STATEMENT FOR THE RECORD

OF

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

PENDING LEGISLATION

MAY 17, 2017

Chairman Isakson, Ranking Member Tester, and members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on legislation pending before the Committee.

S. 23, the "Biological Implant Tracking and Veteran Safety Act of 2017"

S. 23 intends to have the VA adopt and implement a standard identification protocol for use in the tracking and procurement of biological implants by the Department of Veterans Affairs, and for other purposes. While we understand and generally support some of the provisions of this legislation, PVA objects to the provisions of the draft legislation that would exclude the purchase of biological implants from the authority of title 38 U.S.C., Section 8123.

Section 8123 states, "the Secretary may procure prosthetic appliances (which includes surgical biological implants) and necessary services required in the fitting, supplying, and training and

use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any other provision of law."

The Federal Acquisition Regulations (FAR) were issued pursuant to the Office of Federal Procurement Policy Act of 1974. Statutory authority to issue and maintain the FAR resides with the Secretary of Defense, the Administrator of General Services, and the Administrator, National Aeronautics and Space Administration—agencies that do not bear the responsibility of providing lifelong care for disabled veterans. However, the VA does bear the heavy weight of that responsibility.

With this in mind, it is important to note the distinction between VA's responsibility to meet specialized needs versus a federal agency's responsibility to respond to emergency needs. The FAR provides for procuring prosthetics in cases where, for example, a natural disaster damaged a veteran's equipment. However, the writers who formulated the FAR in 1974 recognized there was a need for special provisions under which VA could purchase prosthetics for disabled veterans with specialized needs in a timelier manner than the FAR allowed, irrespective of whether a bona fide emergency existed. The authors of the FAR recognized this fact and the need for Section 8123 as evidenced by the fact that it is referenced in the FAR. This was reconfirmed in subsequent updates and amendments to the FAR.

Unfortunately, this S. 23 seems to imply that the Federal Supply Schedule and the FAR is all that is needed to procure Prosthetic appliances (biological implants) and services based on a misunderstanding of the difference between "specialized needs" and "emergency needs." Rather than erode a clinician's ability to acquire these prosthetics in a timely manner or manipulate how these prosthetics are defined in order to exclude them from the authority of Section 8123, we believe that the legislation should focus on accountability and oversight. It should not be making efforts to overturn a system that has served veterans well for over half a century. We encourage the removal of the provision of the legislation that eliminates the authority of Section 8123.

S. 112, the "Creating a Reliable Environment for Veterans' Dependents Act"

PVA supports S. 112, the "Creating a Reliable Environment for Veterans' Dependents Act." Currently, the VA Grant and Per Diem program does not reimburse VA-funded facilities for services provided to a homeless veteran's dependent. This bill would allow VA to reimburse facilities who care for the child of a veteran receiving care at a shelter funded through VA.

Veteran homelessness remains a serious problem. Children of homeless veteran parents can be turned away from receiving care at the very facilities where their parents are expected to seek services to get themselves and their families back on their feet. The supportive housing and service centers also provide case management, education, crisis intervention, and specialized services to homeless women veterans.

Congress must ensure VA is able to provide consistent, reliable services to veterans whose lives are in upheaval. Denying access for dependents does nothing but add more uncertainty for veterans in need stable circumstances for their families. While PVA supports this legislation we urge Congress to see that VA is adequately resourced to provide these reimbursements.

S. 324, the "State Veterans Home Adult Day Care Improvement Act of 2017"

PVA supports S. 324, a bill that would provide "no cost" medical model adult day health care (ADHC) services to veterans who are 70 percent or more service connected disabled. By authorizing the Secretary to enter into agreements with state veterans homes the bill would provide ADHC to those veterans who are eligible for, but do not receive, skilled nursing home care under section 1745(a) of title 38, USC. Currently, VA pays State Homes a per diem for ADHC. The per diem rate covers around one-third the cost of the program. S. 324 is an extension to the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Pub. L. 109-461), which provides "no cost" nursing home care at any State Veterans Home to veterans who are 70 percent or more service connected disabled. This means that currently there are some veterans making a choice between 100% free nursing home care or expensive, out of pocket ADHC. The payment to a state home under this legislation would be 65 percent the amount payable to the state home if the veteran were an inpatient for skilled nursing care.

Adult day health care is a crucial service that allows veterans to remain in their homes and communities by delaying entry into traditional nursing care. While a veteran may need long-term services and supports, it is not necessarily the case those must be received in an institutional setting. Rather, a veteran can receive comprehensive medical care and socializing without the disruption of leaving their home. The program is staffed by a team of multi-disciplinary healthcare professionals who evaluate each participant and customize an individualized plan of care specific to their health and social needs. ADHC is designed to promote social stimulation and maximize independence while also receiving quality of life nursing and personal care services.

Additionally, we know that the wellbeing of a caregiver directly impacts the quality of care they provide to the veteran. ADHC allows caregivers the means the ability to meet other professional and family responsibilities. Especially for those caregivers whose veteran was injured before 9/11 and is not eligible for the VA Comprehensive Caregiver Program, ADHC offers critically needed support.

