Congressional Statement of VFW National Commander Brian Duffy

Mar 01, 2017

Statement of
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Before the

Joint Hearing of
the Committees on Veterans' Affairs
United States Senate and United States House of Representatives

Washington, D.C.

Chairmen Isakson and Roe, Ranking Members Tester and Walz, Members of the Senate and House Veteran's Affairs Committees, it is my honor to represent the nearly 1.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary. It is a great pleasure to advocate on behalf of our nation's veterans, military service members, and their families. Thank you for inviting me to present VFW's legislative priorities before these committees today.

VA's Budget Request and Legislative Priorities

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

As a result, the arbitrary budget caps have significantly limited the government's ability to carry out programs that have seen spikes in demand, such as military training and the

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Department of Veterans Affairs (VA) health care. To the VFW, sequestration is the most significant readiness and national security threat of the 21st century, and despite almost universal congressional opposition to such haphazard budgeting, Congress has failed to end it.

Over the past two years, countless pieces of legislation have been introduced to improve the lives of our nation's veterans. Unfortunately, outdated budget caps, the threat of sequestration, and congressional budget rules requiring veterans to exchange one benefit for another have prevented these important bills from becoming law. Many of these bills are urgently needed and would significantly improve the well-being of veterans, service members and their families.

Put simply, less funding for critical benefits programs and services means more stress and more financial burden for our military, our veterans, and their communities. Our nation has a long-standing obligation to provide for the needs of those who have already sacrificed so much for our well-being.

The VFW, in partnership with the Independent Budget (IB), produces annual budget recommendations for each of VA's major funding accounts and compares them to the Administration's request. With the Administration's FY 2018 budget submission release forecasted for May 2017, we are unable to compare our budget recommendations. But what we can do is highlight the fact that the FY18 advance appropriations funding has continued the historical trend between what the IB has recommended and what Congress has appropriated over the past few years.

For nearly a decade the VFW has warned Congress and VA that perpetual underfunding had allowed VA infrastructure to erode while its capacity swelled from 81 percent in 2004 to over 120 percent in 2010, and we predicted that this need for space and chronic underfunding of medical services could lead VA to ration care. In our estimate, medical care and infrastructure continue to be underfunded.

Medical care must be funded at $64.5 billion, which includes all care delivered by VA directly (medical services account) and through community providers (community care account). Regardless of the continued commitment and investment in community care, VA will need to invest heavily in improving, maintaining and replacing its infrastructure. The IB recommends that Congress appropriate $1.5 billion in major and $700 million in minor construction. The vast majority of the major construction funds must be invested in closing safety gaps and on the 20 major projects that are already partially funded. Over the past two years, thanks to the funding that Congress provided through the Veterans Access, Choice and Accountability Act of 2014 (VACAA), VA made headway in reducing the number of minor construction projects outlined in the Strategic Capital Infrastructure Planning (SCIP) process. To keep up with the 10-year minor construction needs forecast, Congress

will need to invest $700 million in minor construction for FY2018.

VA Medical Care

In the past two years the VFW, Congress, VA, independent organizations and other stakeholders have evaluated the VA health care system to determine its ability to care for veterans and how to use other public and private sector health care providers in each community to supplement VA's mission. That is why we are pleased Congress, VA and the Commission on Care have rejected radical reform ideas, which would reverse the progress VA has made by privatizing the VA health care system or erode the benefits of VA's holistic approach to medicine by limiting VA to a payer of veterans' health care.

As a grassroots organization with more than a century of experience advocating on behalf of the brave men and women who put their lives on the line in foreign lands to defend our freedom, the VFW bases its priority goals and reform proposals on the views, preferences and experiences of our members. Nearly 80 percent of our members choose to use VA health care because they believe VA provides high quality care; it knows how to care for veterans; and because VA health care is an earned benefit. In fact, 65 percent of VFW members report that they use VA every time or almost every time they need health care. This means that VFW members have a vested interest in the future of the VA health care system and any changes made by Congress or VA will have a major impact on their lives.

