093,498
Misc	\$6,150,437	\$6,435,032
Total	\$2,011,275,976	\$2,141,119,045
Services and Repairs	\$414,863,774	\$435,749,329
Grand total	\$2,426,139,750	\$2,576,868,374

VA Central Office could better account for the national prosthetics budget and medical equipment funding related to specialized services, including needs of veterans with spinal cord injury, traumatic brain injury, and amputations. *The Independent Budget* veterans service organizations strongly encourage VA to maintain a dedicated, centrally funded prosthetic budget to ensure the continuation of timely delivery of quality prosthetic services to the thousands of veterans who rely on artificial devices to recover and maintain a reasonable quality of life.

In FY 2014, PSAS expenditures were approximately \$ 2,426,139,750. The FY 2015 proposed budget allocation for prosthetics is estimated at \$ 2,576,868,374. The proposed increased funding allocations for FY 2015 are based primarily on FY 2014 National Prosthetics Patient Database (NPPD) expenditure data, which also included Denver Acquisition and Logistics Center billing, and expansion of funding for the addition of advancements in new technology.

The accuracy of the NPPD data is critical to informed decision making at the national, network, and local management levels. Therefore, the VHA senior leadership must ensure that field managers regularly update the NPPD database for accuracy. Table 2 shows NPPD costs in FY 2014 with projected new and repair equipment costs for FY 2015.

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

RECOMMENDATIONS:

VA should include Veteran Service Organization (VSO) stakeholders in the development of rules, policies, and directives to ensure veterans gain input to the issues that affect them.

VA should promote more open communication between the VSOs and VA offices on routine matters without needing to be routed through the VSO liaison office.

BACKGROUND AND JUSTIFICATION:

Within the last 5 years the VHA has excluded the VSOs in the development of rules, policies, directives, and other issues that affect the veteran community they represent. Consequently, the VHA offices operate in a vacuum without veteran input, which has caused numerous of problems. As a result, the published documents lack the necessary information to adequately serve the veteran. The VSOs are not only excluded from the process of providing input, they receive no communication from the VHA that a document has been written nor are they informed when the document has been sent to the field. This blindsides the VSOs who are unable to provide answers to the veterans who are affected by the changes in the new document.

The VHA has excluded the VSOs from participating in prosthetics meetings with the VISN prosthetics representatives and has required that all VSO communications with the VHA offices must go through the VHA liaison offices on all issues, no matter how routine. This “stonewalling” has caused an atmosphere of mistrust between the VSOs and the VHA. In the past the VSOs could bring issues and problems directly to the VHA office involved so that solutions could be worked out, but that has not been the case in the past five years.

The result has been a disservice to the disabled veterans who depend on VA to provide top quality care. The IBVSOs consider themselves to be an advocate for veterans and for the VHA, but the attitude of the VHA towards the VSOs has caused that relationship to deteriorate.

Timely Delivery of Prosthetic Devices

RECOMMENDATIONS:

The Independent Budget veterans service organizations recommend strong Congressional oversight of new procurement and contracting practices in prosthetics and sensory aids.

The VHA must continue to address delays that prolong the prosthetics ordering process. The Prosthetics and Sensory Aids Service (PSAS) and the Veterans Health Administration (VHA) Procurement and Logistics Office must continue to work together to ensure prosthetics orders that are placed are tracked from prescription to delivery along process flows that show the actions and timelines required at each step.

The VHA Procurement and Logistics Office and the PSAS must continue development of the VHA Acquisition Prosthetics Dashboard, which measures the timeliness of the purchasing process. These and other reports should be published on a monthly basis and provided to the Veterans Service Organizations.

BACKGROUND AND JUSTIFICATION:

As the Prosthetics and Sensory Aids Service further develops a prosthetic and surgical products contracting center within the Office of Acquisition and Logistics, VA leadership must maintain the quality and accuracy of prosthetics delivered to veterans. At the end of FY 2013, the Department of Veterans Affairs completed the prosthetics procurement transition of prosthetics purchases costing over \$3000, from the VHA Prosthetics and Sensory Aids Service (PSAS) to the VHA Procurement and Logistics Office. This action essentially divided the responsibility for conducting prosthetic purchases between two separate services, creating a complicated, bureaucratic process that, at all levels within the VA, adversely affected the quality and accuracy of prosthetics delivered to veterans.

While the VHA leadership had reassured stakeholders that the transition of warrant authority would not impact the timely delivery of prosthetics to veterans, the IBVSOs remain concerned over the reported number of delayed or dropped orders, the diminution of quality service delivery for disabled veterans, and standardized purchasing of some prosthetics items and devices that are intended to be specialized and designed for unique applications. The effort to increasingly standardize products and capture savings through bulk purchasing reflects the disconnect between the veteran and clinician, who together understand the nuances of specialized care, and the contracting specialist who procures an item such as a standard hospital bed for a veteran who needs a specialized one with automatic pressure relief features. Under the former system, these oversights were prevented through close communication between clinical professionals and veterans, both of whom could convey individualized needs directly to purchasing agents. Recognizing the importance of meeting the unique needs of veterans requiring specialized care, the VHA issued the *VHA Handbook 1173.1*, which exempted prosthetic items intended for direct patient issuance from VHA standardization efforts. The exempted list of items included specialized wheelchairs, surgical implants, and customized artificial limbs.

The IBVSOs recognize that the transition to a prosthetic purchasing process shared by the PSAS and the VHA Procurement and Logistics Office was born from a series of Office of Inspector General and Congressional hearings that identified systemic deficiencies involving questions of waste and poor accountability of prosthetics inventories. Following these investigations, VA removed warrant authority from prosthetics purchasing agents. Under this change and in accordance with the Federal Acquisition Regulation 8123, statute authority and the ability to conduct transactions above the micro-purchase threshold would be reserved only for GS-1102 series contracting specialists who would be located in network contracting offices within each Veterans Integrated Service Network. This change, in essence, returned the PSAS to its pre-8123 status, characterized by inflexible adherence to contract regulations and generating lengthy workflow processes. After a phased

trial-and-error rollout of this “warrant transition” across the VISNs, full implementation was completed at the end of FY 2013.

Alongside the warrant transition, a convoluted PSAS funding model evolved, in which centralized funding occurred at the VISN level in some networks while others delegated prosthetics funding and management authority down to the facility level, with VA Central Office retaining very little, if any, control over the prosthetics budget. This new funding model not only obscured accountability, it allowed for localized standards and budget priorities to trump longstanding interpretations of VHA policies, particularly those that favored veterans receiving individualized services.

As a result of these changes, veterans with unique medical needs (paralysis, amputation, etc.), whose quality of life relies on prosthetic devices, reported undue delays across the VA system. Although there was an overall improvement in FY 2014, delays continued to be a problem. These delays are attributed to a range of factors, including staffing shortages, poor communication between prosthetics and contracting staff who make up the process, unclear expectations and inconsistently applied workflow metrics, and a lack of a coherent set of policies, all of which have obscured lines of authority and accountability in the process. While several VISNs have been able to work through the challenges, the majority still faces resource, communication, and performance barriers that have hindered successful implementation and resulted in continued delays and inefficiencies.

The IBVSOs are concerned about the increased amount of time it takes VA to execute procurements above the micro-purchase threshold since warrant transition and about the increased burden upon clinicians to procure what is medically needed for these special populations. Although these highly customized procurements represent a small percentage of the total workload for the VHA, they represent the most life-critical equipment, such as artificial limbs, mobility aids, and surgical implants. Delays in these procurements prove costly to both the government, in terms of the cost of unnecessarily extended hospital stays while veterans await delivery, and to veterans, who lose independence and quality of life.

To address these issues, the VHA the PSAS and the VHA Office of Procurement and Logistics developed a VHA Acquisitions Prosthetics Dashboard to track timeliness from prescription to delivery to veteran. The Dashboard enables the VHA to determine how long the consult stays in prosthetics and acquisition each step of the way. It measures performance at the facility and VISN levels. This change is a positive proactive effort, which the IBVSOs fully support. We also support the publication of ordering and timeliness metrics to be provided to the VSOs on a monthly basis.

Effective communication between PSAS and procurement staff is paramount to serving veterans who rely on prosthetics devices and services. Also, the IBVSOs strongly encourage VA to work closely with stakeholders in the veteran community, particularly during periods of major change and transition. We strongly encourage Congressional oversight of the VHA new procurement and contracting practices to ensure that purchasing decisions are made to optimize the health and independence of veterans and are not solely to cut costs or adhere to Federal and VA Acquisition Regulations that place cost or procedure over meeting the specialized needs of veterans with disabilities.

Consistent Administration of the Prosthetics Program

RECOMMENDATIONS:

The VA Central Office Prosthetics and Procurement leadership must communicate a clear set of standards for procurement activities, both over and under the micro-purchase threshold, and establish model workflow processes against which prosthetics orders can be measured.

In order to reduce variability in the delivery of prosthetics services across the country, VA must make certain that Veterans Integrated Service Network (VISN) prosthetics representatives have a direct line of authority over all prosthetics and orthotics personnel in VISNs.

The VISN Prosthetic Representatives must be held accountable to ensure the Prosthetic Services in the Medical Centers are following the directives and policies in a consistent manner.

BACKGROUND AND JUSTIFICATION:

In times of sweeping change in an organization with longstanding institutional practices, the importance of effective communication at all levels cannot be overemphasized. While Veterans Integrated Service Networks (VISNs) enjoy significant autonomy and discretion in executing policy, the lack of standardization and direction from VA Central Office on how the warrant transition was to be implemented made VISN variability a liability.

The VHA maintains the responsibility for ensuring that all VISNs adopt consistent operational standards in accordance with national prosthetics policies. However, the failure to enact and enforce a national standard has resulted in the VHA national prosthetics staff and procurement staff having to navigate through a maze of varying local interpretations of VA policy. This lack of a national standard has led to the inconsistent administration of prosthetics services throughout the VHA. With the implementation of the new prosthetic procurement procedures, the opportunity for inconsistencies is increased with more complex procurement. VISN directors and VHA Central Office staff should be accountable for implementing a standardized prosthetics program throughout the health care system, one that ensures consistent clinical care that meets veterans' individualized rehabilitative needs.

To improve communication and consistency, VA provides every VISN with a qualified prosthetics representative to be the technical expert responsible for ensuring implementation and compliance with national goals. The VISN prosthetics representative maintains and disseminates objectives, policies, guidelines, and regulations on all issues of interpretation of the prosthetics policies, including administration and oversight of the VHA prosthetics and orthotics laboratories. However, as new policies and procedures have evolved, VA Central Office has not provided adequate top-down guidance on how the changes impact the role and responsibilities of VISN Prosthetics Representatives nor provided metrics to govern and measure performance. This lack of guidance has resulted in wide variability in how VISNs execute the prosthetics ordering process and its resulting timelines.

Ensuring Quality and Accuracy of Prosthetics Prescriptions

RECOMMENDATIONS:

The Veterans Health Administration (VHA) should continue the Prosthetics Clinical Management Program (PCMP), provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must develop national standards for the prioritization and monitor the expedited handling of orders involving veterans facing health-related hardships. VA Office of Acquisition and Logistics should remain available to address and resolve any concerns involving uneven interpretation of policies.

VA must implement safeguards to make certain that the issuance and delivery of prosthetics devices and equipment will be provided based on the unique needs of veterans and to help veterans maximize their quality of life. Such protections will ensure that such principles are not lost during any VHA reorganization. The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on the quality of life of disabled veterans.

The VHA should ensure that clinicians are allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, including emerging technologies. VHA clinicians must be permitted to prescribe devices that are “off-contract” without arduous waiver procedures that serve as barriers or because of fear of repercussion.

BACKGROUND AND JUSTIFICATION:

The Department of Veterans Affairs must work to ensure that the new prosthetics procurement process does not degrade the quality or accuracy of services provided to disabled veterans or to veterans with health-related hardships. *The Independent Budget* veterans service organizations continue to cautiously support VHA efforts to assess and develop “best practices” to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through the VHA Prosthetics Clinical Management Program (PCMP). This caution is based on our concern that those “best practices” could spur inappropriate standardization or systematic limits on the types of prosthetic devices that the VHA would approve for veterans.

To address the issue of delayed prosthetics for veterans facing hardships, particularly those with terminal illness, delayed hospital discharge, and housebound circumstances because of mobility barriers, the VHA needs to develop and implement a clear policy on expedited handling of these procurements. Currently, the Prosthetics and Sensory Aids Service can flag purchase requests as emergencies when it sends the requests to the Network Contracting Office. Contracting can then act on these flagged requests immediately, assuming the office is adequately staffed and the purchase request is complete. However, the system does not distinguish among types of emergencies, creating circumstances, for example, where delayed payment to a vendor competes with a delayed hospital discharge because both cases are flagged as emergencies. The warrant transition has widened the gap between the VA desire to meet the needs of veterans and its ability to provide greater oversight and adherence to regulations.

Developing Future Prosthetics Staff

RECOMMENDATIONS:

VA must fully fund and support its National Prosthetics Technical Career program to meet current shortages and future personnel projections.

The Veterans Health Administration (VHA) and its Veterans Integrated Service Network (VISN) directors must ensure that prosthetics departments are staffed by certified professional personnel or contracted staff that can maintain and repair the latest technological prosthetics devices.

The VHA must require VISN directors to reserve sufficient training funds to sponsor prosthetics conferences, meetings, and online training for all service line personnel.

BACKGROUND AND JUSTIFICATION:

The VHA must ensure that the PSAS program office and VISN directors work collaboratively to select candidates for vacant VISN prosthetic representative positions who are competent to carry out the responsibilities of these positions. Similarly, the VHA must revise qualification standards for both prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

In 2003 the VHA developed and requested 12 training positions for the National Prosthetics Technical Career Field (TCF) program, formerly referred to as the Prosthetics Representative Training Program. The program was initiated to ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. The national program is a two-year training program for prosthetics representatives responsible for management of all prosthetics services within their assigned networks. In 2011 this allotment was increased to 18 training positions because of the number of vacancies of critical staff.

Veterans Integrated Service Networks (VISNs) have also developed their own local Prosthetics Representative training programs. While the *Independent Budget* Veterans Service Organizations support local VISNs conducting such training to enhance the quality of health care services within the VHA system and to increase the number of qualified applicants, we believe local VISNs must also support and strongly encourage participation in the TCF program to develop future leaders of the Prosthetics and Sensory Aids Service (PSAS). The VHA must also revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VHA and to attract and retain qualified individuals.

As the Department of Veterans Affairs continues to improve the TCF program, leadership must make certain that veterans are made aware of employment opportunities throughout the PSAS, as well as opportunities to apply for admittance in the TCF program. Employing veterans will ensure a balance between the perspective of the clinical professionals and the personal needs of disabled veterans. VA must ensure that the current and future leadership of the PSAS is appropriately diversified to maintain a perspective that is patient-centric and empathetic to the unique needs of veterans with severe disabilities.

Additionally, each prosthetic service within VA must have trained and certified professionals who can advise other medical professionals on appropriate prescription, building/fabrication, maintenance, and repair of prosthetic and orthotic devices. Because VA implemented the medical, home-care delivery model using patient-aligned care teams, the IBVSOs believe additional prosthetic representatives will be needed. Adding representatives is particularly important as new programs in polytrauma, traumatic brain injury, and amputation systems of care are implemented and expanded in the VHA.

PSAS leadership must consist of a well-rounded team, including trained and experienced prosthetics representatives, appropriate clinicians and managers, and position-qualified disabled veterans with significant mobility or other impairments requiring the use of prosthetic devices. The IBVSOs believe the future strength and viability of the VA prosthetics program depends on the selection of high-caliber leaders in the PSAS who appreciate the lived experiences of the veterans they support. Therefore, the PSAS must continue to improve and fund succession programs such as TCF to identify, train, and retain these professionals.

Meeting the Prosthetic Needs of Women Veterans

RECOMMENDATIONS:

The Veterans Health Administration (VHA) must provide training funds to educate Prosthetic and Sensory Aids Service and VHA Procurement staff on the special prosthetic needs of women.