Delaying institutional settings for veterans with long term care needs is the rare jewel in health care, it is the least costly care and the best care for certain populations. ADHC saves the taxpayer, is the most appropriate care for some sick and disabled veterans, and allows spouses, children, parents, and communities more time together.

S. 543, the "PACT Act"

PVA has no formal position on the "Performance Accountability and Contractor Transparency Act" at this time.

S. 591, the "Military and Veteran Caregiver Services Improvement Act of 2017"

PVA strongly supports S. 591, the "Military and Veteran Caregiver Services Improvement Act of 2017." No group of veterans understands the importance of caregivers more than PVA members and their families.

This legislation would expand VA's Comprehensive Family Caregiver Program to veterans of all eras. Currently, a veteran is eligible if they require the services of a caregiver due to an injury incurred in service on or after September 11, 2001. This date of eligibility, and the exclusion of service connected illnesses, is unjust and indefensible. As many as 70,000 veterans (with estimates as high as 88,000) would be eligible for the Comprehensive Family Caregiver Program if the September 11, 2001 date was eliminated as a barrier. Expansion would make available the resources that caregivers need to provide quality care to veterans. These resources include a monthly stipend based on the hours of care provided, healthcare through CHAMPVA, respite care, additional training, and paid travel expenses to and from veterans' medical appointments.

Caregivers play the most critical role in maintaining the wellbeing of a catastrophically disabled veteran. From activities of daily living, to psycho-social interaction, to maintaining health to prevent institutional care- these caregivers have been sacrificing their own financial and physical wellbeing to care for veterans, with little to no support from VA. Congress has no justification for denying access to veterans because of the date of injury or denying those of any era who were made ill as a result of service. This legislation would rectify this inequity.

Additionally, the Military and Veteran Caregiver Services Improvement Act would make the program more inclusive of mental health injuries; reauthorize the Lifespan Respite Care Act and expand essential respite options for caregivers; give veterans the opportunity to transfer GI Bill benefits to a dependent, to help unemployed or underemployed spouses of injured veterans prepare to become the primary income for the family; make caregivers who work in the federal government eligible for flexible work schedules; provide assistance with childcare, financial advice and legal counseling, which are all top, and currently unmet, needs.

The majority of catastrophically injured, service-connected veterans who rely on a caregiver for their daily living are ineligible for the Comprehensive Caregiver Program. Moreover, the need for a caregiver is not lessened simply because a veteran's service left him or her with a catastrophic illness, rather than an injury. PVA is pleased to see that S. 591 includes catastrophic illness as a program qualifier. For PVA's members, a spinal cord disease is no less devastating than a spinal cord injury. Veterans that have been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and Multiple Sclerosis (MS) will eventually experience significant decline in their ability to perform activities of daily living and unquestionably become dependent on a caregiver.

Pre-9/11 caregivers have provided decades of uncompensated work to our disabled veterans, often with no support services of any kind and at the expense of their own health and livelihood. A study by the Rand Corp. in 2014 estimated that veterans' caregivers save taxpayers $3 billion a year.

When Congress says the cost of expansion of the program is prohibitive they suggest financial burden for caregivers is not prohibitive, that the insecurity of their lives is a just consequence of their family's sacrifice. They are paying for what Congress should, and what Congress does when injured after 9/11. Ensuring that a veteran is able to reside in their home, in their community, has been shown time and again to reduce medical complications, hospital stays, and

costs. At the same time, the veteran and their family maintain a psychosocial wellness that is impossible to achieve in an institution.

PVA understands the costs concerns with expanding the program but believes doing right by veterans is more important, and hopes Congress will believe so too. At the same time, we challenge the very premise of the concerns about cost. While Congress generally ignores the principles of "dynamic scoring" except when it is politically expedient, consider the cost of providing caregiver services versus the cost of institutional services. For catastrophically disabled veterans, if their caregiver can no longer afford to continue, or has suffered their own injury, their veteran has no option but to be placed in an institutional setting. Consider the long term cost savings for the taxpayer by providing caregivers the ability to delay their veteran's admittance to a nursing home. In a VA nursing home the VA spends, on average, $366,000 per veteran, per year. In a community nursing home the cost averages $86,000 per veteran, per year. At a state veteran's home, costs average $45,000 per veteran, per year. Meanwhile, the average costs under the Comprehensive Family Caregiver Program is $36,000 per veteran, per year. Expansion could save the federal government between approximately $2.5 billion and $7.0 billion in a given year. Moreover, the health outcomes and quality of life experienced by veterans served at home by caregivers outperforms any institutional measure.