The good news is that VFW members across the country are starting to notice improvements at their local VA medical facilities. Over the past two years, VA has undergone an organizational and cultural transformation –– called MyVA, it is designed to improve access and veterans' experience through implementation of new and innovative programs and initiatives, increasing the use of community care, and hiring additional health care staff. These efforts are starting to manifest into real change at local VA medical centers, which is improving how veterans view VA.

When asked in a recent VFW health care survey – completed by nearly 10,000 veterans – if they have noticed an improvement at their local VA health care facility, 41 percent of veterans said yes; 17 percent of them said no, but indicated that no improvements were needed. This means that nearly 60 percent of veterans who have used VA in the past year believe their VA medical facilities have improved or are already high performing facilities and do not need to improve.

When asked what has changed, veterans said VA has improved its customer service by being more caring and friendly. Veterans also report waiting less time for their appointments, some even commending VA for having same day appointments. They also note that VA has made capital infrastructure changes that improved their experience such as expanded parking structures, new clinics or cosmetic improvements. VA has also made several

technological advances that have improved patient experience, such as secure messaging, new medical equipment, and kiosks for self-check-in and beneficiary travel reimbursement.

The MyVA transformation has also enabled VA to collect and implement more than 400 best practices, which have improved access, quality, and patient satisfaction for veterans who rely on VA for their care. MyVA has also lead to streamlined and simplified processes that have reduced expenditures, expedited hiring, and improved how veterans apply for health care and benefits. For those and many more reasons, the VFW strongly urges Congress to make the MyVA Advisory Committee, which was the impetus for many of these improvements, a permanent statutory advisory committee.

To be clear, the VFW is not content with the status quo. To the contrary, as high users of the system, we understand the improvements that are needed to ensure all VA medical facilities provide veterans timely access to high quality, comprehensive and veteran-centric health care. While veterans are beginning to notice improvements, we know that VA still has a long way to go. Nearly 40 percent of veterans who participated in the VFW's latest VA health care survey indicated that they have not seen an improvement at their local VA medical facilities and that improvement is needed.

When asked what improvements they would suggest, veterans said: VA needs to improve access; properly train its employees; hold wrongdoers accountable; and update its aging capital infrastructure. To make these improvements, Congress must ensure VA has the resources and authorities to quickly hire high quality health care professionals so all veterans have access to timely care. VA must train its employees to be empathetic and provide high quality customer service, which includes hiring more veterans at VA medical facilities who can help other employees understand that VA exists because of the veterans they serve –– not the other way around.

Community Care: VFW members overwhelmingly agree that veterans must have access to community care doctors when VA care is not readily available. However, VA must improve the current systems and processes to integrate private sector providers and other public health care systems into the veterans' health care system to ensure veterans have a seamless experience when accessing community care doctors.

To bridge the gap between thousands of veterans waiting too long for care, and the integrated system veterans believe must be implemented to meet their needs, Congress established the Veterans Choice Program. The Choice Program had a rough start, but it has made significant progress and has helped more than a million veterans receive needed health care. However, the current program continues to face several challenges and must be improved before it is made permanent.

In the past three years, the VFW has assisted hundreds of veterans who have faced delays

receiving care through the Choice Program and has surveyed more than 8,000 veterans specifically on their experience using VA community care and the Choice Program. Through this work, the VFW has identified a number of issues with the program which must be addressed. For example, veterans continue to receive bills from private sector doctors who were unable to receive payment from VA because of complicated rules determining when VA is able to pay and when it serves as a secondary payer. Veterans should never be billed for care that VA is responsible for paying. To address this issue, the VFW urges Congress to remove the secondary payer requirement under the Choice Program.