The VHA must maintain support for a dedicated committee and special workgroups that evaluate whether the needs of women veterans are being met and provide recommendations directly to the VA Secretary for consideration.

The VHA must explore contracting and procurement actions that provide devices made specifically for women.

The VHA must identify emerging technology for women and propose ideas for research and development.

BACKGROUND AND JUSTIFICATION:

Over the past 15 years, women have joined the military in record numbers to contribute to the increasing role of America's military presence in the world. While women have always been a part of the military, the number of women serving and their roles were largely limited. Because more women have joined the military and serve in expanded roles, including inherently dangerous occupational specialties, more women veterans have been killed or wounded than in times past. According to the Defense Casualty Analysis System, 375 female service members were wounded in action in Afghanistan, and 51 were killed. In Iraq, 639 were wounded in action, and 110 were killed.

This new reality requires a focus on meeting the unique needs of an increasing number of women veterans in a health care system historically devoted to the treatment of males. Learning how to care for wounded women veterans, half of whom are of childbearing age, and their particular health issues and needs includes learning how to best meet their needs for prosthetics and assisted devices. *The Independent Budget* veterans service organizations recognize and commend the VA efforts to enhance the care of female veterans in regard to technology, research, training, repair, and replacement of prosthetic appliances through the establishment of a women's prosthetic workgroup. The workgroup's mission was to eliminate barriers to prosthetics care experienced by women veterans and change culture and perception of women veterans through education and information dissemination. The IBVSOs believe the Department of Veterans Affairs must continue to support efforts to train VA Central Office and field staff on the special prosthetic needs of women.

Prosthetics and Sensory Aids and Research

RECOMMENDATIONS:

VA must maintain its role as a world leader in prosthetics research and ensure that the VA Office of Research and Development and the Prosthetics and Sensory Aids Service work collaboratively to expeditiously apply new technologic development and transfer to maximally restore veterans' quality of life.

VA must ensure that institutional barriers to accessing new technologies are eliminated, and veterans whose lives would benefit from innovative, properly prescribed prosthetics items are given the opportunity to explore novel approaches to restoring function.

BACKGROUND AND JUSTIFICATION:

Many of the wounded veterans returning from the conflicts in Afghanistan and Iraq have sustained polytrauma injuries requiring extensive rehabilitation periods and the most sophisticated and advanced technologies, such as hearing and vision implants and computerized or robotic prosthetic items, to help them rebuild their lives and gain independence. According to the VA Office of Research and Development, approximately six percent of wounded veterans returning from Iraq are amputees, and the number of veterans accessing VA health care for prosthetics and sensory aids continues to rise.

Advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. The Veterans Health Administration is still contributing to this type of research, from funding basic prosthetic research to assisting with clinical trials for new devices. As new technologies and devices become available for wide-scale use, the VHA must ensure that these products prescribed for veterans are made available to them and that funding is made available for timely issuance of such items.

SCI/D System of Care: Staffing and Capacity

RECOMMENDATIONS:

The Veterans Health Administration (VHA) should ensure that the spinal cord injury/disease (SCI/D) continuum of care model is available to all SCI/D veterans nationwide. VA must also continue mandatory national training for the SCI/D “spoke” facilities.

The VHA needs to centralize policies and funding for system-wide recruitment and retention bonuses for nursing staff.

Congress should appropriate the funding necessary to provide competitive salaries for SCI/D nurses.

Congress should establish a specialty pay provision for nurses working in spinal cord injury centers.

Congress should renew legislation or VA should codify rules according P.L. 113-146 to require the annual reporting requirement to measure capacity for VA spinal cord care and other specialized services as originally required by P.L. 104-262.

VA and Congress must work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term care centers, as well as increase the number of centers throughout VA.

VA should design a SCI/D long-term care strategic plan that addresses the need for increased access, and makes certain that VA SCI/D long-term care services “help SCI/D Veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability”³

BACKGROUND AND JUSTIFICATION:

VA spinal cord injury/disease (SCI/D) care is provided using in a “hub-and-spokes” model. Because of staff turnover and a general lack of education and training in outlying “spoke” facilities, not all SCI/D patients have the advantage of referrals, consults, and annual evaluations in an SCI/D Center. Some SCI/D Centers treat patients with spinal cord diseases, such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS), while others deny admission.

Nursing Staff

SCI/D Units are the most difficult places to recruit and retain nursing staff. Caring for an SCI/D Veteran is physically demanding and requires nursing staff to provide hands-on care that involves bending, lifting, and stooping. These repetitive movements and heavy lifting often lead to work related injuries.

Recruitment and retention bonuses have proven effective at several VA SCI/D Centers, resulting in an improvement in both quality of care for veterans as well as in the morale of the nursing staff. The funding necessary to support this effort is taken from local facility budgets, placing further pressure on tightened budgets. A consistent national policy of salary enhancement for specialty services should be implemented across the country to ensure that qualified staff is recruited.

The current nurse staffing numbers still do not reflect an accurate picture of bedside nursing care, as they incorrectly include non-bedside specialty nurses and light-duty staff as part of the total number of nurses providing bedside care for SCI/D patients.

At the end of FY 2014, the actual number of nursing personnel delivering bedside care was 152 full-time employee equivalents (FTEEs) below the minimum nurse-staffing requirement. Factoring in the average facility acuity level, a 786.8-FTEE deficit exists between nursing FTEEs needed and the actual amount of FTEEs, and a 585.3-FTEE deficit exists between nursing FTEEs needed and required FTEEs. The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients put SCI/D Veterans at increased risk for complications secondary to their injuries, causing an increase in adverse patient outcomes and longer hospital stays.

The nurse shortage has also resulted in VA facilities restricting admissions to SCI/D Centers. Reports describe bed consolidations or closures attributed to nursing shortages. SCI/D Centers receive funds based on center utilization. Refusing care to veterans does not accurately depict the growing needs of SCI/D veterans and stymies VA ability to address the needs of new incoming and returning veterans. Such situations severely compromise patient safety and serve as evidence for the need to enhance the nurse recruitment and retention programs.

Patient Classification

The Department of Veterans Affairs has a system of classifying patients according to the hours of bedside nursing care needed. Five levels of patient care take into account significant differences in the level of care required during hospitalization, amount of time spent with the patient, technical expertise, and clinical needs of each

³ Department of Veterans Affairs, Veterans Health Administration, “Spinal Cord Injury and Disorders System of Care.” VHA Handbook 1176.01, February 2011. p. 36. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2365

patient. Acuity level III has been used to define the national average acuity/patient classification for the SCI/D patient. These levels are converted into the number of FTEEs needed for continuous coverage.

This national acuity average was established over a decade ago. Currently, SCI/D inpatients require a higher level of care than acuity level III because of multiple chronic complications. Realistically, the average acuity of an SCI/D Veteran in acute and extended care is acuity level IV.

Statutory Requirement for Maintenance of Capacity in VA SCI/D Centers

The IBVSOs are concerned about continuing trends toward reduced capacity in the VA Spinal Cord Injury/Disease (SCI/D) Program. Reductions in beds and staff in both the VA acute and extended-care settings continue to be reported.

P.L. 104-262 also requires that VA provide an annual capacity-reporting requirement, to be certified by, or otherwise commented upon by, the Inspector General. The requirement was in effect from April 1, 1999, through April 1, 2001. Congress later passed an extension of the reporting requirement through 2004. Expired for 10 years, the IBVSOs have called upon Congress to reinstate the specialized services capacity-reporting requirement and to make this report an annual requirement without a specific end date. We strongly encourage Congress to reinstate and implement this reporting requirement in The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) and to prevent a future expiration of this fundamental measure of capacity.

SCI/D Long-Term Care

As the veteran population ages, VA must assess and prepare for veterans' long-term-care (LTC)/extended-care needs. Nationwide, VA operates only five designated extended-care facilities for SCI/D veterans with a total of 188 staffed beds. However, only two out of these five extended-care SCI/D Centers accept ventilator patients. These facilities manage long waiting lists for admission and veterans remain underserved, bearing long-term costs that remain invisible to decision makers who focus on the short term gains.

Although the majority of SCI/D Veterans in LTC reside in Community Living Centers (CLCs), these facilities do not have the same rigorous staffing requirements as extended-care SCI/D Units. Additionally, staff is likely in not trained in caring for SCI/D LTC patients. In a PVA survey conducted in FY 2014, 131 of the 135 VA CLCs responded and revealed that in the whole CLC system, there are only 13 CLCs with beds dedicated for SCI/D. Additionally, only 8 percent of the CLCs accept ventilator patients.

PVA also surveyed 343 state veterans homes and skilled nursing facilities within a 50-mile catchment area of all SCI/D Centers. The data concerning ventilator patients were most disconcerting. Of the 343 skilled nursing facilities surveyed, only 49 accepted ventilator patients (14 percent). Only 9 of the of the 49 facilities were in the eastern U.S., 28 were in the central U.S., and 12 were located in the western U.S. State veterans homes cannot ease the ventilator case load immediately as none surveyed could accept ventilator patients.

According to the VA SCI/D census results from 2010 to 2013, the Level 5 acuity (ventilator patient) census has been steadily growing, averaging 125 patients in 2010 and 129 in 2011. The number of patients peaked in 2012 with 161 Level 5 acuity patients and remained high in 2013 with 145. Historically, the Memphis, Long Beach, Dallas, Tampa, Hines, and Cleveland catchment areas have had the highest ventilator patient counts. Yet, the Cleveland and Dallas catchment areas do not contain any skilled nursing facilities of the ones surveyed that accept ventilator patients. However, the Cleveland CLC did report that they accept vent patients. The Memphis catchment area surveyed contains three skilled nursing facilities that take ventilator patients; Long Beach contains four; Tampa contains one; and Hines contains ten. None of the CLCs in Long Beach, Tampa, Dallas, or Hines accept vent patients.

While VA has identified a need to provide additional SCI/D Extended Care Centers and has included these additional centers in ongoing facility renovation plans, many of these plans have been languishing for years.

Therefore, the IBVSOs strongly recommend that VA and Congress work together to ensure that the Spinal Cord Injury System of Care has adequate resources to staff existing long-term-care centers, as well as increase the number of centers throughout VA.



Access to Specialty Care

RECOMMENDATIONS:

VA must make certain that veterans who have a spinal cord injury or disease (SCI/D) are appropriately referred by VA spinal cord injury clinics to VA SCI Centers to receive proper care when needed.

VA must enforce its policies that require staff at SCI/D clinics (spokes) to refer veterans in need of acute care to SCI/D Centers (hubs). VA and Congress must also work to provide all VA SCI/D Centers with the resources needed to care for veterans with SCI/D.

Congress and VA must work together to identify SCI/D Centers that are in need of the critical resources and currently not able to care for referred veterans and make certain that all Centers within the VA SCI/D System of Care are fully capable of providing the services outlined in VA policy.

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

Expanding the VA beneficiary travel benefit to catastrophically disabled, nonservice-connected veterans will lead to an increasing number of disabled veterans receiving quality comprehensive care as well as result in long-term cost savings for VA.

BACKGROUND AND JUSTIFICATION:

Veterans who have incurred a spinal cord injury or disease (SCI/D) are entitled to health care through the VA SCI/D System of Care. This model is often referred to as the “hub-and-spoke” system of SCI/D care. Veterans with SCI/D receive care at a VA SCI/D Center (hub), or a VA SCI/D Clinic (spoke). The SCI/D Center provides veterans with primary care and specialty care with a full continuum of acute stabilization, acute rehabilitation, subacute rehabilitation, medical and surgical care, ventilator management and weaning, respite care, preventative services, sustaining health care, SCI home care, and long-term care. The SCI/D Clinic provides basic primary and preventative health care. When veterans with a SCI/D are in need of care for recurrent problems have complex issues, procedures that require specialized knowledge, major surgeries, or acute rehabilitation, they also must have access to the comprehensive health care services that can only be provided by a SCI/D Center.

To ensure that veterans receive appropriate, quality SCI/D care, VA must strictly enforce uniform standards for patient referrals from spokes to hubs when acute care is needed. VA must also make certain that SCI/D Centers have adequate staff and resources to provide the necessary care to veterans transferred from SCI/D clinics and ensure that veterans’ access to SCI/D Centers for critical care is not hindered by transportation barriers.

Veterans are often informed that they cannot be transferred to a hub because the hub does not have the necessary resources to provide the specialty care that is needed. These resources include nurses, administrative staff, or patient beds. VA must enforce its policy requiring staff at SCI/D clinics to refer veterans in need of acute care to SCI/D Centers. When SCI/D Centers are lacking resources, such as staff or patient beds, spokes are

forced to care for veterans in need of more complex, acute care. The care is substandard because the spokes are only equipped to provide basic primary and preventative health care.

VA policy also identifies transportation as a major component to providing veterans with a SCI/D comprehensive health care. Currently, VA does not provide travel reimbursement for catastrophically disabled nonservice-connected veterans who are seeking VA medical care. For this population of veterans, routine annual examinations often require inpatient stays, incurring significant travel costs. When veterans do not meet the eligibility requirements for travel reimbursement and they do not have the financial means to travel, the chances of their receiving the proper medical attention are significantly decreased. When necessary care is not available to catastrophically disabled veterans, associated illnesses quickly manifest and create complications that often result in reoccurring hospitalizations and long-term, if not permanent, medical conditions that diminish veterans' overall quality of life and independence.

Eliminating the burden of transportation costs as a barrier to care for this population will improve veterans' overall health and well-being as well as decrease, if not prevent, future costs associated with both primary and long-term, chronic, acute care. With access to SCI/D Centers, the need for long-term chronic acute care will be decreased, if not prevented. Most important, improving access will help support full rehabilitation of catastrophically disabled veterans and enable them to become healthy and productive individuals.

Amyotrophic Lateral Sclerosis

RECOMMENDATIONS:

VA should develop a veterans' amyotrophic lateral sclerosis (ALS) registry to collect and assess the quality of care that is being provided, as well as evaluate ALS patient satisfaction within VA.

The VA ALS System of Care should be further integrated with the VA Spinal Cord Injury/Disorders System of Care.

BACKGROUND AND JUSTIFICATION:

Amyotrophic lateral sclerosis (ALS) is a degenerative neurological disease that destroys nerve cells in the body that allow for voluntary muscle control. ALS leads to the gradual loss of brain and spinal cord cells that facilitate motor skills like walking or running, eventually eliminating one's ability to move voluntarily.⁴ ALS is fatal and usually progresses at a fast rate after diagnosis. For this reason, veterans must receive timely care, and VA must be able to provide the clinical expertise that is needed to meet veterans' medical needs.

VA issued the VHA Handbook 1101.07: ALS System of Care Procedures in July 2014. This handbook describes the essential components and procedures to ensure that all enrolled veterans have access to ALS care and that the veteran and his or her family and caregivers are given requisite clinical care and support provided by a comprehensive, professional ALS interdisciplinary care team.

The ALS Handbook highlights, given the limited life expectancy for veterans with ALS, the need to expedite provision of assistive technology (AT) and durable medical equipment (DME). Procurement and delivery of all prescribed devices must be expedited to facilitate provision to the veteran prior to further decline in function. Additionally, AT services must be coordinated by a skilled AT professional at a VA ALS clinic, a related clinical service, or by using equivalent fee-based support.

⁴The Department of Veterans Affairs, "Agent Orange Review," Vol. 25, No 1; July 2010. www.publichealth.va.gov/exposures/agentorange.

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

Care integration is also an essential aspect in the ALS System of Care. It is vital that VA utilize the established programs within other systems of care to help inform veterans of available treatment modalities and support services. The ALS Handbook encourages the use of the having ALS clinics within SCI/D Centers as well as stating that on SCI/D Units, the social worker, advance practice registered nurse (APRN), or RN case manager would be the best points of contact for veterans and their caregivers. However, more than be done to integrate the two services. For example, once the veteran has been diagnosed with ALS, the veteran must receive an evaluation by the SCI service as soon as possible since ALS is defined as an SCI/D.