The exclusion of "serious illnesses and diseases," and the use of the "date of injury" as eligibility requirements for such an important program are indefensible. As a result, the veterans and their families suffer. Congress continues to find excuses to deny access. It has never been more urgent for those excuses to stop. As the largest cohort of veterans (Vietnam-era) ages, the demand for long-term care resources will continue to grow significantly. Catastrophically injured veterans will require the most intensive and expensive institutional care. By providing their caregivers the means to care for the veterans at home with family, they will delay the costs of institutional care. But most importantly, these veterans will have more time at home, in their communities, and among those they love.

S. 609, the "Chiropractic Care Available to All Veterans Act of 2017"

PVA supports S. 609, the "Chiropractic Care Available to All Veterans Act of 2017." Chiropractic care is a widely accepted and invaluable medical treatment. This bill would establish a program for the provision of chiropractic care and services at all medical centers by 2020. Likewise, it would see that "chiropractic services" be included in title 38, United States Code, as a medical service, a rehabilitative service, and a preventative health service.

The process of integrating chiropractic care into VA health care has been slow. At least 65 VA medical centers have chiropractors on site, integrated into the care teams. Approximately 52 percent of veterans returning from Iraq and Afghanistan are seeking care because of musculoskeletal ailments, specifically back and joint pain. The common causes for these chronic pains are heavy gear, vehicle accidents, and blast injuries. The overwhelming majority of affected veterans still do not have readily available access to chiropractic care.

With an ever present awareness of VA overreliance on pharmacological solutions for chronic pain and the resulting trends of opioid dependence and accidental overdose, PVA strongly

encourages the utilization of alternative treatments. At the same time we would encourage a less prescriptive approach. It is possible that not every VA medical center will have need of chiropractic services.

S. 681, the "Deborah Sampson Act of 2017"

PVA supports S. 681, the "Deborah Sampson Act of 2017." This bill would help to address some of the quality of care barriers that are unique to women veterans. From transition services, to health care access, to the availability of prosthetics, this bill is a critical and timely step to enhancing the health and well-being of women veterans and their families. As women veterans are the fastest growing population of veterans, we urge Congress to enable VA to fully meet the needs for specialized services for women.

This bill would initiate a pilot program for peer-to-peer counseling for women veterans transitioning out of the military and make permanent the availability of readjustment counseling services in group retreat settings. Of the existing readjustment counseling retreats provided through VA, participants consistently showed better understanding of how to develop support systems and to access resources at VA and in their communities. The OEF/OIF women veterans at the existing retreats are most often coping with effects of severe Post-Traumatic Stress and Military Sexual Trauma. They work with counselors and peers, building on existing support. If needed there is financial and occupational counseling. These programs are marked successes and the feedback is overwhelmingly positive for women veterans, who show consistent reductions in stress symptoms as a result of their participation. Other long lasting improvements included increased coping skills. It is essential for women veterans that Congress make this program permanent. We believe the value and efficacy is undeniable.

The legislation would also direct VA to partner with community organizations to provide support services for women veterans needing assistance, particularly prevention of eviction, child support issues, and the restoration of driver's licenses.

The bill would authorize hospital stays of up to 14 days for newborns under VA care. The current provision allows a maximum stay of seven days. As the average stay for a healthy newborn is two days, any newborn needing additional coverage is likely to be facing complications immediate after birth or a severe infant illness. The current seven day coverage is in a non-department facility for eligible women veterans who are receiving VA maternity care. Beyond the seven days, the cost of care is the responsibility of the veteran and not VA, even if complications require continued care beyond the coverage period. Post-natal health is critical to newborn health which directly impacts the lives and wellbeing of veterans and their families. PVA is particularly concerned about those veterans with catastrophic injuries or mental illnesses that can cause high-risk pregnancies or pre-term deliveries. A seven day limit arguably impacts veterans with disabilities at a greater rate than other veterans. Extending newborn coverage to 14 days is the right thing to do.

The legislation aims to eliminate barriers to care by ensuring every facility has at least one full-time or part-time women's health provider. An additional $20 million would be authorized to carry out the retrofitting of existing facilities to improve privacy, safety and environmental needs

for women veterans. Finally, the bill would require data collection and reporting by gender and minority status on VA programs serving veterans. PVA is pleased to see the reporting requirement of prosthetic availability for women veterans.

S. 764, the "Veterans Education Priority Enrollment Act of 2017"

PVA supports this measure. Education benefits as administered are calculated to fund a veteran through the completion of a standard four-year course of study resulting in a degree. In some cases, a student is unable to register for a prerequisite, which in turn leaves them unable to advance on schedule in that degree program. When this happens, the student veteran now must continue his or her course of study beyond the enrollment period covered by GI Bill benefits. Such a result dilutes the overall value of the benefit when the veteran does not earn the degree the assistance was intended to cover, and it simultaneously wastes government money while the veteran, unable to secure a spot in a relevant course, takes unnecessary classes to pass the time. Not getting a seat in a class might be due to pure luck of the draw, but often veterans have substantially different circumstances than traditional students that complicate the course selection process. If a service member in the National Guard or a Reserve Component gets called away for duty, he or she should have priority enrollment to ensure they have the ability to quickly get back on track. Many veterans might also be coming to school at a later point in their lives and have families. Veterans should not be penalized for trying to fit courses in around other significant obligations such as caring for children.