Choice Program doctors also tell us it takes too long for them to receive the medical documentation from VA that they need in order to treat veterans. One doctor said "it's easier to get gold out of Fort Knox, than it is to get medical records from VA." VA is taking steps to improve this process and will implement a new program soon to ensure Choice providers can view a veteran's medical record. However, an outdated law which requires VA to withhold the medical information of veterans who have been diagnosed with substance use disorder, human immunodeficiency virus, and sickle cell anemia hinders VA's ability to transfer medical records with its community care partners. Congress must remove this statutory limitation to ensure veterans who use the Choice Program do not encounter scheduling delays.

As the VFW has highlighted in our two Choice Program reports, which can be found on our website, www.vfw.org/vawatch, the eligibility criteria for the Choice Program must be improved. The VFW thanks the Veterans' Affairs Committees and VA for making several improvements the VFW has recommended, such as measuring mileage by driving distance instead of "how the crow flies" and making the clinically indicated date the date on which veterans become eligible for the program. However, several recommendations remain. First, the VFW firmly believes that VA must reevaluate how its measures wait times. In the VFW's most recent VA health care report, only 67 percent of veterans indicated they obtained a VA appointment within 30 days, which is significantly less than the 93 percent VA reported in its most recent access report. This is because the way VA measures wait times is not aligned with the realities of scheduling a health care appointment.

VA uses a metric called the preferred date to measure the difference from when a veteran would like to be seen and when they are given an appointment. However, this completely ignores and fails to account for the full length of time a veteran waits for care. The VFW is also concerned that VA's wait time metric remains susceptive to data manipulation. Although VA has asked its local medical facilities to cease the use of prohibited scheduling practices, such practices may still be used. For example, when veterans call to schedule an appointment they are asked when they prefer to be seen. The first question they logically ask is, "When is the next available appointment?" If VA's scheduling system does not preclude them from doing so, schedulers have the ability to input the medical facility's next available appointment as the veteran's preferred date –– essentially zeroing out the wait

time. VA must correct its wait time metric to more accuracy reflect how long veterans wait for their care.

However, VA's wait time measurements must not be used as the basis for Choice Program eligibility. While the VFW agrees that using a clinically indicated date to determine eligibility is the right approach, we do not believe Congress or VA should dictate how long veterans must wait before receiving care from community care providers. Arbitrary thresholds such as 30 days or 40 miles do not reflect the health care landscape of our country. Veterans may not need to be seen within 30 days and they do not see is as burden to wait 30 days for appointments like routine checkups. Likewise, such arbitrary thresholds do not account for veterans with urgent medical needs for which they need to be seen sooner than 30 days, or a veteran who suffer from several disabilities which prevent the veteran from traveling 40 miles.

A recent independent assessment on VA access standards by the Institute of Medicine (IOM) was unable to find a national standard for access similar to the Choice Program's 40 mile and 30 day standards. Instead of focusing on set mileage or days, IOM found that industry best practices focus on clinical need and the interaction between clinicians and their patients.

That is why Congress should not dictate how wait times are determined or measured with arbitrary federally-regulated access standards, such as 30 days or 40 miles. When and where veterans need to be seen must be a clinical decision made between a veteran and his or her doctor. Once the clinical parameters are determined, veterans must be able to choose among the options developed within an integrated health care network. Veterans not satisfied with clinical determinations or scheduling options must be able to seek a clinical review of their health care needs.

Overall, Congress and VA must take the lessons learned from the Choice Program and other community care programs such as Project ARCH, Project HERO, and PC3, and create a single, sustainable community care program that integrates the private sector into the VA health care system. VA has outlined its vision for consolidating its community care programs in a report it was required to send Congress under Public Law (PL) 114-41, the *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015*. It is time for Congress to act on VA's proposal to ensure VA is able to transform the way it provides community care.

Congress' self-imposed budget rules have precluded bills that would enable VA to begin implementing its consolidation plan. As the Choice Program gets closer to expiring, Congress continues to debate on the way forward. Instead of waiting until the 11th hour to act on a consolidation bill, which would limit VA's ability continue to serve veterans, Congress must ensure VA is appropriated $64.5 billion for medical services for fiscal year

2018, which will enable VA to continue the Choice Program through existing community care authorities until Congress is able to act. VA currently issues more than 100,000 authorizations for care a month through the Choice Program and will be required to immediately cease the program –– requiring it to start from scratch and losing the trust and confidence it has worked so hard to restore –– if it does not receive the funding needed to continue the program before it expires.