Improving the VA National System of Care for Multiple Sclerosis

RECOMMENDATIONS:

VA must provide mandated direction to make certain that all VISNs are in compliance with the Multiple Sclerosis (MS) System of Care Procedures, Veterans Health Administration Handbook 1011.06.

VA should take further national efforts to integrate the MS System of Care with Spinal Cord Injury/Disorders.

VA must comply with the MS care-delivery model, which requires an appointed MS care coordinator to partner with veterans, their caregivers, and family members to help coordinate and manage all medical care provided by VA and non-VA providers.

VA must provide adequate funding to properly staff and support MS regional programs and MS support programs that provide the full continuum of MS specialty care.

Congress and VA must ensure that medical facilities are adequately funded to provide funding for cognitive rehabilitation, respite care, long-term care, and home care services for veterans with MS.

BACKGROUND AND JUSTIFICATION:

VA reports that, for the period of FY 1998 through FY 2013, roughly 37,000 Veterans with MS sought care within the VHA. Additionally over the past five years, the VHA has averaged about 17,500 unique MS patients per year. The disease of MS is a complex and chronic neurological challenge that results in cognitive deficits such as short term memory loss and physical impairment; veterans often must give up employment and often lose their independence. VA must increase access to quality care for veterans with MS by ensuring adequate staffing, coordinating care across disciplines, and enforcing the handbook on MS care.

Despite the establishment of the Multiple Sclerosis Centers of Excellence (MSCoE) and the Multiple Sclerosis System of Care Procedures, VHA Handbook 1011.06 in 2009, veterans still do not have consistent access to timely care for MS within VA. Issues such as the shortage of appropriate medical staff or the lack of care coordination are still precluding veterans from receiving care when it is needed.

The handbook states that VA must have “at least two MSCoEs, and at least one MS Regional Program in

each Veteran Integrated Service Network (VISN)... Any VA medical center caring for veterans with MS and not designated as an MS Regional Program must have a MS Support Program, spoke sites for MS care.” The handbook also speaks to the importance of coordinating care with SCI/D services (i.e. bowel and bladder care), encouraging ALS clinics to be located within SCI/D Centers, and incorporating SCI/D staff into the ALS interdisciplinary care team. Therefore, more of a national effort should be taken to integrate the MS System of Care with SCI/D instead of leaving it up to the local level.

The Independent Budget Veteran Service Organizations (IBVSOs) are concerned that the VHA Handbook 1011.06 is not being enforced, and as a result, veterans do not have adequate access to MS care because of the lack of resources in local and regional facilities. Local facilities are not adequately funded and therefore are not able to recruit and retain medical professionals with this specific experience to meet the staffing requirement. VA must provide local facilities with the necessary resources and funding to provide the appropriate health care services and cognitive rehabilitation that veterans with MS need. Equally important is the need for adequate funding for respite care, long-term care, and home care services for this population. Quality care can only be provided if all the medical needs of veterans are being addressed and all individuals involved are informed.

Increase Veteran-Centric Medical and Prosthetic Research and Development

RECOMMENDATIONS:

The Administration and Congress should provide at least \$619 million for the VA Medical and Prosthetic Research program for FY 2016 to support current research on chronic conditions of aging veterans and for emerging research on conditions prevalent among younger Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans.

The Administration and Congress should provide funding for up to five major construction projects in VA research facilities in the amount of at least \$50 million and appropriate \$175 million in nonrecurring maintenance and for minor construction projects to address deficiencies identified in the independent VA research facilities review provided to Congress in 2012.

The Administration and Congress should preserve the integrity of the VA research program as an exclusively intramural program, firmly grounded in scientific peer review, and should oppose designated funding for specific areas of research outside of the VA national management of the entire VA research portfolio.

BACKGROUND AND JUSTIFICATION:

The VA Medical and Prosthetic Research and Development program is widely acknowledged as a success on many levels, all directly leading to improved care for veterans and an elevated standard of care for all Americans:

- **Advancing Patient Care** - VA Research has made critical contributions to advance standards of care for veterans in areas ranging from tuberculosis in the 1940s to immunoassay in the 1950s to today’s ongoing projects dealing with Alzheimer’s disease, developing and perfecting the DEKA advanced prosthetic arm and other inventions to help the recovery of veterans grievously injured in war, studies in genomics and in chronic pain, cardiology, diabetes, and improved treatments for PTSD and other mental health challenges in veterans. These studies and their findings ultimately aid the health of all Americans.

- **Recruitment and Retention** - VA Research is a completely intramural program that recruits clinicians to care for veterans while conducting biomedical research. More than 70 percent of these clinicians are VA-funded researchers. VA also awards over 500 career development grants each year designed to help retain its best and brightest researchers for long and productive careers in VA health care.
- **High-Quality Research** - VA researchers are well published (between 8,000 and 10,000 refereed articles annually) and boast three Nobel laureates and seven awardees of the Lasker Award (the “American Nobel Prize”); this level of success translates effectively from the bench to the veteran’s bedside.
- **Investing Taxpayers’ Dollars Wisely** - Through a nationwide array of synergistic relationships with other federal agencies, academic affiliates, nonprofit organizations, and for-profit industries, the program leverages a current annual appropriation of \$589 million into a \$1.88 billion overall research enterprise.

Despite documented success, since FY 2010 appropriated funding for VA research and development has lagged far behind biomedical research inflation, resulting in a net loss of nearly 10 percent of VA purchasing power. As estimated by the Department of Commerce Bureau of Economic Analysis and the National Institutes of Health (NIH), to maintain VA research at current service levels, the VA Medical and Prosthetic Research appropriation would require \$15 million in FY 2016 (a 2.5 percent increase over the 2015 pending appropriation). Should availability of research awards decline as a function of budgetary policy, VA risks terminating ongoing research projects and losing these clinician researchers who are integral to providing direct care for our nation’s veterans. Numerous meritorious proposals for new VA research cannot be awarded without a significant infusion of additional funding for this vital program.

The IBVSOs believe an additional \$15 million in FY 2016, beyond uncontrollable inflation, is necessary for expanding research on conditions prevalent among OIF/OEF/OND veterans as well as continuing inquiries in chronic conditions of aging veterans from previous wartime periods. For example, VA Research is uniquely positioned to advance genomic medicine through the Million Veteran Program, an effort that seeks to collect genetic samples and general health information from one million veterans over the next five years. Additional funding will also help VA support emerging areas that remain critically underfunded, including:

- post-deployment mental health concerns such as PTSD, depression, anxiety, and suicide;
- the gender-specific health care needs of the VA growing population of women veterans;
- engineering and technology to improve the lives of veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- studies dedicated to understanding chronic multi-symptom illnesses among Gulf War veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- innovative health services strategies, such as telehealth and self-directed care, relatively new concepts that lead to accessible, high-quality, cost-effective care for all veterans, as VA works to address chronic patient backlogs and reduce waiting times.

State-of-the-art research also requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities. The impact of this funding shortage was observed in a congressionally mandated report that found a clear need for research infrastructure improvements systemwide. Nearly 40 percent of the deficiencies found were designated “Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards.”

The IBVSOs believe designating funds to specific VA research facilities is the only way to break this stalemate. In 2010, VA estimated that approximately \$774 million would be needed to correct all of the deficiencies found throughout the system; only a fraction of that funding has been appropriated since. A follow up report in 2015 will guide VA and Congress in further investment in VA research infrastructure to recruit the next generation of clinicians to care for the nation’s next generation of veterans. However, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life safety hazards for VA scientists and staff, and veterans who volunteer as research subjects.

Long-Term Services and Supports

RECOMMENDATIONS:

VA must make a coordinated effort and sustained commitment to successfully balance long-term services and supports.

Congress should enact legislation expanding VA Home and Community-Based Services program.

Congress should conduct oversight of the VA long-term services and supports (LTSS) balancing efforts to meet the needs of veterans, including the effects on access to and availability of LTSS because of current statutory authority.

VA should design a spinal cord injury/disease (SCI/D) long-term-care strategic plan that addresses the need for increased access, and makes certain that VA SCI/D long-term-care services “help SCI/D veterans attain or maintain a community level of adjustment, and maximal independence despite their loss of functional ability.”

BACKGROUND AND JUSTIFICATION:

Long-term services and supports (LTSSs) include many types of health and health-related services for individuals of any age who have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions. LTSSs are provided in institutional settings, such as nursing homes, and in home- and community-based settings (HCBSs), such as adult foster care and in-home care.

With the increasing number of veterans most likely to require VA LTSSs—those ages 85 and older, and those of any age with significant disabilities because of chronic diseases or severe injuries—the projected need and potential cost for VA LTSSs in the coming decade will continue to increase.

Studies have shown that expanding HCBSs entails a short-term increase in spending followed by a slower rate of institutional spending and overall LTSS cost containment. Reductions in cost can be achieved by diverting and transitioning individuals from nursing home care to HCBSs.

VA spending for institutional nursing home grew from \$3.5 billion to \$5.2 billion between 2007 and 2014; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBSs—indicating the cost of institutional care is rising.

Despite doubling HCBS spending between 2007 and 2014, VA currently spends less than 25 percent of its LTSS budget on HCBSs, which is less than half the national spending average for these services among the states.

The need for VA LTSSs for veterans with a spinal cord injury/disease (SCI/D) is vastly growing. While the life expectancy for SCI/D veterans has increased significantly over the years, so too has the secondary illnesses and complications associated with both aging and SCI/D. The number of SCI/D veterans needing long-term-care services is rising, and VA does not have sufficient resources to meet the demand.

Ending Veterans Homelessness

RECOMMENDATIONS:

To continue the trend in reducing the number of homeless veterans, Congress must: provide sustained funding to VA for supportive services and housing, continue research to identify risks of homelessness, maintain effective prevention strategies, and to enhance collaboration with community partners.

Congress should ensure that the DOD assesses all separating service members to determine their risk of homelessness and to help them avoid homelessness by providing life skills training if needed.

Congress should ensure that correctional, residential health care, other custodial, and VA facilities receiving federal funds (including Medicare and Medicaid reimbursements) have policies and procedures in place to ensure all service members being discharged have stable transitional or permanent housing arrangements with supportive services. For those who apply for income security and health security benefits (i.e. Supplemental Security Income, Social Security Disability Insurance, VA disability compensation, or Medicaid) prior to discharge, information about available VA resources and assistance should be provided to them.

VA should continue to work with community partners to meet the needs of homeless veterans and those at risk of homelessness and continue its outreach efforts to help homeless veterans gain access to VA programs.

BACKGROUND AND JUSTIFICATION:

In FY 2013, VA served more than 349,000 veterans who were homeless or at risk of becoming homeless—43 percent more than the year before. Additionally, 111,549 calls were made to the VA National Call Center for Homeless Veterans, a 38 percent increase from the prior fiscal year. Since 2010 the VA five-year program to end homelessness among veterans has seen homelessness decline 33 percent to about 49,933, according to the January 2014 count of homeless veterans on a given night conducted by hundreds of teams in communities nationwide.

Established in 2009 as part of the VA five-year program to end homelessness among veterans, the VA National Center on Homelessness Among Veterans (NCHAV) works to promote recovery-oriented care for veterans who are homeless or at-risk for homelessness. Through a series of studies, the NCHAV is producing a more accurate and reliable estimate of veteran homelessness, investigating the demographic make-up of this population, and determining where they reside. In addition, the NCHAV is uncovering the factors that predict homelessness among veterans; developing and implementing evidence-based interventions in housing, healthcare, and supportive services; formulating policy recommendations; and disseminating findings and training opportunities.

In late 2014, the President authorized a new round of funding to help VA meet its goal of ending veteran homelessness by 2015, providing nearly \$270 million for programs aimed at addressing the problem. VA has committed more than \$1 billion in 2014 to strengthen programs that prevent and end homelessness among veterans. Specifically, HUD is awarding \$57 million to support 8,276 tenant-based vouchers for rental units in the private market and \$5 million for 730 project-based vouchers for existing units or new construction in specific developments. The President's 2015 budget proposal asks for an additional \$75 million in vouchers to serve veterans experiencing homelessness. The goal is to issue 10,000 new vouchers a year.

Project Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) was launched in 1994 with a guiding principle that VA must work closely with the local community to identify needed services and deliver the full spectrum of services required to help homeless veterans reach their potential. CHALENG data identifies “met” needs as services that the Veterans Health Administration can provide directly and “unmet” needs as services that require community partnership to meet. Eight of the top ten

unmet needs were the same for male and female veterans: housing for registered sex offenders; child care; legal assistance in four separate areas (preventing eviction/foreclosure, dealing with child support issues, restoring a driver's license, and addressing outstanding warrants and fines), family reconciliation assistance, and financial guardianship. Nine of the top ten *met* needs were also the same for male and female veterans: medical service, testing, and treatment in three separate areas (tuberculosis, hepatitis C, and HIV/AIDS); case management services for emotional or psychiatric problems; medication management; substance-abuse treatment; and food.

According to VA, nearly 50,000 Iraq and Afghanistan veterans were either homeless or in a federal program aimed at keeping them off the streets during 2013, almost triple the number in 2011. VA notes that the number of these veterans struggling with homeless issues has grown because the department has expanded efforts to identify and assist them. The department has programs throughout all 50 states, working with community groups to target homeless veterans, and as a consequence, a more accurate picture of the number of these veterans is emerging. A lack of affordable housing, however, has contributed to veteran homelessness as a whole.

While much progress has been made and should be recognized, advocates for homeless veterans say meeting the 2015 goal will be difficult. The challenge includes the over 1.3 million veterans who received VA treatment for post-traumatic stress disorder and other mental health issues, up 400,000 since 2006. In addition, an average of 22 veterans a day commit suicide. Continued outreach, funding, and research are vital to carry on the marked progress that VA has made and to reach the goal to end homelessness among veterans.

Persian Gulf War Veterans

RECOMMENDATIONS:

Congress should conduct oversight on the direction of research for Gulf War illness and provide sufficient funding to resume robust research to identify effective treatments for veterans suffering from Gulf War illnesses.

Congress should conduct oversight on VA efforts to achieve the goals and implement actions outlined in the Gulf War Veterans' Illnesses Task Force (GWVI-TF) reports.

VA should provide lines of responsibility for implementing lines of effort outlined in its annual GWVI-TF report as well as measurable outcomes and report reliable and valid data to achieve the goal of meeting the needs of veterans suffering from Gulf War illness.

VA should amend the charter of Research Advisory Committee on Gulf War Veterans Illness to reinstate its independence and oversight responsibilities.

BACKGROUND AND JUSTIFICATION:

Congress and the Department of Veterans Affairs must aggressively pursue answers to the health consequences of veterans' Persian Gulf War service. Longitudinal studies of veterans who fought in the Persian Gulf War confirm that today, many years after the war ended, at least 175,000 veterans who served in-theater remain seriously ill.

An Institute of Medicine (IOM) Committee noted individualized health care management plans are necessary and recommended that VA implement a systemwide, integrated, multimodal, long-term management approach

for veterans who have chronic multisymptom illness. Veterans suffering from Gulf War illness require a holistic approach to the care they receive to combat the continuing decline in health status, function, or quality of life of ill Gulf War veterans.

VA's Gulf War Veterans' Illnesses Task Force has issued three annual reports highlighting the agency's efforts on addressing the unique needs of ill Gulf War veterans in several areas including clinical care, clinical education and training, and targeted research efforts. However, the report lacks meaningful outcomes, measures, and accountability to properly evaluate performance, improvements, and achievement of goals to improve the health and quality of life of ill Gulf War veterans.

For nearly a decade, ill Gulf War veterans have been marginalized, and their chronic and often debilitating symptoms were decidedly cast aside as trivial—until the landmark report by the IOM was published in 2010 that suggests a path forward to speed development of effective treatments, cures, and prevention.