The evidence already exists that offering veterans priority enrollment is feasible and important. Many private universities already offer priority enrollment, and some states such as Pennsylvania, California and Ohio require it to be offered in all publicly-funded institutions.

S. 784, the "Veterans' Compensation Cost-of-Living Adjustment Act of 2017"

PVA supports S. 784, the "Veterans' Compensation Cost-of-Living Act of 2017," which would increase, effective as of December 1, 2017, the rates of compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation (DIC) for the survivors of certain disabled veterans. This would include increases in wartime disability compensation, additional compensation for dependents, clothing allowance, and dependency and indemnity compensation for children.

S. 804, the "Women Veterans Access to Quality Care Act of 2017"

PVA supports S. 804, the "Women Veterans Access to Quality Care Act of 2017." This bill would establish structural standards in VA health care facilities that are necessary to meet the health care needs of women veterans. Implementation of this bill would generate a report to the House and Senate Veterans' Affairs Committees listing the facilities that fail to meet these standards and the projected cost to do so. VA would be required to publish the health outcomes of women in each facility, juxtaposed with the men that facility serves. VA would be required to hire a full-time obstetrician or gynecologist at every VA Medical Center, and pilot an OB-GYN graduate medical education program to increase the quality of and access to care for women veterans.

The women veteran population who use VA health care doubled between 2003 and 2012, from 200,631 to 362,014. By 2040, it will have doubled again. Given this projection, VA must increase their capacity to meet the needs of women veterans. This legislation is a crucial step in assessing the quality of care women veterans receive and the steps needed to improve it.

S. 899, the "Department of Veterans Affairs Veteran Transition Improvement Act"

PVA supports S. 899, the "Department of Veterans Affairs Veteran Transition Improvement Act." Currently, new Title 5 employees with a thirty percent or higher service-connected disability rating are entitled during their first twelve-month period of employment to leave for purposes of undergoing medical treatment related to such disability. PVA supports this bill which would apply the same entitlement to health care professionals under 38 U.S.C. § 7401(1).

S. 1024, the "Veterans Appeals Improvement and Modernization Act of 2017"

PVA employs a highly-trained force of over 70 service officers who develop veterans' claims for both member and non-member clients. These frontline employees spend a minimum of two years in specialized training. We maintain a national appeals office staffed by attorneys and legal interns who represent clients at the Board of Veterans' Appeals (Board). We also have attorneys who practice before the Board, the Court of Appeals for Veterans Claims (CAVC), and the United States Court of Appeals for the Federal Circuit. Of all the major Veteran Service Organizations (VSO), only PVA offers such continuity of representation throughout subsequent appellate review.

Our most important attribute, though, is that our service officers and attorneys consistently advocate for catastrophically disabled veterans. Complex claims are the norm, not the exception. As we attempt to bring greater efficiency to the claims and appeals system, our perspective is geared toward ensuring that the due process rights of the most vulnerable among us—those most deserving of benefits—are not watered down for the sake of expediency. To reinforce this position, we would advise the Committee to include a sense of Congress or other preamble with this legislation indicating that no part of the new framework should be read to abrogate or displace the non-adversarial nature of VA claims adjudication. An overhaul of this size and scope invites subsequent litigation and new legal interpretations. Clarifying this point with direct legislative history on the subject would be an easy but important effort.

Background

The number of pending appeals is approaching 500,000. VA projects that if we fail to address the process, within a decade the average wait time for resolving an appeal will reach 8.5 years. We believe reform is necessary, and we support this legislation moving forward.

There is no shortage of news articles and academic pieces that attempt to illustrate for readers the level of complexity and redundancy in the current appeals process. It is a unique system that has added layer after layer of substantive and procedural rights for veterans over the years. The most notable aspect differentiating it from other U.S. court systems is the ability for a claimant to

inject new evidence at almost any phase. While this non-adversarial process offers veterans the unique ability to continuously supplement their claim with new evidence and seek a new decision, it prevents VA from accurately identifying faulty links in the process, whether it be individual raters or certain aspects of the process itself.

It is important that as we approach this major issue that we do not lose sight of the fact that veterans have earned these benefits through the highest service to their country and have every right to pursue these earned benefits to the fullest. As we promote and seek public support for change, it is easy to use statements such as, "there are veterans who are currently rated at 100% who are still pursuing appeals," to illustrate the problems that pervade the system. PVA will be the first to point out, though, that a veteran rated at 100% under 38 U.S.C. § 1114(j) might also be incapacitated to the point that he or she requires 24 hour caregiver assistance. A 100% service-connected disability rating does not contemplate the cost of this care, and veterans may seek special monthly compensation (SMC) to the tune of thousands of dollars needed to address their individual needs. Few people would disagree that pursuing these added disability benefits are vital to a veteran's ability to survive and maintain some level of quality of life. Without clarification, such statements lead people to believe that veterans are the problem.