VA has also requested authority to develop a nationwide system of urgent care at existing VA medical facilities, and to reimburse veterans for urgent care they receive from smaller urgent care clinics around the country to fill the gap between emergency care and traditional appointment-based outpatient care. Doing so would ensure veterans with non-life threatening, acute medical conditions that require urgent attention, such as the flu, infections, or non-life threatening injuries, do not wait days or weeks for a primary care appointment. Establishing urgent care would also curb the reliance on emergency rooms for non-emergent care, which is more expensive for veterans and VA. The VFW urges Congress to consider and swiftly pass legislation authorizing VA to reimburse veterans for using community urgent care clinics.

Provider Agreements: The VFW also urges Congress to authorize VA to purchase health care through agreements that are not subject to provisions of law governing federal contracts. Authorizing VA to enter into non-federal acquisition regulation (FAR) based agreements with private sector providers, similar to agreements under Medicare, would ensure VA is able to quickly provide veterans with care when community care programs like the Choice Program are not viable options.

Provider agreements are particularly important for VA's ability to provide long-term care through community nursing homes. The majority of the homes who partner with VA do not have the staff, resources or expertise to navigate and comply with FAR requirements and have indicated they would end their partnerships with VA if required to bid for FAR contracts. In fact, VA's community nursing home program has lost 400 homes in the past two years and will continue to lose 200 homes per year without provider agreement authority. This means thousands of veterans are forced to leave the place they have called home for years simply because VA is not able to renew agreements with community nursing homes. Congress must end this injustice by quickly passing provider agreement legislation.

Accountability and Workforce Reform: The VFW strongly believes that proper accountability is vital to ensuring VA fulfills its mission. VFW members across the country have firsthand experience with VA's inability to quickly discipline wrongdoers and know how such inaction impacts the quality of the care and benefits they receive.

That is why the VFW strongly believes that employee accountability is critical to correcting past problems at VA and restoring the trust of the veterans they serve. While the

overwhelming majority of VA employees are excellent civil servants who deserve to be praised for their tireless work and dedication to our nation's veterans, those who commit malfeasance must be held accountable for their actions immediately –– not relocated or placed on administrative leave and allowed to collect a paycheck while they wait two years for a final decision. This includes authorizing the Secretary of Veterans Affairs to properly discipline VA employees who deliberately delay or withhold care from a veteran. Congress must pass strong accountability legislation to ensure the Secretary of Veterans Affairs is able to hold his employees accountable.

However, Congress cannot simply focus on firing bad employees. It must also ensure VA is able to quickly hire high quality employees. If VA is not able to replace wrongdoers with high quality employees, it will lack the staff needed to accomplish its mission. In our report, "Hurry Up and Wait," we highlight deficiencies in VA human resources practices. The VFW recommended Congress ease federal hiring protocols for VA health care professionals to ensure VA can compete with private industry to hire and retain the best health care providers in a timely manner. VA must also implement proper whistleblower protections for VA employees who seek to expose improper practices in VA facilities, and implement comprehensive training for all VA employees that focuses on quality customer service and positive health outcome.

Section 203 of the *Veterans Access, Choice and Accountability Act of 2014* called for a Technology Task Force to perform a review of the Department of Veterans Affairs' scheduling system and software development. In their review, the Northern Virginia Technology Council (NVTC) reinforced our concerns that VA's hiring process moves too slowly. NVTC suggested that for VA to be successful, it must aggressively redesign its human resources processes by prioritizing efforts to recruit, train, and retain clerical and support staff.