Established under P.L. 105-368 as amended, the Research Advisory Committee on Gulf War Veterans has achieved much to bring positive sweeping and lasting change to the research and treatment of Gulf War veterans' illness; the Committee must not be allowed to falter. Changes made by VA to the Committee's charter are inconsistent with the relevant authority for this advisory committee.

While progress has been made in assisting Gulf War veterans, research programs at VA often run counter to the advice of scientific experts. Estimates state that 60 percent or more of the millions of dollars identified for Gulf War research has been used for research with no appreciable link to veterans of the 1990-1991 Persian Gulf War.

Hearing Loss and Tinnitus: The Forgotten Invisible Wounds

RECOMMENDATIONS:

VA must continue to dedicate itself to programs for research and treatment of tinnitus.

Congress must continue providing funding for VA and the DOD to prevent, treat, and cure tinnitus, including in peripherally related researchable conditions, such as traumatic brain injury.

The DOD and VA must provide better education to service members and veterans on the importance of hearing protection and preventative actions.

BACKGROUND AND JUSTIFICATION:

Tinnitus, commonly referred to as “ringing in the ears,” is a potentially devastating condition; its relentless noise is often an unwelcome reminder of war for many veterans. These facts are illustrative of the nature of the problem:

- Tinnitus is currently the most frequent service-connected disability of veterans from all periods of service and is particularly prevalent in Iraq and Afghanistan veterans.
- Tinnitus and hearing loss top the list of war-related health costs.
- Since 2000, the number of veterans receiving service-connected disability for tinnitus has increased by at least 16.5 percent each year.

- According to the *VA Fiscal Year 2013 Annual Benefits Report*, the total number of veterans awarded disability compensation for tinnitus is 1,121,709.
- At this alarming rate, the year 2016 will see more than 1.5 million veterans receiving disability compensation for tinnitus, at a cost of more than \$2.75 billion annually.⁵

Tinnitus is a growing problem for America's veterans. Tinnitus threatens veterans' futures with potentially long-term sleep disruption, changes in cognitive ability, stress in relationships, and employability challenges. These changes can be a hindrance to veterans' transition into their communities, as well as veterans' overall quality of life.

Acoustic trauma has long been part of military life since muskets and cannons were part of the arsenal, and the experience of Operations Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans is no exception. America's newest generation of veterans were and are exposed to some of the noisiest battle-grounds our military has ever experienced. Improvised explosive devices (IEDs) continue to be the signature weapon of the insurgency and regularly hit patrols, causing a wealth of health problems, including hearing loss and tinnitus. Although the noise emitted from IEDs is the main source of recent increases of tinnitus within the veteran population, tinnitus can also be caused from head and neck trauma, including traumatic brain injury (TBI). TBI has become one of the signature wounds of recent conflicts and is producing a whole new generation of veterans with both mild and severe head injuries. TBI is reported to have caused approximately 60 percent of VA diagnosed cases of tinnitus.⁶

A 2010 Department of Defense study on hearing loss and tinnitus in Iraq veterans found that 70 percent of those exposed to a blast reported tinnitus within the first 72 hours after the incident, and 43 percent of those seen one month after exposure to blast continued to report chronic tinnitus. While the rate decreases over time, tinnitus rates exceeded hearing loss rates at all time points. These findings also demonstrate the need for more comprehensive diagnostics and a broader range of therapeutic approaches for tinnitus, particularly when it is not accompanied by hearing loss, which can only be achieved by continued and additional research on the condition.

For many veterans, tinnitus gets worse at times of high emotion or anxiety. Clinical depression rates are estimated to be more than twice the national average among tinnitus patients.⁷ Service members are thus dealing with tinnitus and hearing loss coupled with post-traumatic stress disorder or general anxiety disorder, making their recovery that much more difficult.

While VA has made great advances in treating hearing loss, tinnitus options are still very limited. A VA research team based at the James Haley VA Medical Center in Tampa, Florida, developed the progressive tinnitus management (PTM) approach to treating tinnitus. The culmination of years of studies and clinical trials, PTM has started to evolve into a national management protocol for VA medical centers.

The model is designed to address the needs of all patients who complain about tinnitus, while efficiently utilizing clinical resources. There are five hierarchical levels of management: triage, audiologic evaluation, group education, interdisciplinary evaluation, and individualized support. Throughout the process, patients work with a team of clinicians to create a personalized action plan that will help manage their reactions to tinnitus and make it less of a problem.⁸

While newer options for treatment of tinnitus, such as PTM are emerging, the IBVSOs still have no cure to alleviate the phantom sounds plaguing the veterans community. The only way to avoid tinnitus is prevention,

⁵Analysis of VA data from their annual Veterans benefits report done by the American Tinnitus Association; http://www.ata.org/sites/ata.org/files/docs/2012_ADV_Master_Packet.pdf.

⁶Stephen Fausti, Debra J. Wilmington, Frederick J. Gallun, et al., "Auditory and Vestibular Dysfunction Associated with Blast-related Traumatic Brain Injury," *Journal of Rehabilitation Research & Development* 46 (November 6, 2009): 797-8.

⁷<http://www.pbs.org/newshour/updates/science/jan-june11/tinnitus.html>.

⁸<http://www.va.gov/health/NewsFeatures/20110524a.asp>.

and the DOD must continue to educate service members on the importance of wearing hearing protection in high noise environments whenever possible. While VA currently paying out \$1.76 billion annually in disability compensation for tinnitus, only about \$10 million is spent on research between all public and private funding in the United States. The focus of tinnitus research on the brain has led to new research techniques and is attracting new disciplines to the field, which in turn, is expediting progress in the way tinnitus is researched and ultimately treated.⁹ This progress clearly illustrates the importance of continued research and funding in order to find a way to help the millions of veterans suffering from tinnitus.

⁹http://www.ata.org/sites/ata.org/files/pdf/ADV_FactSheet_Feb2013_FINAL.pdf

Administrative Issues

VA Human Resources: A Vital, but Flawed Service

RECOMMENDATIONS:

The Independent Budget Veterans Service Organizations (IBVSOs) recommend VA work aggressively to streamline the VA hiring process, and eliminate recruitment and on-boarding delays that serve as barriers to VA employment.

The IBVSOs recommend VA establish performance measures and accountability that connect results achieved by human resources personnel to the goals and needs of VA elements that actually provide direct services to veterans.

In both the Veterans Health Administration and Veterans Benefits Administration, VA facilities must fully utilize all their recruitment and retention tools as broad-based employment incentives, not only a select few as determined locally.

The IBVSOs recommend VA increase professional development programs and opportunities for career growth as well as create a more attractive work environment for potential employees.

VA and Congress should reconsider the current restrictions on scientific conferences and training activities that affect veterans' health.

Given the VA Secretary's recent decision to elevate pay for some physician categories in an urgent recruitment effort to respond to Public Law 113-146, Congress should conduct oversight to determine whether VA had adequately implemented its original intent in responding to P.L. 108-445, "Department of Veterans Affairs Personnel Enhancement Act of 2004."

The IBVSOs recommend VA provide ample opportunities for veterans to secure VA employment, and Congress should enact legislation to reverse a federal appeals court decision holding that some VA veteran employees lack veterans-preference appeal rights under the Veterans Employment Opportunities Act of 1998.

BACKGROUND AND JUSTIFICATION:

As a federal health care provider for veterans, VA has been provided tools by Congress that provide distinctive benefits to some VA employment categories that other federal agencies cannot match. For example, VA is in the unique position of employing individuals within the same profession under two differing hiring authorities, title 5 and title 38 of the United States Code. VA also has been given the authority to classify employees in a "hybrid" employee status, which removes employees from a Title 5 competitive service system and empowers VA to create and interpret rules for hiring and promoting certain health care employees exclusively under its own unique authority.

VA must work to provide a work environment that equally respects the rights and benefits of all employees. Unfortunately, instances have been reported in which employees are denied certain rights that are reserved for their counterparts who were hired under a different hiring status. For instance, a federal appeals court ruled that VA health care employees appointed under title 38, section 7401 (primarily direct-care clinicians), lack the right to appeal violations of their veterans' preference rights because such title 38 appointees are not covered by the Veterans Employment Opportunities Act of 1998. (*Scarnati v. Department of Veterans Affairs*, 344 F.

3d 1246 [Fed. Cir. 2003]). Congress should reverse this decision to ensure that these parallel hiring authorities cannot be used to infringe upon rights of veterans who choose VA as their employer.

Retaining valuable professionals who can make significant contributions to the advancement of the VA mission cannot be accomplished without VA providing employees with relevant training, promotion, and educational opportunities. Despite the current budget constraints and the recent concern and scrutiny surrounding high costs associated with certain VA training conferences and travel, VA must make certain that employees gain opportunities for professional development and continuing education and training. The VA current reaction to Congressional and media scrutiny over large VA conferences has resulted in the virtual cancellation of nearly all VA conferences, whether or not those cancellations are fully justified. The IBVSOs understand that for the few conferences that are now approved through a new bureaucratic process biased toward disapproval, VA has placed an arbitrary limitation on VA employee attendance, whether or not travel is required. While the IBVSOs were concerned about the waste of taxpayer funds at some VA conferences in 2010 and 2011, to cancel all conferences outright (particularly in key areas such as mental health, biomedical research, and scientific meetings affecting veterans' health) was an unwise policy. Given these events' importance in advancing science and professions and in promoting quality of care and services, we ask Congress and VA to reconsider the VA current policy and create a more balanced approach to enable VA to continue providing excellence of services and care.

Whether in health, benefits or other services, VA invests a significant amount of effort and resources into training its workforce to meet the specific needs of veterans. Maintaining the wealth of experience, skills and knowledge needed by VA employees is essential to carry out the VA mission. Therefore, retention of VA employees is vital to providing veterans with high-quality and timely benefits and health care services. To retain quality employees, VA needs to provide employee incentives and programs that include child care benefits, flexible scheduling, and adequate continuing-education allowances (or equivalent reimbursements) to enhance skills and contribute to board certification, career mobility, and employee satisfaction.

Developing marketing and advertising strategies and utilizing recruitment tools such as competitive compensation packages are only initial steps toward refining VA human resources and hiring processes. VA leadership must also make certain that such strategies and recruitment goals are shared by local HR staff across the system as they carry out their duties. VA administrations produce annual Workforce and Succession Strategic Plans that establish VA-wide HR recruitment and retention goals. VA recent access-to-care revelations make these plans ever more important in determining whether VA is staffed at adequate levels to meet its mission. VA must create and adopt performance measures and standards that systematically identify when these recruitment and retention goals are achieved, and when they are not.

Specifically, VA must develop and implement defined goals for recruitment and retention as components of performance plans for Human Resource (HR) staff. VA HR management staff should be held accountable to direct service providers when recruitment efforts do not produce outcomes consistent with VA goals, or when goals are not achieved. The failure to fill critical vacancies in a timely manner directly impacts the VA ability to provide services to veterans. VA HR staff need to better understand the importance of their efforts and how they connect to direct services to veterans.

The bureaucratic and lengthy process VA requires for candidates to receive employment commitments and onboarding continues to hinder the VA ability to recruit and officially appoint new employees. This lengthy bureaucratic process especially hinders the appointment of physicians, nurses, and most commonly of new graduates, who are often in debt from student loans. VA must reduce the amount of time it consumes to bring these new employees on board, and provide its human resources management staff adequate support through updated, streamlined hiring systems, new procedures, and better training, to maintain the VA ability as a provider of health care, benefits, and other services to veterans.

VA Purchased Care

RECOMMENDATIONS:

The Department of Veterans Affairs must fully integrate non-VA purchased care into its healthcare delivery model by using care coordination to realize the best health outcomes and achieve veterans' health goals. The VA also must improve administrative functions and business practices and employ data analytics to ensure the purchase is cost effective, preserves agency interests, and enhances the level of service VA directly provides veterans.

VA must ensure the new organizational structure of managing non-VA purchased care is properly staffed and able to achieve integrated care, address system inefficiencies, as well as meet the need for clear guidance, supportive information technology, and meaningful data reporting.

The VA Office of Inspector General and the Government Accountability Office should conduct a follow-up review to audit the progress of actions VA has taken to improve purchasing care from non-VA providers.

Congress should conduct proper oversight and provide the necessary resources to facilitate full integration of non-VA purchased care into the VA healthcare system.

BACKGROUND AND JUSTIFICATION:

Under specific authorities, VA purchases a broad spectrum of health care services from non-VA providers for veterans, their families and survivors. From fiscal year 2006 to 2013, the number of veterans who received VA purchased care doubled to over one million while spending increased nearly 170 percent to \$4.8 billion.

The Government Accounting Office and Office of Inspector General (OIG) reports describe a lack of integration of non-VA medical care programs across all levels of the VHA. Integrated health care refers to the delivery of comprehensive health care services that are well coordinated, with good communication and health information sharing among providers. Patients are informed and involved in their treatment, and when properly integrated, the care is timely, of high quality, and cost effective.

Until recently, support and resources for non-VA medical care programs did not match its growth. While there are improvements in timely payments and reducing improper payments, recent OIG audit reports show a lack of coordination of purchased care where VA medical center officials limited the use of purchased home care services for ill and injured veterans with limited physical functions.

VA has the obligation to lift the burden from veteran patients—especially critical for chronically ill and complex patients—who are trying to bridge the fragmented and disconnected care VA buys from the private sector. Absent care coordination, VA is not fully optimizing its resources, and value is lost to both the patient and VA.

Information Technology: A Key to the VA Mission

RECOMMENDATIONS:

The Office of Information and Technology should continually improve and actively address effective Office of Information and Technology-Administration collaboration and important interagency coordination challenges.

VA should modernize and update the Veterans Health Information Systems and Technology Architecture electronic health-record system to provide an electronic health record that meets national health information technology standards.

VA should improve participation rates of the 9 million VA veterans enrolled in its “Blue Button” initiative in personal electronic health records, with the goal of participation by a majority of the currently enrolled VA veterans and 100 percent of new veteran enrollees.

VA and the DOD must continue to pursue development of a fully interoperable health information system with real-time access to comprehensive, computable electronic health records, on a high priority basis.

VA should fully fund IT infrastructure so that such infrastructure receives proper maintenance and upgrades in preparation for new and successor technologies. New technologies running on outdated infrastructure are apt to fail.

Congress, VA, and the Navy must strongly support the efforts of the joint VA North Chicago-Great Lakes Navy health facility consolidation with continued, significant IT funding and oversight. Productivity and success in this merger provide both lessons learned and enhancements that will enable progress in establishing electronic records at hundreds of health care facilities of each department and influence private-sector IT developments.

VA should continue to seek a national leadership role in developing crucial health information technology efforts.

VA and the DOD, with the assistance Congressional oversight, should solve the organizational governance, budget formulation, and policy differences that have served as barriers to past efforts in formulating the virtual lifetime electronic record.

BACKGROUND AND JUSTIFICATION:

The history of VA information technology (IT) has been characterized by both enormous successes and catastrophic failures. Some of these programs were mismanaged, delayed, or internally flawed so that in the end they could not be saved, resulting in the waste of hundreds of millions of dollars.

In contrast to significant department-level failures, the VHA, over more than 30 years, successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the VHA’s self-developed Veterans Health Information Systems and Technology Architecture (VistA) public domain software, sets the standard for EHR systems in the United States and has been publicly praised by the President and many independent observers.

VistA has been a critical tool in VHA efforts to improve health care quality, continuity, and coordination of care. This EHR system literally saves lives by reducing medication errors and enhances the effectiveness and safety of health care delivery in general. Therefore, the IBVSOs are acutely aware of the critical importance of effective IT management to veterans’ health care and to their very lives.

Despite its superiority and historic success, several years ago VHA officials recognized that VistA was aging and needed to be modernized. However, myriad efforts to “re-platform” and update the VHA electronic health system and its components have lagged.

The VistA system (and its successor) needs to be harnessed seamlessly to laptop, desktop, and a wide variety of mobile devices used both by VA providers and by veterans. Also, a number of health care mobile applications need to be developed and deployed as a part of the VA next-generation IT system to promote outreach, information, access, and better treatment and care for all generations of veterans who need and rely on VA.