This is why PVA believes it is so important to ensure that VSO's remain as involved in the follow-on development process and implementation as they are now if this plan is to succeed. This is a procedural overhaul, and VSO's are the bulwark that prevents procedural change from diluting the substantive rights of veterans.

The Framework

As the working group came together and began considering ways to address the appeals inventory, it became clear that a long-term fix would require looking beyond appeals and taking a holistic view of the entire claims process. The work product in front of us today proposes a system with three distinct lanes that a claimant may enter following an initial claims decision—the local higher-level review lane, the new evidence lane, and the Board review lane. The work horse in this system is the new evidence lane. The other two serve distinct purposes focused on correcting errors. A decision to enter any of the lanes must be made within one year of receiving the previous decision. Doing so preserves the effective date relating back to the date of the original claim—a key feature of this new framework.

When a claimant receives a decision and determines that an obvious error or oversight has occurred, the local higher-level review lane, also known as the difference of opinion lane, offers a fast-track ability to have a more experienced rater review the alleged mistake. Review within this lane is limited to the evidence in the record at the time of the original decision. It is designed for speed and to allow veterans with simple resolutions to avoid languishing on appeal.

If a claimant learns that a specific piece of evidence is obtainable and would help him or her succeed on their claim, the new evidence lane offers the option to resubmit the claim with new evidence for consideration. VA indicates that its goal is a 125-day turn around on decisions within this lane. Another important aspect is that the statutory duty to assist applies only to

activity within this lane. This is where VA will concentrate its resources for developing evidence.

The third lane offers an appeal to the Board. Within this lane there are two tracks with separate dockets. One track permits the addition of new evidence and option for a Board hearing. The other track permits a faster resolution by the Board for those not seeking to supplement the record. A claimant within this track will not be permitted to submit new evidence, but they will have an opportunity to provide a written argument to accompany the appeal.

If the claimant receives an unfavorable opinion at the Board, he or she may either revert to the new evidence lane within one year or file a notice of appeal with the CAVC within 120 days. Notably different from earlier versions of this legislation, this draft bill would preserve the claim's effective date even after an adverse decision at the Court.

Concerns Specific to the Framework

Throughout the development of this new framework, PVA's biggest concern has been the proposed dissolution of the Board's authority to procure an independent medical examination or opinion (IME) under 38 U.S.C. § 7109. An IME is a tool used by the Board on a case-by-case basis when it "is warranted by the medical complexity or controversy involved in an appeal case." § 7109(a). The veteran may petition the Board to request an IME, but the decision to do so remains in the discretion of the Board. The Board may also request an IME *sua sponte*. Experienced Board personnel thoroughly consider the issues which provoke the need for an outside opinion. Complicating the process further, the CAVC has carefully set parameters for the proposed questions to be answered by experts. A question presented to a medical expert may be neither too vague, nor too specific and leading. A question too vague renders the opinion faulty for failing to address the specific issue, while a question too specific tends to lead the fact finder to a predisposed result.

The standard for granting such a request is quite stringent. 38 C.F.R. 3.328(c) states, "approval shall be granted only upon a determination . . . that the issue under consideration poses a medical problem of such obscurity or complexity, or has generated such controversy in the medical community at large, as to justify solicitation of an independent medical opinion." The number granted each year usually amounts to no more than one hundred, with approximately fifty percent of those IME's being requested by the Board itself. The regional offices have long held a companion authority under 38 U.S.C. § 5109. Incredibly, in a room full of practitioners convened in March 2016 as part of this current reform process, not one among them could recall an instance of a rating officer requesting an IME. And yet the original proposal was to eliminate the Board's authority to procure an IME and rely solely on a rating officer exercising his or her authority under § 5109.

VA's rationale for dissolving this authority is primarily based on having all development of evidence take place at the Agency of Original Jurisdiction (AOJ) level in the New or Supplemental Evidence Lane. This unwavering desire to rid the Board of any development

stems in part from an attempt to exploit its experienced Veteran Law Judges (VLJ) to the greatest possible extent. VLJ's who adjudicate appeals are a human capital commodity and form a critical component of the system. Because employees and outside attorneys cannot reach the experience and qualifications of a VLJ overnight, VA is limited in its ability to scale this particular resource simply by hiring new employees.

These concerns are valid to a degree, and we have worked with officials to find a solution that allows the Board to realize the benefit of making the best use of VLJ's while attempting to preserve the beneficial aspects of IME's procured by the Board. Part of the mitigating measures are reflected in this draft bill's proposed amendments to 38 U.S.C. § 5109, permitting the Board to remand specifically for procurement of an IME and requiring the VLJ to articulate the specific questions to be presented to the expert.

We applaud the Committee's change to the remand language. In earlier versions of this legislation, the Board would only be permitted to remand for an IME if it determined an error existed on the part of the AOJ to satisfy its duty to assist under 38 U.S.C. § 5103A. Since the duty to assist is necessarily inconsistent with the discretionary nature of an IME, this circumstance would never arise, and IME's would come to a halt. Using an abuse of discretion standard instead fixes this issue.

Dissolving § 7109 would have the additional effect of abolishing the centralized office of outside medical opinions. This small staff has played a vital role in facilitating IME's and maintaining their effectiveness by developing relationships with doctors who are experts on particular subjects and willing to do this tedious task for almost no money. This office not only expedites the receipt of opinions, but it also ensures a high level of quality. VA has committed verbally to PVA that it will preserve this resource by moving it from the Board and placing it under VBA's management, in essence making it available to the AOJ going forward.

The decreased efficiency with having the process conducted at the AOJ level is also concerning. Instead of the VLJ requesting an IME and receiving the opinion, now a second person must review the claim—the rating officer who received the file on remand. If a veteran wishes to appeal this re-adjudication, we have asked for and received VA's commitment to reroute the appeal by default, with exceptions, back to the same VLJ who remanded the case to avoid yet another person from having to review a claim with enough medical complexity to warrant the IME. Unless this Committee is willing to outright preserve § 7109, we would strongly recommend that the Committee conduct oversight on these specific commitments by VA, perhaps as part of the increased reporting requirements.

We also recommend an additional jurisdictional safeguard for the Board. In 38 U.S.C. § 7104, it would be helpful to include language that addresses situations where the Board finds that an appeal presents extraordinary circumstances. The Board, in its sole discretion, should be able to retain jurisdiction over a remand of that appeal.

Some stakeholders have expressed concern over the replacement of the "new and material" evidence standard with "new and relevant." It is true that there are a number of appeals in the system currently disputing a decision that evidence submitted was not deemed "material." The stated concern is that changing "material" to "relevant" will simply exchange one appealable issue for another. While it is a fair point, "relevant" is a significantly lower legal threshold and as higher numbers of veterans meet this threshold, it should correlate to fewer appeals. Those expressing concern propose having VA simply accept all "new" evidence and make a decision. Under this proposal, if the evidence is so weak that it is not even relevant, then VA can easily deny the claim. For every denial, VA will be required to do the work of providing the improved notice explaining its decision. Conversely, a legal determination that new evidence is not relevant would not be subject to this requirement, thus a reduced workload for VA. PVA believes "new and relevant" is an acceptable standard for veterans to meet. But at this point, it is unclear whether dealing with continued appeals on relevance determinations or processing improved notice for denials will lead to a greater aggregate negative impact on the system.

Earlier objections were raised concerning the specificity with which a veteran was required to identify issues of fact or law being contested on appeal in a notice of disagreement. At first glance, the prior language appeared to be quite "legalese," requiring a sophisticated level of pleadings. Placing such burden on veterans would be at odds with the non-adversarial nature of the system. We are pleased to see that the current draft bill has addressed this issue.

Judicial Review

We noted above that this draft bill would preserve a claim's effective date following an adverse decision from CAVC. It would also provide the same relief after an adverse decision from the Federal Circuit and the Supreme Court of the United States. The concept of imposing finality after a Court decision has provoked a significant debate among the stakeholders. Unfortunately, the strongest objections to imposing finality at the Court have not been met with much discussion regarding why VA, or some of the other stakeholders, are comfortable with finality at that stage. We would encourage the Committee to draw out this discussion and fully examine the issue. There are arguments and perspectives on both sides that warrant attention.

Our initial impression is that while VA is trying to create new efficiencies in its claims and appeals processing, we must remember that the CAVC is not part of that system, and it does not exist for VA's benefit or efficiency. Nor does it exist to create precedent. Precedent is a byproduct of an individual availing him or herself of the Court. The Court exists to hear veterans' individual claims and gives veterans an independent avenue to challenge whether VA considered a claim correctly. We in the veterans community fought long and hard for judicial review, and it is precious. PVA is uniquely positioned in this regard. Our organization has boxes full of claims that, but for the Court, the veteran would never have had a full and fair review. When we approach analyzing the impact on the Court, we should not focus on the systematic efficiencies or precedent, because these are not the Court's purpose. We should focus

on what an individual veteran's right to judicial review is and what it takes to avail him or herself of that right.

There are reasonable assertions that failing to provide effective date relief following a Court decision will have a chilling effect on the Court. They should be addressed unless willing to be conceded. One scenario presented is where a veteran, who having received a denial under what she believes is an erroneous application of law to the case, also has new evidence to attach to the claim. She is faced with deciding whether to pursue Court review on the legal issue or circulate back through the system with new evidence. If she chooses the Court and loses, she can still continue to pursue the claim with new evidence, but she will have lost her effective date. If she chooses to handle the new evidence first, her claim will again be adjudicated under what she considers to be an erroneous interpretation of law. This predicament, so the argument goes, will likely force veterans to choose to avoid the Court at the risk of missing an opportunity to strengthen the record. Hence the chilling effect. It also inconveniences the veteran by having them cycle through the system while being again scrutinized under a misinterpretation of the law.