VA and the DOD have been working on electronic health information sharing for nearly three decades. Despite strong and consistent Congressional mandates and oversight, these efforts remain fragmented. The DOD and VA have moved in divergent directions.

A dozen years ago, VA and the DOD began development of their information-sharing initiatives with the establishment of the Government Computerized Patient Record program. In 2004 the Federal Health Information Exchange (FHIE) was fully implemented. The FHIE enables the DOD to electronically transfer service members' electronic health information to VA when the members leave active duty. Since 2002 the DOD has collected information on 4.8 million service members from its various electronic systems and forwarded those data to VA. The Laboratory Data Sharing Interface allows DOD and VA facilities to share laboratory orders and test results, but the system is in use at only nine locations. In addition, in 2004 the Bidirectional Health Information Exchange (BHIE) was developed to allow VA and DOD health care providers to view records on patients who receive care from both. The BHIE has been used successfully to provide viewable access to records of some of the seriously injured service members wounded in Iraq and Afghanistan.

The development of an integrated DOD-VA EHR has been beset with problems. As indicated, VA operates the VistA system that supports its computerized patient record system (CPRS). The VistA CPRS promotes use in a broad array of health provider settings and establishes extensive clinical and administrative capabilities from its clinical, financial, administrative, and infrastructure functions. The DOD Armed Forces Health Longitudinal Technology Application system, primarily designed as an outpatient care EHR, has consistently experienced performance problems and has not delivered the full operational capabilities as originally intended.

The VistA CPRS system is unacceptable to the DOD, and the DOD AHLTA system is unacceptable to VA. In February 2013 the Secretaries of Defense and VA announced their decision to halt further development of a joint EHR and to instead pursue separate IT solutions, including a plan to eventually join these two next-generation systems through a commercial software interface.

The DOD and VA health care providers generally expect to gain access to some kind of electronic health record information between the departments for transitioning veterans, yet these health care providers are not able to electronically share complete health records of recovering service members when they move from the DOD to VA. Therefore, to provide clinical transition, providers resort to more burdensome methods of records transfer (including the use of paper records).

The IBVSOs believe VA and the DOD must continue to aggressively pursue development of a fully interoperable health information system with real-time access to comprehensive, computable EHRs, and medical images, and to do so on a high priority basis.

The Veterans Benefits Administration (VBA) has completed implementation of a new organizational model and IT system in order to fix the broken veterans benefits claims-processing system. For more than five years, the VBA has been engaged in a comprehensive transformation process designed to transition from paper-based processing. The initiative is working and merits continued support for the current transformation efforts.

Construction Programs



INTRODUCTION

Gaps in access, utilization, and safety in the VA health care system's infrastructure exacerbated the conditions that led to the VA's secret appointment wait lists, causing veterans to wait too long to receive the care they need and deserve. The Department of Veterans Affairs currently sits at 119 percent capacity and admits to needing \$10 billion just to close current safety gaps.¹⁰ *The Independent Budget* veterans service organizations (IBVSOs) believe VA must make every effort to ensure these facilities remain safe and sufficient environments to deliver care. Annual VA budgets that do not adequately fund facility maintenance and construction projects will continue to reduce the timeliness and quality of care for veterans.

The vastness of the VA capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a plant replacement value of approximately \$45 billion. Although VA has decreased the number of critical infrastructure gaps, more than 4,000 gaps remain that will cost between \$56 and \$68 billion to close, including \$10 billion in activation costs.¹¹

In addition, the Strategic Capital Investment Planning (SCIP) process is a tool that is intended to help VA make more informed decisions on capital investments. One key element that appears to be missing from the gap analysis criteria is a comprehensive assessment of the resources that exist outside of VA through existing contracts and sharing agreements. Unlike VA-built and leased space, contracts can be amended, cancelled, or sited differently to respond to any geographic changes and health care needs of veterans eligible for this care. This flexibility in contracting is especially relevant in the Veterans Health Administration as VA, Congress and the IBVSOs have increasingly supported leveraging community resources to provide accessible care to veterans in rural, remote, and underserved areas. Without a comprehensive understanding of the health care resources that exist within and outside of VA, the Department cannot make sound decisions on capital investments and right-sizing its inventory for the near-, mid-, or long- term horizon. Another apparent flaw of SCIP is the lack of transparency on the costs of VA future real property priorities that hinders the VA ability to make informed decisions. This flaw was among the findings in a report that the Government Accountability Office issued on January 31, 2011, which is entitled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*.

Quality, accessible health care continues to be the focus of the IBVSOs, and to achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital-asset plan, which VA has attempted to do, is important, but not adequately funding that plan will prevent VA from closing current access, utilization, and safety gaps and only will cause those gaps to grow.

¹⁰ Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 10.3-12, 9.3-11.

¹¹ Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 1-4, 9.2-7.

Immediate Infrastructure Needs

RECOMMENDATIONS:

VA must request and Congress must appropriate sufficient funding to close all major construction seismic safety gaps within five years.

VA must use a substantial amount of the funding provided through the Veterans Access, Choice and Accountability Act of 2014 to improve access to quickly prioritize and fund outstanding minor construction and nonrecurring maintenance projects.

VA must submit a Plant Replacement Value for all VA-owned property and calculate its baseline nonrecurring maintenance funding request from that value.

BACKGROUND AND JUSTIFICATION:

Decades of underfunding have left VA medical facilities ill-equipped to provide timely and accessible care for veterans, and in many locations safety is the chief concern. Four years ago, VA began analyzing current and future gaps in veterans' access, usage, and safety. VA found that nearly \$60 billion is needed to close all these gaps over a 10-year period. The IBVSOs understand that this level of funding is unachievable, but VA and Congress must look at the most compelling gaps and formulate a plan to quickly close those gaps to ensure existing facilities last as long as they should in areas where no other options exist. VA has the capability to build and maintain adequate infrastructure to provide safe and effective care to our nation's veterans.

Twelve major construction seismic deficiencies currently exist, nine of which are partially funded. To close these safety gaps requires \$4.7 billion. VA must make correcting these deficiencies a priority and provide a plan to achieve these goals. VA must request funding that will support this remediation.

The Veterans Access, Choice and Accountability Act provided VA \$5 billion to begin closing the access gaps in infrastructure, including funding nonrecurring maintenance and minor construction projects. VA has identified approximately 700 minor and nonrecurring maintenance (NRM) projects that will not only ensure the access gaps are closed, but ensure existing facilities are maintained and that existing facilities last for their projected life-cycles.

To maintain existing infrastructure, annual investments in nonrecurring maintenance must occur to ensure the buildings will last for their projected life-cycles. Over the past several years, VA has requested just more than \$700 million for NRM, barely half of what is needed based on the IBVSOs estimated plant replacement value for VA-owned properties.

VA is a world leader in research, but many of its facilities and labs are outdated and insufficient to conduct the research that is required for VA to remain a leader. The IBVSOs request that \$50 million be invested in research facility major construction projects and an addition \$175 million in minor and NRM research facility projects. This specific funding could address the Priority 1 and 2 deficiencies that were identified in the 2012 VA research capital infrastructure report.

Maintaining Current Capital Infrastructure and Planning for Its Future

RECOMMENDATIONS:

VA must determine the life-cycle cost of each medical facility and include those totals in its annual nonrecurring maintenance appropriations request.

VA must develop a program to establish architectural master plans for each medical facility.

VA must engage existing and potential community partners when analyzing alternatives to close major construction access and utilization gaps.

VA must continue to work to repurpose, lease or dispose of unused and underutilized property.

BACKGROUND AND JUSTIFICATION:

The Department of Veterans Affairs has improved its capital infrastructure gap analysis through its Strategic Capital Investment Planning (SCIP) process, which shows the current and projected 10-year gaps in access, utilization and safety VA has continually fallen short on requesting the funds necessary to close these gaps, and Congress continues to appropriate only the amount VA requests. A long-term strategy on methods to close these gaps is missing as is an appropriations request to match the strategy.

VA must build a strong plan on how to best close all currently identified and future access, utilization, and safety gaps. The first step of the plan should be calculating the annual life-cycle cost, including Nonrecurring Maintenance (NRM) needs, of each facility and establish that funding level as a baseline for its operations and maintenance-budget request. Currently, VA makes an NRM request and then determines which projects will be funded. VA must start funding based on need and not on a dollar amount.

Over the life cycle of a medical facility, utilization and services often change because of a changing demographic of patients and new technologies that change the way health care is delivered. VA must invest in medical center architectural master planning so these changes can be better anticipated and funding can be available as the needs arise, not years later. Congress must appropriate an additional \$15 million to allow VA to fund 10-year comprehensive facility master plans.

VA must do a better job of engaging local community partners to increase access and better utilize resources. Each facility master plan should contain an analysis of services provided and services needed, and when it makes sense, VA must leverage those partnerships with the local community to improve care and better allocate resources.

Last year VA identified nearly 500 buildings totaling 7.5 million square feet of under- or unutilized space that VA must continue to maintain. Unused space is a financial drain on VA overall operations and maintenance budget. Every effort must be made to repurpose, lease, or dispose of these properties.

Education, Employment, and Training



Since the Revolutionary War, the question of what a service member does when he or she is no longer in the service has been a problem, not only for themselves and their families, but also for society as a whole. From the late-nineteenth century to the early twentieth century, the national solution to this ‘veteran problem’ was, to some extent, to isolate and segregate them from civil society. Isolating veterans led to soldiers’ and sailors’ homes, federal vocational schools, and veteran farm colonies. With the emergence of expanding social mores following the aftermath of WWI, it became increasingly obvious that this policy was severely flawed, and *The Independent Budget* veterans service organizations (IBVSOs) began to see developments toward our current veterans policies.

In light of the extraordinary service and sacrifice required of our all-volunteer military, the IBVSOs believe that our nation has not only a moral obligation to assist our transitioning service members but a practical one as well. The economic reasons are perhaps more true than ever, as our transitioning service members continue to return to a slowly recovering economy which continues to offer limited, living-wage employment opportunities.

From a purely economic point of view, assisting transitioning service members in reaching their employment potential is truly a win-win-win situation – employing veterans is good for the economy, good for employers and good for our veterans. Veteran employment is especially important as the majority of working-age veterans want to remain as productive in the civilian workplace as they were while in the service, and nation has a solemn obligation to ensure them every opportunity to be successful in that endeavor. The most critical time for action in attaining employment is immediately after a service member transitions to civilian life, but IBVSOs must provide support and resources to veterans from all eras.

According to a recent VA National Center for Veterans Analysis and Statistics report:

- the population of Caucasian, male veterans will decline overall through 2043;
- the population of female veterans will simultaneously increase through 2043;
- the minority veteran population is expected to increase through 2014

Much of the projected decrease in the male veteran population cohort is because of a dwindling of the last draft-era veterans from WWII (1.2 million as of 9/30/13), the Korean Conflict (2.1 million as of 9/30/13) and Vietnam (7.3 million as of 9/30/13). At the end of the Vietnam War, the veteran population stood at nearly 60 million, compared to the roughly 21,973,000 current living veterans, which means that over the course of the past 40 years America has lost more than two thirds of its veterans. This downward trend in the veteran population should not be viewed as a decrease in the educational, employment or training needs of our service members: rather, while the numbers of veterans may gradually diminish, their needs will remain high.

A 2012 survey done by Prudential Financial, Inc., entitled, “Veteran Employment Challenges,” addresses both the specific employment roadblocks, as well as the numbers, of our newest veterans. The report indicates that as of the first quarter of 2013, approximately 783,000 veterans were unemployed, of whom, 207,000 were post-9/11 veterans. The IBVSOs note that in light of the continuing military troop strength drawdown over the course of the next few years, close to 1,000,000 service members will be transitioning out of the military.

The IBVSOs gratefully acknowledge the continued support of both the Administration and Congress for their efforts in not only recognizing, but prioritizing, the specific employment challenges being faced by transitioning service members. We also believe that our service members need and deserve:

- ongoing access to relevant career development and employment resources throughout their military service geared toward their current and future employment needs;
- the opportunity to continue or pursue an education;
- support in earning any required licenses and/or credentials to ensure veterans are able to equitably compete with their civilian counterparts for living wage jobs; and
- the opportunity to continue serving their country in a meaningful career once veterans return to civilian life.

Our nation has many reasons to support our veterans as they transition from military to civilian society, and this discussion will outline some of the ongoing problems facing veterans, many of the resources that are available to assist them, and specific recommendations for improvement.

Ensure Veteran Success in Higher Education

RECOMMENDATIONS:

Congress, VA, the Department of Defense, and the Department of Education must work together to ensure that college-bound veterans have access to quality pre-enrollment consumer information and post-enrollment consumer protections when utilizing their earned education benefits at the college or university of their choice.

VA must develop quality metrics that evaluate student veteran success in higher education, identify potential problems, and develop quantifiable solutions.

Congress must continue to invest in campus-based support resources for student veterans to include expansion of the VetSuccess on Campus program or additional programs that support peer-to-peer support or offer resources to develop veteran centers of excellence.

BACKGROUND AND JUSTIFICATION:

In 2009, Congress made a significant investment in the future of our nation's veterans by commissioning the Post-9/11 GI Bill. This landmark benefit would provide veterans who served in support of the Global War on Terror with the financial means to pursue higher education.

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

With such a significant investment in the future success of today's military service personnel and newer veterans, Congress, as well as VA and its partner agencies, have an obligation to ensure that veterans not only enroll in college but that they succeed when they get there. As a nation, we also have the responsibility to ensure that veterans will not become victims of fraud, waste, or abuse when they seek to use these earned benefits.

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

By implementing *The Independent Budget's* recommendations, we can work to ensure that college-bound veterans make informed decisions on how to best utilize their benefits, that campuses are prepared to best serve the unique needs of student veterans, and that we can demonstrate return on investment in our nation's veterans.

Licensing and Credentialing

RECOMMENDATIONS:

The DOD, VA, the Department of Labor and other federal, state, and local government agencies tasked with assisting transitioning service members should continue coordinated efforts with private sector entities to address the many challenges veterans face in obtaining civilian licenses and credentials. Such efforts must focus on identifying equivalencies between military and civilian occupations and developing processes to bridge the gap between state credentialing, licensing, and certification requirements and military training. Such processes should ensure veterans are able seamlessly to transfer their military training into meaningful civilian employment in any state, regardless in which state veterans received their military training.

Congress and the DOD must work to remove barriers so states can recognize military training that leads to occupational licenses and or credentials.

Congress should ensure that all the military service branches cover the costs of credentialing examinations and fees for all enlisted service members.

BACKGROUND AND JUSTIFICATION:

Every year, between 240,000 and 360,000 military members make the transition from military to civilian life and employment, and as the drawdown continues, the military expects a million service members will transition from military service back to civilian life over the next few years. During this transition, veterans will undoubtedly face many challenges. Obtaining meaningful employment continues to be one of the biggest challenges they face during this often-difficult transition. IBVSOs cannot over-emphasize the importance of transferring veterans' military training into civilian licensing and credentialing when veterans seek to obtain gainful employment.

We recognize that the Federal government cannot solely resolve the many challenges transitioning service members face when obtaining civilian licenses and credentials. The Administration has worked with stakeholders at all levels, including employers, to establish a task force and numerous specialized workgroups, issued targeted grants, created a variety of programs, and implemented several valuable initiatives to develop best practices and workable solutions which, while seeking to maintain high standards, eliminate or minimize employment obstacles for veterans. While progress has been made, the military and veteran communities continue to be concerned that veterans face undue burdens when they seek to obtain the civilian licenses and credentials they need to succeed in the civilian workforce.

According the DOD Military Credentialing and Licensing Task Force's September 2014, report, almost 3,500 service members from 57 military occupational specialties have participated in credentialing and licensing pilot programs.