One might argue, though, that there is no chilling effect in this scenario. The veteran is in fact inconvenienced. But ultimately, if the veteran cycles through again with the new evidence, strengthening the record, she arrives in the exact same position if denied, this time without the predicament. The choice is obvious, and she heads to the Court. The only person in this scenario who ultimately would not reach the Court is one who received an earlier and favorable adjudication at a lower level of review. This is precisely what we want for veterans. Any reduction in claims reaching the Court would be attributed to more efficient outcomes for the veterans. Making a decision about the framework that accommodates veterans facing this scenario also requires a belief that the veteran's legal interpretation is always correct and, necessarily, that VA's is always wrong. This is not how sound policy is formed. Further, it is hard to weigh at this point a single veteran's inconvenience in this scenario against the potential gains for numerous veterans who are benefitting from a more efficient system due to the finality imposed after a Court decision.

There is, perhaps, also an undue assumption that a chilling effect on the Court would in fact reduce precedent and oversight on VA. Conceptually, one may concede that a reduction in volume of claims at the Court raises the possibility that a "perfect case" for setting precedent will not arrive. But it is possible that a reduction in the Court's workload would offer greater opportunity to give more time and attention to a precedent-setting claim, which otherwise might have slipped through the cracks or not garnered a more thorough opinion.

There are other scenarios that argue in favor of granting effective date relief following review by the CAVC. If the Board rules against a veteran and finds that a medical exam being challenged was adequate for purposes of his rating decision, he is faced with two choices. He could appeal to the CAVC, or he could develop independent evidence that would strengthen his argument that the exam provided by VA was inadequate. The latter option costs money. If effective date relief

followed a decision at the CAVC, the veteran could wait and see if the Court agreed with his position before he was forced to shell out money he likely does not have to invest in proving his claim. Veterans with means may not see this as an issue. For those without means, it would be an unwarranted obstacle in a system that is designed to be non-adversarial.

One aspect of this framework that has not been discussed at all is the fact that you can technically take one issue from a multi-issue claim up to the Court, and cycle back through the other lanes in the framework on the remaining issues. Currently, the Court takes jurisdiction over issues that are expressly identified by the veteran, and issues not appealed after a Board decision are final. Nothing in this draft bill changes the way an issue reaches the CAVC. But because this new framework has provided liberal effective date relief, new incentives for action have been introduced. There should be further discussion among stakeholders and VA about how claims are dealt with that end up being split up between the Court and the agency. There is no precedent for this in the current system.

PVA was a supporter early on of judicial review, and we believe the availability of that review has improved the appeals process for veterans. Determining the best way to preserve that protection deserves more conversation at this point in time.

Implementation

We applaud the heavy reporting requirements found within this bill. One of the biggest reservations that the collective stakeholders have voiced is the absence of information related to implementation. GAO's recent report reinforced our claim that the success of this new framework hinges on how VA makes the transition, and VA has yet to fully demonstrate what it needs to accomplish this task. We also agree that it is important that VA provide a full accounting of the bases for certain assumptions that have been used to support the feasibility of this new framework. For example, what is the basis for the assumption that within the "hearing lane" at the Board, thirty-five percent of veterans will choose to have a hearing? What is the impact on the system if that estimate is drastically wrong?

Within the reporting requirements, we recommend including a mandate to track legacy appeals that have transitioned into the new system. The goal would be to ensure that Congress can easily identify how many legacy appeals have been truly resolved as opposed to being reclassified in the new system.

We support VA's proposed first step toward combatting the backlog of legacy appeals. One of the hurdles to permitting veterans with legacy appeals to join the new system was that veterans in the legacy system may not have been provided sufficient notice to make an educated decision. Allowing veterans to join after they have received a statement of the case or supplemental statement of the case addresses this concern and will help stem the flow of new claims into the old, broken system. The quicker we can shut off that valve, the quicker the backlog of legacy appeals will be handled.

We note in closing that this is not simply a VA problem. As stated earlier, PVA has many service representatives and spends a great deal of time, funds, and effort on ensuring they accomplish their duties at a high level of effectiveness. However, it is important that veterans and their representatives also share responsibility when appeals arrive at the Board without merit. A disability claim that is denied by VBA should not automatically become an appeal simply based on the claimant's disagreement with the decision. When a claimant either files an appeal on his own behalf, or compels an accredited representative to do so with no legal basis for appealing, that appeal clogs the system and draws resources away from legitimate appeals. Since 2012, PVA has taken steps to reduce frivolous appeals by having claimants sign a "Notice Concerning Limits on PVA Representation Before the Board of Veterans' Appeals" at the time they execute the Form 21-22 Power of Attorney (POA) form. PVA clients are notified at the time we accept POA that we do not guarantee we will appeal every adverse decision and reserve the right to refuse to advance any frivolous appeal, in keeping with VA regulations.