Currently, the Navy is the only military service that pays for credentialing examinations and fees for all enlisted service members. According to the DOD Military Credentialing and Licensing Task Force, other services will fund credentials in a targeted manner and are exploring broader funding. Congress must maintain oversight of this process to ensure a uniform and equitable system of payments for these opportunities for enlisted personnel.

Strengthen Veteran-Owned Small Business Programs

RECOMMENDATIONS:

Congress must take the necessary steps to prevent excessive delays in awarding contracts to service-disabled veteran and veteran-owned companies by requiring all federal agencies to use a single-source verification database.

The Department of Labor and VA must improve oversight and assist in development and implementation of stronger strategies to reach the federally mandated minimum three percent procurement goal.

Congress must provide for a reasonable transition period for family members of all service-disabled veteran-owned small businesses in the event of the death of the veteran owner.

BACKGROUND AND JUSTIFICATION:

The government's support of VOSBs and SDVOSBs contributes significantly in restoring veterans' quality of life while aiding in their transitions from active duty. Yet veterans' ability to compete for contract awards remains problematic since many federal agencies have not reached the three percent goal of set-aside contracts. Federal agencies must be held accountable to meet the federal procurement goals outlined by Executive Order No. 13360 and sections 15(g) and 36 of the Small Business Act, which gives agency contracting officers the authority to reserve certain procurements for SDVOBs.

Because of changes in the verification system, timely verification continues to be an issue for SDVOSBs and VOSBs. VA must hire and train a sufficient number of employees to quickly and effectively certify and recertify veterans' small businesses.

Finally, while acquiring an initial federal contract and meeting its many prerequisites may be a big challenge for SDVOSBs, the death of a service-disabled business owner presents significant obstacles that can lead to the surviving spouse or children's loss of the business. Currently, surviving spouses of 100 percent disabled veteran business owners have a 10-year period to re-categorize the business after the date of the veteran's death if the death is related to his or her disability. All other surviving spouses have one year to transition if the contract is through VA and loss of status is immediate if the contract is held by any other federal agency.

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

Assure Proper Oversight of and Support for Non-VA Workforce Development Programs

RECOMMENDATIONS:

Congress must monitor the implementation of the Workforce Innovation and Opportunity Act to ensure that the law's promised improvements in state workforce programs for veterans and their families come to fruition.

Congress should restore the access of veterans with nonservice-connected disabilities to veteran specialist employment assistance provided by Disabled Veterans Outreach Programs and Local Veterans' Employment Representatives.

Congress should ensure that the Department of Labor properly enforces the new Vietnam Era Veterans Readjustment and Assistance Act regulations governing federal contractor obligations to recruit, hire, and advance veterans.

Congress should permanently authorize the Work Opportunity Tax Credit because of its importance to companies in hiring veterans.

BACKGROUND AND JUSTIFICATION:

Several programs outside of the Department of Veterans Affairs have an impact on the employment prospects of veterans. These include the Jobs for Veterans State Grants program under the Workforce Innovation and Opportunity Act (WIOA), federal contracting rules under the Vietnam Era Veterans Readjustment and Assistance Act (VEVRAA) and veteran hiring incentives provided by the Work Opportunity Tax Credit (WOTC). *Workforce Innovation and Opportunity Act* — On July 22, 2014, the President signed WIOA, a law reauthorizing the nation's workforce development system. The law, which becomes effective July 1, 2015, contains several major provisions of interest to the veteran community including:

- Representation on state and local workforce boards of organizations serving veterans with barriers to employment.
- Requirements that state workforce plans specify how they will implement priority of service for veteran.
- Funding to help veterans and people with disabilities navigate multiple service programs and activities.
- Looser Job Corps eligibility rules for veterans within six months of discharge.
- Assurances that veterans with disabilities will be better served by state vocational rehabilitation programs.

The Department of Labor (DOL) is analyzing how WIOA provisions affect the Jobs for Veterans State Grants program and plans to issue further guidance as needed. However, in April 2014, the DOL issued a directive that could have an impact on the effectiveness of the WIOA in serving certain veterans with disabilities. In a Training and Employment Guidance Letter (TEGL 19-13), the agency narrowed the scope of services provided by Local Veterans' Employment Representatives (LVERs) and Disabled Veterans' Outreach Program (DVOP) specialists. LVERs are no longer allowed to perform any casework for individual veterans, and DVOP specialists are no longer allowed to serve veterans with nonservice-connected disabilities, even if these staffers have time to do so. Estimates state that 70 percent of veterans, including veterans with disabilities, will be denied access to these veterans' employment specialists.

WIOA was hailed as important bipartisan legislation that aims to streamline and focus the nation's workforce-development system on the most effective tools for improving employment prospects for those most in need of assistance. Strong Congressional oversight will be required to ensure that veterans receive the attention they deserve as implementation of WIOA moves forward. Moreover, Congress should act to enable LVERs to provide individual casework to veterans and allow DVOP specialists to serve all veterans covered by 38 U.S.C. § 4103 (A).

VEVRAA – On September 24, 2013, the U.S. Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) published a Final Rule that makes changes to the regulations implementing the Vietnam Era Veterans’ Readjustment Assistance Act (VEVRAA), at 41 C.F.R Part 60-300. These new regulations became effective on March 24, 2014.

In 2012 according to Bureau of Labor Statistics data, the unemployment rate for Gulf War-era II veterans was 9.9 percent, compared to 7.9 percent for nonveterans. To address these and other disparities affecting veterans, the Office of Federal Contract Compliance Programs (OFCCP) strengthened the regulations implementing VEVRAA by making affirmative action requirements more specific and by requiring contractors to establish benchmarks to measure their progress toward achieving equal opportunity for protected veterans. The new VEVRAA regulations also make it easier for veterans to find and apply for the jobs that federal contractors list with job agencies. The OFCCP plans to use the additional documentation requirements called for by the regulations to conduct more effective compliance evaluations of federal contractors. Congress must monitor the implementation of VEVRAA to make sure that companies receiving federal contracts are abiding by their obligations to recruit, hire, and advance covered veterans.

WOTC – The Work Opportunity Tax Credit (WOTC) has offered employers tax incentives to hire certain targeted populations, including veterans, since 1996. In 2011 the Veterans Opportunity to Work (VOW) to Hire Heroes Act expanded provisions in the WOTC to cover additional veterans with employment barriers. Department of Labor statistics indicate that, in FY 2013 alone, over 65,000 veterans were certified by state workforce agencies, allowing employers to claim the tax credit on their tax returns. Unfortunately, WOTC authorization expired as of January 1, 2014 so that companies making new hires after that date would not be able to use the tax credit. Legislation has been introduced to make the WOTC permanent. Congress should act to reauthorize WOTC retroactively and make its authority permanent so that employers will continue to have access to this hiring incentive.

Helping Veterans with Disabilities Successfully Transition to Employment

RECOMMENDATIONS:

Transition Goals, Plans, Success must include meaningful information about disability employment rights and protections as required by Section 521 of the Fiscal Year 2014 National Defense Authorization Act (Public Law 113-66).

The Department of Labor must work with internal and external partners to share resources on disability employment protections for transitioning service members.

BACKGROUND AND JUSTIFICATION:

The Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011 (Public Law 112-56) requires service members to participate in Transition GPS as part of their transition out of the military. The goal of Transition Goals, Plans, Success (GPS) is to provide service members and their families with the resources they need to help them in returning to civilian life. Required transition briefings include information about Department of Veterans Affairs benefits and a DOL employment workshop.

Despite efforts to facilitate the transition to civilian employment, many veterans with disability ratings from VA of 60 percent or higher are not participating in the workforce, according to data from the U.S. Bureau of Labor Statistics. For example, approximately 24 percent of Gulf War-era veterans reported having a disability related to their military service. Of those veterans, 431,000 reported having a disability rating of 60 percent or higher. Their workforce participation rate was 53.9 percent compared to 80.1 percent for veterans without a service-connected disability.

Many of these disabled veterans do not possess the information that they need about their employment rights and protections as people with disabilities. For example, a study of veterans with disabilities found that nearly half believed that a person with a disability must let an employer know if he or she has a disability. Furthermore, nearly half believed that an employer isn't required to make appropriate job-related accommodations for an employee with a disability.

Veterans who have acquired disabilities as a result of their military service need to gain a basic understanding of the protections available to them under the law as they return to the workforce or pursue educational opportunities. Section 521 of the FY 2014 National Defense Authorization Act (Public Law 113-66) seeks to address this knowledge gap by requiring Transition GPS to include information about disability-related employment and education protections. This requirement must be met no later than April 1, 2015.

Information about disability-related employment and education protections is an important component to the DOL employment workshop. The protections available can assist anyone who is discriminated against because of a disability. To ensure that meaningful information about workers with disabilities returning to the workforce is included, the DOL Veterans' Employment and Training Service must work with internal partners such as the DOL Office of Disability Employment Policy and external partners, including the Equal Employment Opportunity Commission. These partners can provide expert information about the Americans with Disabilities Act, reasonable accommodations, and other areas impacting veterans with disabilities who are returning to the workforce.



Enhance Vocational Rehabilitation Productivity and Partnerships

RECOMMENDATIONS:

VA must provide a more timely and effective transition into the workforce and provide placement follow-up with employers for a minimum of 12 months.

VA should improve its partnership with state agencies by incorporating the services of non-VA counselors and constituent-specific, vocational-assistance programs (those able to accommodate the needs of women, combat-exposed, paralyzed, blind, amputee, traumatic brain injured, etc.) to ensure that all eligible veterans receive the full array of benefits and level of customization necessary for meaningful and effective vocational intervention.

The Technical Assistance Guide must be updated regularly to ensure both the Department of Labor and VA are providing appropriate step-by-step services in a consistent manner to disabled veterans, essential in helping make disabled veterans "job ready."

Congress must provide the necessary funding to carry out a longitudinal study over a period of at least 20 years, as directed by P.L. 110-389, section 334.

BACKGROUND AND JUSTIFICATION:

Current Vocational Rehabilitation and Employment (VR&E) resources are insufficient to meet the needs of our nation's veterans in a timely manner. Cooperative partnerships between VA, the DOL, and other federal and state agencies must be enhanced to provide the full array of benefits and customized services to veterans in key demographics. VA needs to strengthen the VR&E program to meet the demands of disabled veterans, particularly those returning from the conflicts in Southwest Asia. The importance of this type of collaboration was woven into the VOW to Hire Heroes Act of 2011, which authorizes government agencies to forge partnerships with nonprofit organizations in the development of job mentoring programs.

The task before VR&E is critical, and the need becomes clearer in the face of the statistics from the current conflicts. Since September 11, 2001, more than 2.4 million service members have been deployed. Of that group nearly one million have been deployed two or more times. As a result many of these service members will be eligible for VA disability benefits and VR&E services if they are found to have an employment handicap. Far too many veterans are unaware of the services available to them. VA can close these informational gaps through cooperative agreements with nongovernmental agencies, nonprofit organizations, and veterans service organizations through structured referral processes intended to supplement services by state agencies that cannot serve lower-priority veterans because of budget shortfalls and understaffing.

Because of the increasing number of service members returning from tours in Southwest Asia with serious disabilities, we must provide VR&E with the resources to further strengthen its program and partnerships with local and federal entities. No mission is more important than that of enabling injured military personnel to lead productive lives after serving their country. For disabled veterans who need employment services, many must work with state counselors who are unfamiliar with the unique aspects of combat acquired post-traumatic stress disorder or traumatic brain injury. Such injuries make sustainable job placement a challenge, and were an under-recognized problem that similarly plagued Vietnam veterans.

The IBVSOs believe state agencies and VA VR&E program staff would greatly benefit from training conducted by subject-matter experts on the functional challenges of traumatic brain injury, post-traumatic stress disorder, spinal cord injury, and other severe or catastrophic disabilities to improve the delivery of vocational intervention services to those veterans.

The IBVSOs believe there should be a study to determine if the VR&E's current tracking of whether a veteran participating in the program remains employed beyond the current standard of 60 days is adequate. Because many employers have probationary employment periods in excess of 60 days, we believe a lengthier period of time, such as one year, for the VR&E to follow-up with an employer would be more appropriate.

To further the understanding of a joint services approach towards getting disabled veterans into suitable employment, a Technical Assistance Guide (TAG), a joint venture between the Department of Labor's Veterans' Employment and Training Service and the Department of Veterans Affairs VR&E Service, was created in 2008. The TAG provides step-by-step instructions on how to get a "job-ready" disabled veteran into the workforce.

The VOW Act of 2011 will influence changes within the TAG; the TAG must be revised and updated to conform to this new legislation. Additionally, lessons learned among the respective departments since the 2008 TAG was established will help to shape the newest version. The new version should incorporate best practices from 2008 to the present so they are repeated and ineffective practices discontinued.

The IBVSOs support a requirement in P.L. 110-389, "Veterans Benefits Improvement Act of 2008," that VA conduct a 20-year longitudinal study of the long-term outcomes of individuals participating in VA vocational rehabilitation programs, beginning with the group that entered vocational rehabilitation in 2010. However, this study is conditioned on the availability of discretionary appropriations; thus, funds to support it must be taken from VR&E's existing resources. Over the course of this study period, the IBVSOs would expect that VA

would develop new interventions based on this longitudinal review. Also, the IBVSOs believe Congress should continue to support this study with sufficient appropriated funding.

We believe the existence of better data, including success rates and evaluation of VA ongoing approaches, are essential to promote an effective vocational rehabilitation effort. This study should include an acute focus on the reasons veterans discontinue participation in the VR&E program and provide a foundation for designing interventions that may ease lack of participation or discontinuance.

Enhance Vocational Rehabilitation and Employment Services

RECOMMENDATIONS:

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

Congress should study changing the current program eligibility standards to determine if doing so would streamline the process by expanding eligibility to all veterans who have been awarded service-connected disability ratings, regardless of the degree of disability.

Congress should provide childcare vouchers, linked to cost-of-living increases, for veterans who have families and are undergoing a VR&E program.

Congress must provide sufficient resources for VR&E to establish a maximum client-to-counselor standard of 125:1 or better and explore new methodologies to formulate a proper client-to-counselor ratio based on the challenges associated with more severely disabled veterans.

BACKGROUND AND JUSTIFICATION:

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

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

In 2003 the Government Accountability Office designated the VA disability program as "high risk" because of program management difficulties; transformation was needed. In March 2004 the VR&E task force, created by the Congressional Commission on Service Members and Veterans Transition Assistance (Commission), released a report with 110 recommendations for VR&E improvements. As a direct result of that report, VR&E

implemented the five-track process that strengthened the program's focus on employment. In response to the 2004 task force report, VA implemented 100 out of the 110 VR&E task force recommendations.

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

While the Veterans Benefits Administration (VBA) has implemented most of the 110 VR&E task-force recommendations, The IBVSOs continue to support its recommendations as well as those of the Commission to further enhance this important benefit by expanding VR&E access to all medically separated service members, making all disabled veterans eligible for VR&E counseling services, creating a monthly stipend for those participating in the employment track of VR&E's programs, creating incentives to encourage disabled veterans to complete their rehabilitation plans, and eliminating the current 12-year eligibility limit for veterans to take advantage of VR&E benefits.

As a consequence of increased demand placed upon VR&E's workload and additional collateral responsibilities, the number of veterans in the various phases of VR&E programs is expected to continue rising. As more service members return from the conflicts in Southwest Asia and as the VBA continues to process more claims at an accelerated rate because of gains achieved through its transformation and automation, the IBVSOs are concerned with the current constraints placed on VR&E because of an average client-to-counselor ratio of 145:1, and the disparity among caseloads within some VA regional offices, compared to the VA standard ratio of 125:1.

The VR&E will not be able to provide adequate service, especially one-on-one counseling, at the 145:1 ratio. Given the anticipated increased VR&E caseload that future downsizing of the military will produce, and the complex nature associated with rendering appropriate services for our more severely disabled veterans, accurately determining staffing requirements based upon a more comprehensive manpower formula is imperative; a new methodology must be developed.