PVA believes that substantial reform can be achieved, and the time is ripe to accomplish this task. Our organization represents clients with some of the most complex issues, and we cannot stress enough that moving forward should not be done at the expense of the most vulnerable veterans. We must remain vigilant and appreciate the benefits of bringing together the variety of stakeholders who are participating and bringing different perspectives and viewpoints—it is a healthy development process that ensures veterans remain the focus.

S. 2210, the "Veteran PEER Act"

The "Veteran Partners' Efforts to Enhance Reintegration Act" would require VA to develop and institute a program to integrate Peer Specialists within patient aligned care teams. PVA recognizes the importance of promoting the use of mental health care services in the context of the primary care setting. The veteran-centric, holistic view of the patient epitomizes one of the key distinctions we have long made about care in a VA setting and care delivered in the community. We have a concern, though, with this bill's strict requirements, as opposed to the discretionary nature. To serve as a Peer Specialist, the person must be a veteran with a mental health condition, be in recovery for at least one year without hospitalization or legal issues related to that condition, and willing to openly acknowledge and discuss their condition. If there is an insufficient population willing to openly discuss their own private mental health history and want to do this job professionally, VA may not be able meet this requirement through no fault of its own. While PVA supports the intent of this legislation, we believe more thought should be put into how best to implement this requirement before mandating VA take these steps.

Draft legislation, the "Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017"

PVA supports the draft legislation, the "Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017." This legislation would bring greater accountability and protect those employees who have the courage to call out fraud, waste, and abuse in VA. We

firmly believe that the culture of a company, organization, or federal agency is shaped by the worst behaviors its leader is willing to tolerate. The "VA Accountability and Whistleblower Protection Act" is the first major step toward reshaping behavior in VA by tolerating bad behavior and poor performance no more. Our veterans deserve it; and so do the hardworking public servants of VA who are tired of being overshadowed by the performance of substandard managers and employees.

PVA has supported efforts to ensure proper accountability at all levels of the VA in the past. In recent years there have been numerous accounts of bad actors in VA senior and lower level management who have failed to fulfill the responsibility of their positions and in some cases arguably violated the law. The focus on accountability in this proposal strikes a reasonable balance to ensure VA leadership has the ability to manage personnel while affording due process protections to employees. We recognize that the question of due process is an important one, and those rights should not be eliminated. However, they cannot be used as a roadblock to accountability either.

PVA appreciates the strong focus on accountability that the Committee has emphasized and we are pleased to see that Secretary Shulkin has made this a priority. There is no doubt that accountability at all levels is an essential part of improving the VA.

Draft bill, "Serving our Rural Veterans Act"

PVA supports the draft bill to authorize payment by the Department of Veterans Affairs for the costs associated with care by medical residents and interns at Indian Health Service (IHS) and Tribal Health Program (THP) facilities operated by federally recognized tribes and carry out a pilot program to expand such residencies and internships at tribal facilities. While recruiting and retaining capable providers continues to be a struggle for VA, rural communities feel these vacancies two fold. In Indian Country particularly, the minimal availability of consistent, high quality health care has resulted in some of the worst health outcomes in the United States.

The federal government has legal and moral obligations to provide health care to two groups—federally recognized tribal nations and eligible veterans. The overlapping, and at times inter-reliability of these groups' respective health care systems is necessary, as American Indians and Native Alaskans have always served in the armed forces at the highest rate of any demographic. In Alaska, where this health care system interoperability is most prevalent, the need for primary care providers is critical.

Physician shortages in the United States, and rural communities particularly, are expected to increase drastically in the coming decade, leaving health care systems with a high volume need and little capacity. This bill would provide some relief, by incentivizing medical residents and interns to work at tribal facilities that have existing reimbursement agreements with VA. The eight-year pilot program would have VA reimburse the tribal facilities for the recruitment and training of residents. These participants would then be eligible for loan forgiveness through Indian Health Service or Department of Veterans Affairs Loan Repayment Program.

In 2010, the Indian Health Care Improvement Act was made permanent. As a result, IHS and VA signed a Memorandum of Understanding (MOU) aiming to improve the health status of American Indian and Alaska Native veterans. In 2012, VA began to establish agreements with tribal governments to reimburse them for the direct care of native veterans enrolled in VA.

Since then around 108 tribes have established agreements with VA. At least 7,000 native veterans have been able receive care. Additionally, VA and IHS have strengthened collaborative relationships and resource sharing. For much of Indian Country, unreliability or unavailability of transportation impacts a veteran's ability to receive care from a VA facility. These agreements allow veterans to receive their care close to home, in a culturally conscious environment they may not find at VA.

The national authority for VA to make reimbursement agreements between agencies is set to expire June 30, 2019. If, for some reason, this authority is not renewed, it is unclear what would happen to the proposed eight year pilot program that is dependent on the existence of an agreement. PVA encourages Congress to ensure this authority is renewed in 2019 in order to continue building on the successes already achieved.

This bill offers a sound step forward to ensuring we meet the needs of those who have served, no matter their zip code.