VA Pension/Work Disincentives

RECOMMENDATION:

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

BACKGROUND AND JUSTIFICATION:

Many veterans, who served honorably and were discharged in good health, later acquire significant disabilities. As a consequence eligible veterans will qualify for the Department of Veterans Affairs nonservice-connected pension. VA pension is often likened to Supplemental Security Income (SSI) under Social Security. However, SSI recipients have access to a work incentive program whereby their public benefit is gradually reduced as their earned income rises. Unlike SSI recipients, VA pensioners face a "cash cliff" in which benefits are terminated once an individual crosses an established earnings limit. Because of a modest work record, many of these veterans or their surviving spouses may also receive a small Social Security Disability Insurance (SSDI) benefit

that supplements their VA pension. If these individuals attempt to return to the workforce, not only is their SSDI benefit terminated but their VA pension benefits are reduced dollar for dollar by their earnings.

More than 20 years ago, under P.L. 98–543, Congress authorized VA to undertake a four-year pilot program of vocational training for veterans awarded a VA pension. Modeled on the Social Security Administration’s trial work period, veterans in the pilot program were allowed to retain eligibility for pension up to 12 months after obtaining employment. In addition, they remained eligible for VA health care up to three years after their pension terminated because of employment. Running from 1985 to 1989, this pilot program achieved some modest success. However, it was discontinued because, prior to VA eligibility reform, most catastrophically disabled veterans were reluctant to risk their access to VA health care by working.

The VA Office of Policy, Planning and Preparedness examined the VA pension program in 2002 and, though small in number, seven percent of unemployed veterans on pension and nine percent of veteran spouses on pension cited the dollar-for-dollar reduction in VA pension benefits as a disincentive to work. Now that veterans with catastrophic nonservice-connected disabilities retain access to VA health care, loss of access to medical care is no longer an impediment to work but the VA pension cash cliff remains a barrier.



Enhance the Independent Living Program

RECOMMENDATIONS:

Congress must remove the cap on the Independent Living Program (ILP) within the Vocational Education and Employment (VR&E) program. All rehabilitation options, including independent living, must be available for veterans that require such services.

VR&E management must provide adequate oversight of the ILP specific Training Performance Support System deployed in FY 2013, to ensure vocational rehabilitation counselors understand the eligibility requirements and benefits that can be achieved through appropriate use of this program.

The VR&E must have the appropriate resources and technologies to collect relevant information for the ILP, including but not limited to the number of disabled veterans applying for the ILP and the goods and services provided to a disabled veteran in the program.

BACKGROUND AND JUSTIFICATION:

The Independent Living Program (ILP) was created by Congress in 1980 as a pilot program with a cap of 500 participants. Realizing the significance of the ILP, Congress increased the cap several times to the current level of 2,700. *The Independent Budget* veterans service organizations firmly oppose a cap on this uniquely individualized rehabilitation assistance for severely disabled veterans. Because Congress placed a mandatory cap on this program, some adverse consequences have been created leading to poor program understanding and utilization including the need for VR&E management to monitor total veterans enrolled in this program to ensure participation will not exceed the cap. The law also mandates that each ILP created for a veteran counts toward the cap; as a veteran may require multiple ILPs within the same fiscal year, each established ILP would count toward the cap.

All veterans, including seriously disabled veterans, who are found eligible and choose to participate in the Vocational Rehabilitation and Employment (VR&E) program are assigned to a Vocational Rehabilitation Coun-

selor (VRC) for a services evaluation. The ILP assistance afforded to wounded, ill, and injured veterans with specific barriers to employment should be allocated according to need rather than by arbitrary program caps. Upon completion of the comprehensive evaluation between the VRC and the veteran, they will then choose one of the five tracks of services within VR&E.

The five tracks include re-employment (with a former employer); direct job placement services for new employment; self-employment; employment through long-term services, including on-the-job training, college, and other training; and finally, independent-living services. For those veterans with severe disabilities who may not be ready to pursue employment goals, VR&E has the option of providing further rehabilitation assistance through the ILP.

VRC's must be better educated about the purpose and benefits of this program. More informed VRC's would ensure that this option is offered to, and available for, all who may benefit. Without proper training and consistent oversight, the administration of the ILP will continue to vary between regional offices and among VRCs.

Finally, adequate systems and technologies are crucial for proper administration of the ILP. The VR&Es current case management system, Corporate Winston-Salem, Indianapolis, Newark, Roanoke, Seattle, lacks the ability to capture ILP-specific data such as the number of applicants, number of plans created for a disabled veteran, and succinct categorization of expenditures for goods and services provided to a veteran.

The National Cemetery Administration



RECOMMENDATIONS:

The Administration and Congress need to provide advance appropriations to the remainder of the discretionary and mandatory programs, services, and benefits accounts of the Department of Veterans Affairs, including the National Cemetery Administration (NCA) to ensure that its critical mission is protected from any and all future budgetary disputes and allowing it to fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

Expand the NCA's Veterans Apprenticeship Program to all administrations within the Department of Veterans Affairs.

Establish a Consistent Applicability Date for Provision of Memorial Headstones and Markers for Eligible Non-Veteran Individuals: Amend 38 U.S.C. § 2306(b) to establish a consistent applicability date of "after November 11, 1998," for provision of memorial headstones and markers for all eligible veterans' spouses, surviving spouses, and dependent children.

Align Eligibility for Burial and Presidential Memorial Certificates for Members of the Reserve Components of the Armed Forces: Amend 38 U.S.C. § 112(a) to allow the Department of Veterans Affairs to provide a Presidential Memorial Certificate to eligible recipients of the reserve components of the Armed Forces of the United States Army or Air National Guard and the Reserve Officers' Training Corps who are eligible for burial in a VA national cemetery.

Use of Character of Service Determinations for Active Duty Deaths: This proposal would amend 38 U.S.C. § 2402(a)(1) to require that a service member who dies in active service must have been serving under conditions other than dishonorable to be eligible for burial in a VA National Cemetery. The proposal would also amend title 38 U.S.C. § 2306(b)(4)(A) and (f)(2), to impose the same requirement for eligibility for a memorial headstone or marker and Section 2301(d) for a burial flag. This proposal seeks to rectify the current inequity in eligibility determinations that exists between active duty service members and veterans.

Expand Authority to Provide Headstones and Markers to Eligible Spouses and Dependents at Tribal Veteran's Cemeteries: This proposal would amend title 38 U.S.C. § 2306, to provide eligibility for headstones and markers for burial and memorialization of veterans' eligible spouses and dependent children interred at tribal veteran's cemeteries.

Expand the VA Authority to Provide an Allowance to transport Certain Deceased Veterans to a State or Tribal Veterans Cemeteries: This proposal would amend title 38 U.S.C. § 2308, to expand the VA current authority to pay the cost of transporting the remains of certain deceased veterans to the closest National Cemetery for burial in a state or tribal veterans cemetery. Under Section 104(b)(2) and (3) of P.L. 112-260, effective January 10, 2014, VA many only pay the cost of transporting the remains of certain deceased veterans to the closest National Cemetery.

Expand the VA Authority to Provide Outer Burial Receptacles to State and Tribal Cemeteries: This proposal would amend title 38 U.S.C. § 2306(e), to direct VA to provide an outer burial receptacle for each new casketed gravesite in a State or Tribal Veterans Cemetery that receives a grant from the VA Veterans Cemetery Grants Program (VCGP), as well as in new VCGP establishment projects.

Expansion of Eligibility for Medallion or Other Device to Signify Status as a Deceased Veteran: This proposal would remove the November 1, 1990 applicability date for provision of medallions to veterans. This proposal also would allow VA to provide the medallion benefit, regardless of date of death, in order to signify the status of the deceased as a veteran who served in the U. S. Armed Forces. A medallion is issued to be affixed to a privately purchased headstone or marker installed at the grave of an eligible veteran buried in a private cemetery.

Allow for the Provision of Government-Furnished Headstones and Markers for the Privately Marked Graves of Medal of Honor Recipients who Died Prior to November 1, 1990: This proposal would amend title 38 U.S.C. § 2306(d), to allow VA to furnish headstones or markers for the privately marked graves of all eligible Medal of Honor recipients who died prior to November 1, 1990.

In its efforts to meet the burial needs of veterans, especially those located in rural or western states, NCA should continue acquiring land and awarding Master Plan/Design Development contracts for new national cemeteries. We further recommend that NCA continue land searches at seven rural locations.

NCA should continue with the largest expansion of the national cemetery system since the Civil War, which, along with continued grant awards to states, territories and tribal organizations, will allow NCA to meet its strategic goal of providing 95 percent of American veterans with a burial option within 75 miles of their homes by 2017.

BACKGROUND AND JUSTIFICATION:

The National Cemetery Administration, which today sustains 131 of the nation's 147 national cemeteries as well as one rural National Veterans Burial Ground and 33 soldiers' lots, has a long and honorable history. The seeds for what would become the National Cemetery Administration were planted in 1862 by President Abraham Lincoln during the second year of a war that many were afraid would be over before they could get involved. On 17 July of that year, Congress passed legislation authorizing the purchase of land to be used as "cemetery grounds...for soldiers who shall have died in the service of the country." At the end of only one year, a total of 14 national cemeteries had already been established, and only eight years later, that total had reached 73. Not surprisingly, the majority of these early cemeteries were located in close proximity to the Southeastern battlefields and campgrounds of the Civil War. At the conclusion of the war, the Army sent out teams to recover the remains of the fallen, and by 1870 over 300,000 Union soldiers had been honorably interred in one of the newly established national cemeteries. After 1873 all honorably discharged Union veterans became eligible for burial alongside their departed comrades.

Following the end of WWI, Congress established an independent agency, the American Battle Monuments Commission, to be responsible for maintaining burial grounds outside of the U.S. for service members who die overseas. The commission maintains 24 American military cemeteries as well as monuments and memorials.

During the 1930s, because of the high concentration of veterans living in metropolitan areas such as New York, Baltimore, Minneapolis, San Diego, San Francisco, and San Antonio, new national cemeteries were established. Additionally, some cemeteries closely associated with major Civil War battlefields of historical significance (i.e. Gettysburg and Antietam), which had been under the control of the U.S. Army, were transferred during this time to the National Park Service. In the early 1970s, Congress again authorized the transfer of 82 of our national cemeteries from U.S. Army control to what would become the Department of Veterans Affairs. The 131 cemeteries and one National Veterans Burial Ground currently under the purview of the NCA are composed of nearly 3.4 million gravesites and are located in 40 states and Puerto Rico.

The most important obligation of the National Cemetery Administration is honoring the memory of the brave American men and women who have, over the course of our country's history, selflessly served in our armed forces. Therefore, it is with this sacred duty in mind that we expect the stewardship, accessibility, and maintenance of our entire NCA cemetery system, as well as Arlington National Cemetery, be treated as the highest priority. *The Independent Budget* veterans service organizations (IBVSOs) believe that the dignified burial of America's veterans is equally as important as any other service provided by VA. With this in mind we support extending advance appropriations to the remainder of the discretionary and mandatory programs, services, and benefits accounts of VA, which would include the NCA. This issue of advance appropriations is at the top of our list of concerns regarding NCA operations.

Advance appropriations for veterans health care have proven to be nothing less than a resounding success for all stakeholders. Timely and predictable funding has produced numerous operational efficiencies in the planning and budgeting process and has enabled VA to more resourcefully utilize its Congressionally provided appropriations in operating its medical facilities and programs. Unfortunately, other veterans benefits and services that rely wholly or partially on discretionary funding face annual threats of funding delays and reductions because of annual budget disputes. Extending advance appropriations would shield all veterans programs from unrelated political and partisan budget disputes so that VA can continue to deliver all the benefits and services that wounded, and ill veterans have earned.

President’s Budget Requests (\$ in Millions) FY14 and FY15		
Line Item	2014	2015
Operations and Maintenance	\$249	\$257
Major Construction	121	10
Minor Construction	89	60
Compensation and Pension	100	121
Veterans Cemetery Grants Program	46	45

As last year’s government shutdown has without a doubt proven, advance appropriations not only work, they work well. Thanks to their advance funding, VA hospitals and clinics were able to provide uninterrupted care to millions of wounded, injured, and ill veterans. By contrast, other critical services for veterans were delayed, disrupted, and suspended. Work was stopped on more than 250,000 Department of Veterans Affairs disability claims awaiting appeals, burials at national cemeteries were scaled back, and vital medical and prosthetic research projects were suspended. Had this stalemate continued for another several weeks, even mandatory obligations of the federal government, such as disability compensation and pension payments to veterans and their survivors, would have been halted. More than four million wounded, injured, ill, and poor veterans rely on these payments; for some it is their primary or only source of income. IBVSOs find it completely unacceptable that even the threat of default on these hard-earned benefits was possible.

Workload and Performance		
	Actual 2014	Actual 2015
Interments	125,188	126,500
Headstone and Marker Application Processed	360,761	361,800
Presidential Memorial Certificate Applications Processed	618,570	723,100
Perpetual care provided for 4.2 million veterans, service members, reservists, and family members in 3.4 million gravesites		

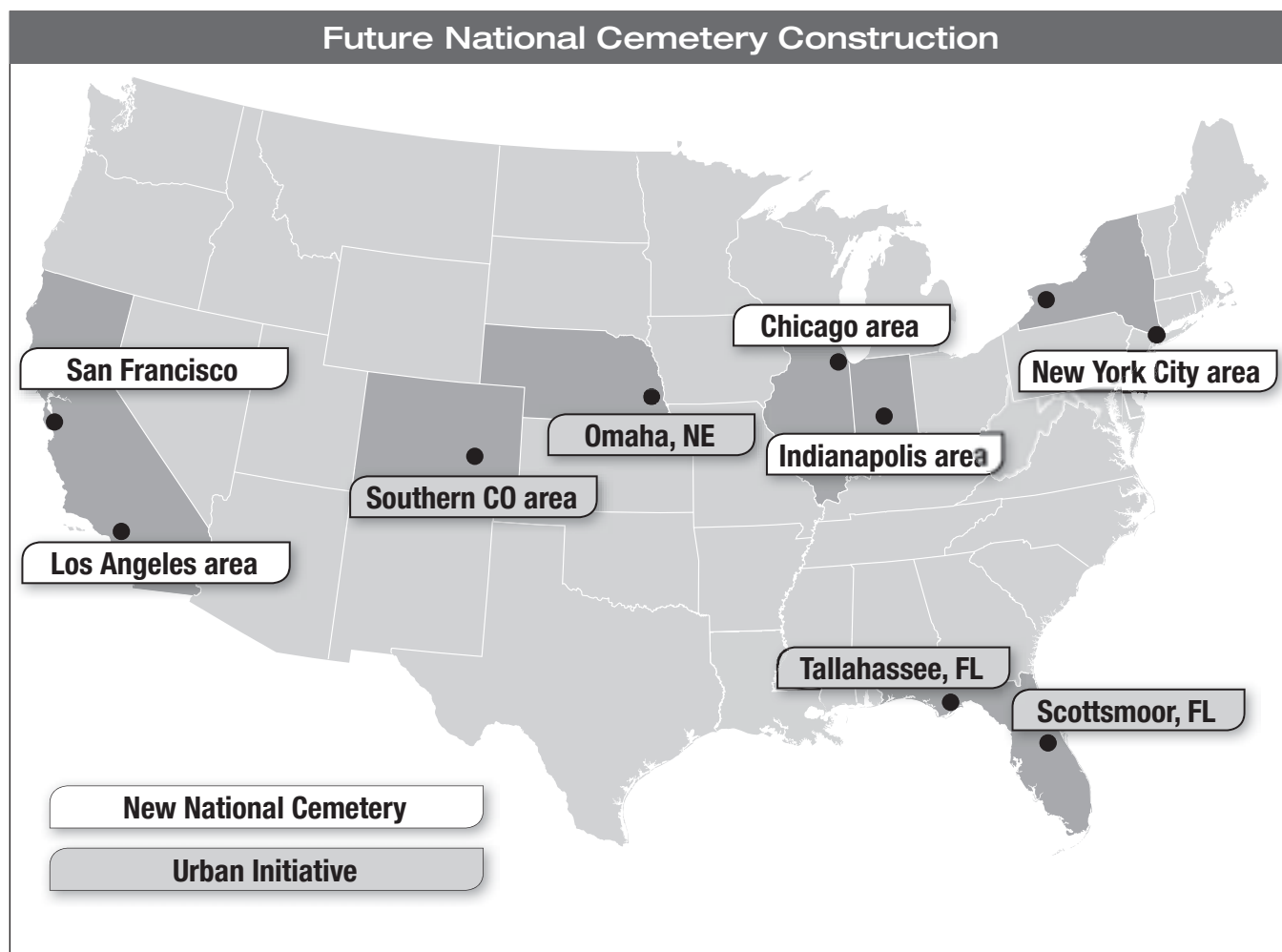
The direct impact of advance appropriations on NCA would be substantial and would prevent the interruption of a myriad of burial and memorial services including:

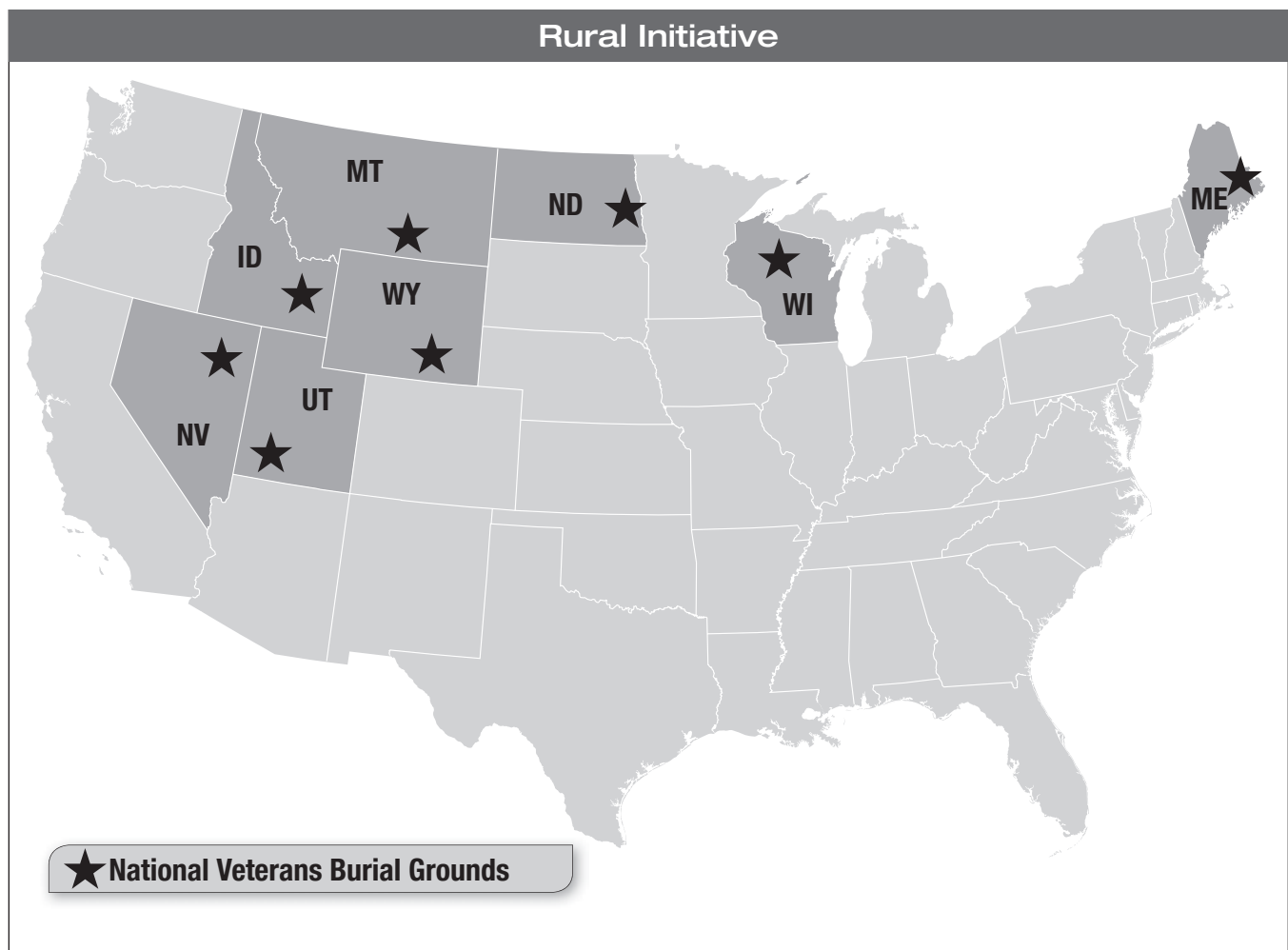
- limited and/or delayed interment schedules;
- cessation of administrative functions – no Presidential Memorial Certificates issued or interruption of headstone/marker/medallion application processing & status;
- termination of maintenance functions;

- inability to provide headstones/markers/medallions and other burial receptacles to veterans and eligible family members

In FY 2014 the NCA performed a total of 125,180 interments, maintained 8,812 acres of land, issued 570,983 Presidential Memorial Certificates, awarded \$28.8 million in National Shrine contracts to repair gravesites, and processed 360,761 headstone and marker applications. NCA has done an excellent job executing the responsibilities of its office to date and with continued funding at appropriate levels, will reach new levels of distinction including:

- continuing to address increasing workload requirements;
 - handling a rising number of interments through 2017
 - maintaining increasing numbers of occupied gravesites and acreage
 - issuing continued requests for Presidential Memorial Certificates
 - processing continued requests for headstones/markers
- expanding burial access for veterans and their eligible family members;
 - develop five new national cemeteries (Cape Canaveral National Cemetery, Tallahassee National Cemetery, and Omaha National Cemetery, and cemeteries in western New York and southern Colorado)
 - develop seven National Veterans Burial Grounds in rural locations (ME, WI, NV, UT, WY, ID, and ND)
 - develop five urban initiative facilities (San Francisco Area, Los Angeles Area, Chicago Area, Indianapolis Area & New York City Area)





- achieving high levels of customer satisfaction;
 - continue customer service best practices
- implementing cost saving and operational improvement measures;
 - headstone support systems;
 - preplaced crypts;
 - water-wise landscaping; and
 - memorial walls

Looking ahead, the IBVSOs support the NCA as the program continues to make progress on several major initiatives critical to the achievement of the mission through implementation of strategic goals including:

- much-needed land acquisition and critical master-planning efforts without which, NCA would be unable to meet the growing needs of our nation’s veterans, especially those in rural areas, and their eligible family members;
- continuously improving preservation and restoration of irreplaceable historic resources which not only commemorate the valor and service of our veterans but record the very historic fabric of our nation’s history;
- continued development and utilization of customer service best practices;
- continued leadership in and expansion of the hiring and training of veterans;
 - the Veterans Apprenticeship Program will be graduated 13 formerly homeless veterans as new caretakers and 20 members of the current class are expected to graduate in December 2014.

- the composition of NCA's current workforce is highly veteran oriented, with over 74 percent of its employees having served in the military.
- in FY 2014, approximately 85 percent of NCA's contracts were awarded to Veteran-Owned and Service Disabled Veteran-Owned small businesses.
- Leading-edge improvements in the area of environmental stewardship and facilities maintenance which not only leverage resources but uphold the high standards required of national shrines.

The IBVSOs believe the NCA continues to meet its goals and the goals set by others because of its true dedication and care for honoring the memories of the men and women who have selflessly served our nation. We applaud the NCA for recognizing that it must continue to be responsive to the preferences and expectations of the veteran community by adapting or adopting new burial options and ensuring access to burial options in the national, state, and tribal government-operated cemeteries. We also believe it is extremely important to recognize the NCA's efforts in employing both disabled and homeless veterans.

Operations, Maintenance and National Shrine Initiative— The Veterans Cemetery Grants Program

RECOMMENDATIONS:

Congress should fund the Veterans Cemetery Grants Program (VCGP) at a level of at least \$25 million for FY 2016. This increase in funding will help the National Cemetery Administration better meet the needs of the VCGP, as its expected demand will continue to rise going forward. Furthermore, this funding level will allow the NCA to continue to expand its efforts of reaching its goal of serving 94 percent of the nation's veteran population by 2015.

Additionally, this funding level will allow the VCGP to begin recovering from previous funding cuts to this important program and establish new cemeteries, at its current rate, that will provide burial options for veterans who live in regions that currently have no reasonably accessible state or national veterans cemetery.

BACKGROUND AND JUSTIFICATION:

The Veterans Cemetery Grants Program (VCGP), which complements the mission of the National Cemetery Administration (NCA) to establish gravesites in areas where it is not currently meeting the burial needs of veterans, awards funding to states, territories and tribal organizations for the establishment, expansion, or improvement of state veterans cemeteries. Several incentives are in place to assist states and tribal organizations in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including establishing a new cemetery and expanding or improving an established state or tribal organization veterans cemetery. New equipment, such as mowers and backhoes, can be provided for new cemeteries.

Grantees under this program are required to adhere to the standards and guidelines pertaining to site selection, planning and construction prescribed by VA. Cemeteries may only be operated solely for the burial of service members who die on active duty, veterans, and their eligible spouses and dependent children. All cemeteries assisted by a VCGP program grant must be maintained and operated according to the strict operational stan-

National Shrine Funding (\$ in Millions) FY14 and FY15	
2014	2015
\$27	\$8.1

Raise and Realign Projects

- **Maintain proper height and alignment**
- **Strict technical specifications**

dards and measures of the NCA. To date, the VA program has helped establish, expand, improve, operate and maintain 93 veterans cemeteries in 45 states and territories including tribal trust lands, Northern Mariana Islands, and Guam, which provided more than 33,000 burials in FY 2014. Since its inception, the NCA has awarded VCGP program grants totaling more than \$618 million.

While each VCGP grant recipient is solely responsible for the administration, operation, and maintenance of its cemetery, NCA is authorized to pay a plot or interment allowance (not to exceed \$700) to a state, territory or tribal government for expenses incurred by that entity in the burial of eligible veterans in a cemetery owned and operated by the state, territory or tribal government if the burial is performed at no cost to the Veteran's next-of-kin. This benefit is administered by the Veterans Benefits Administration (VBA) and the state, territory or tribal government must apply to VBA to receive it.

The importance of the VCGP program, which continues to increase NCA's presence and veteran access in rural areas, cannot be overestimated. NCA predicts that within the next few years, the number of state and tribal cemeteries that provide a full complement of burial options and services will exceed the number of equivalent national cemeteries. The current roster of state and tribal cemetery projects on the FY 2014 priority list with pre-application grant requests totals \$156.1 million, while projects requesting matching funds total \$97.5 million.

In FY 2015, NCA's budget request included \$45 million for the VCGP program and since 1978, has more than doubled the available acreage and accommodated more than a 100 percent increase in burials. The VCGP faces the challenge of meeting a growing interest from states to provide burial services in areas not currently served. The intent of the VCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvement Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those liv-

ing in less densely populated areas without access to a nearby national cemetery. In addition, the Department of Veterans Affairs may also provide operating grants to help cemeteries achieve national shrine standards.

Veterans Shrine Commitment

Because national cemeteries help foster patriotism and help preserve our nation's history, their appearance demonstrates the nation's appreciation for the selfless service and the sacrifices made by all American veterans. The high standards necessary to not only attain, but retain, national shrine status signal our national commitment to honoring our military service members and preserving our nation's history in a very public way. Establishing a national cemetery as a national shrine suggests that the grounds, the gravesites and the surroundings are both beautiful and an awe-inspiring tribute to those who gave so much to preserve the American way of life. Each cemetery provides an enduring memorial to their sacrifice as well as a dignified and respectful setting for their final rest. To satisfy this requirement, pre-applications should include a written assurance that the state, territory or tribal government will maintain the cemetery according to VA National Cemetery Administration standards as established in 38 C.F.R. § 39.6(4).

The FY 2015 NCA budget request included \$8.075 million for the National Shrine Initiative which provides funding for Operations and Maintenance activities, including raise and realign projects.

Veterans' Burial Benefits Have Lost Their Value

RECOMMENDATIONS:

Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model.

Congress should increase the plot allowance from \$700 to \$1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected burial benefits from \$2,000 to \$6,160 for veterans outside the radius threshold and to \$2,793 for veterans inside the radius threshold.

Congress should increase the nonservice-connected burial benefits from \$300 to \$1,918 for all veterans outside the radius threshold and to \$854 for all veterans inside the radius threshold.

The Administration and Congress should provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

BACKGROUND AND JUSTIFICATION:

Since its inception, more than 4 million veterans, from every era and every conflict, have been buried within the 19,000 acres of hallowed grounds of the National Cemetery Administration (NCA). Currently, the NCA has stewardship of more than 131 existing cemeteries, one National Veterans Burial Ground and 33 soldier's lots with additional sites planned to open within the next five years. These new cemeteries will be located in the following areas: Mims and Tallahassee, Florida; Omaha, Nebraska; western New York; and southern Colorado.

In 1973 the Department of Veterans Affairs established a burial allowance that provided partial reimbursement for eligible funeral and burial costs. The current payment is \$2,000 for burial expenses for service-connected deaths and \$300 for nonservice-connected, along with a \$700 plot allowance. At its inception, the payout covered 72 percent of the funeral costs for a service-connected death, 22 percent for a nonservice-connected death, and 54 percent of the cost of a burial plot.

The burial allowance, first introduced in 1917 to prevent veterans from being buried in potter's fields, was modified in 1923. The benefit was determined by a means test until it was removed in 1936. In its early history the burial allowance was paid to all veterans, regardless of their service connectivity of death. Then, in 1973, the allowance was further modified to reflect the status of service connection.

Initially introduced in 1973, the plot allowance was an attempt to provide burial plot benefits for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowance was intended to cover the full cost of a civilian burial in a private cemetery, the recent increase in the benefit's value indicates the intent to provide a meaningful benefit. The IBVSOs are pleased that the 111th Congress acted quickly and passed an increase in the plot allowance for certain veterans from \$300 to \$700, effective October 1, 2011.

However, there is still a serious deficit between the benefit's original value and its current value. In order to bring the benefit back up to its original intended value, the payment for service-connected burial allowance would need to be increased to a minimum of \$6,160; the nonservice-connected burial allowance would need to be increased to at least \$1,918, and the plot allowance would need to be increased to a minimum of \$1,150. Based on accessibility and the desire to provide quality burial benefits, *The Independent Budget* recommends that the NCA separate burial benefits into two categories:

- veterans who live inside the VA accessibility threshold model; and
- those who live outside the VA accessibility threshold model.

Even for veterans who elect to be buried in a private cemetery, regardless of their proximity to a state or national veterans cemetery that could accommodate their burial needs, the benefit should be adjusted. The IBVSOs believe that veterans' burial benefits should be minimally based on the average cost for VA to conduct a funeral. Using this formula, the benefit for a service-connected burial would approximately adjust to \$2,793; the amount for a nonservice-connected burial would roughly increase to \$854; and the plot allowance would increase to \$1,150. This will provide a burial benefit at equal percentages, based on the average cost for a VA funeral and not on the private funeral cost that would be provided for veterans who do not have access to a state or national cemetery.



AMVETS

4647 Forbes Boulevard
Lanham, MD 20706
(301) 459-9600
www.amvets.org



DISABLED AMERICAN VETERANS

807 Maine Avenue, SW
Washington, DC 20024-2410
(202) 554-3501
www.dav.org



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801 Eighteenth Street, NW
Washington, DC 20006-3517
(202) 872-1300
www.pva.org



VETERANS OF FOREIGN WARS OF THE UNITED STATES

200 Maryland Avenue, NE
Washington, DC 20002
(202) 543-2239
www.vfw.org

www.IndependentBudget.org