Specifically, VA's licensing and credentialing process is excessively long and should be modified to make certain VA is able hire high quality doctors on a timely basis. The VFW has heard from countless would-be VA doctors who elected to seek employment elsewhere because the onboarding process for VA was too time consuming and strenuous. Veterans want more doctors at their VA medical facilities. Requiring doctors who want to serve veterans to jump through hoops deters them from doing so.

Congress must also ensure VA has the authority to timely hire front line staff. Due to the lack of support staff, many VA providers are required to spend time on administrative tasks instead of treating patients or spending more time with their patients. VA is in the process of streamlining its hiring process for medical scheduling assistants (MSAs) and has set the goal of hiring MSAs within 30 days, which is half the time it takes, on average, to hire support staff today. The VFW commends VA for its efforts, but it is time Congress expands direct hire authorities to all Veterans Health Administration staff, not just doctors and

nurses. We fear that VA's workforce productivity could decline due to staffing shortages and low employee morale if Congress does not reform VA's hiring authorities.

VA must also conduct exit surveys to determine why its medical professionals are leaving. Doing so would ensure VA is able to address retention issues, which is one of the biggest reasons behind VA staff shortages. VA must also evaluate the impact of changes in the veteran population and develop staffing models based on actual medical need and function level. This would allow VA to properly account for surges in demand as VA health care improves and military downsizing continues.

Mental Health and Suicide: In September 2016, the VFW launched our mental wellness campaign. We partnered with five organizations in our efforts to help service members, veterans and their families cope with their mental health conditions. During this process we consistently heard from our members that the biggest barrier they face when trying to address the health of their brains is stigma, but this is not new. Thirty years ago people were ashamed to talk about cancer. It was a shameful word. Nobody used to talk about diabetes either. It was embarrassing to admit you have a health condition people wrongly associated with an improper diet. Today, people are ashamed to admit they have a mental health condition. Why? The brain is an organ. It is part of our body. It needs treatment to address injuries and illnesses, but can recover just as any other part of the body can.

The VFW has worked tirelessly these past few months to get people talking about mental health; to notice when someone may be in a mental health crisis; and to finally eliminate the stigma our society has held against mental health. The more we talk about it, educate people about it, address the actualities of mental health and suicide, the more comfortable society and individuals suffering from mental health conditions are going to become with accessing the care they need. Most citizens can identify somebody experiencing a heart attack. People who have a heart attack know they must seek medical treatment. Now it is time for people to recognize the five signs of mental distress and to know when to seek help.

This is why 203 VFW posts throughout the world have partaken in the Campaign to Change Direction. Our members reached nearly 17,000 service members, veterans and family members in five countries, all 50 states and the District of Columbia. The majority of these posts partnered with VA to connect VA mental health professionals with their communities to discuss resources available to veterans and family members suffering from mental health conditions. Now they know to look for the five signs of mental distress: personality change, agitation, withdrawn behavior, poor self-care and feelings of hopelessness.

We received overwhelmingly positive feedback from members wanting to do more and help spread awareness. This is why the VFW urges Congress and VA to expand mental health outreach efforts. VA must strive to remove the stigmas associated with mental health

conditions. VA must also do more outreach to ensure veterans know of the mental health treatments and resources available to them not just in VA, but in local communities as well. If we fail to improve and expand outreach efforts, the unacceptable number of veterans who die by suicide may not decrease.

Last year VA released the most extensive study ever conducted on veteran suicide. This study was possible thanks to interagency cooperation and the necessity for VA and Congress to fully understand the details, such as who is more at risk, how many veterans are dying by suicide and where these veterans reside.

The study found that, on average, twenty veterans die by suicide each day, yet only six out of these twenty use VA health care. To the surprise of many, 65 percent of veterans who die from suicide are 50 years old or older. Additionally, the risk for suicide in the female veteran population is 2.4 times higher when compared to their civilian counterparts. While these numbers are all alarming, they are also incredibly insightful for purposes of helping Congress and VA work toward eliminating this current plague of suicide in the veteran population.

In order to eliminate veteran suicides, VA must increase access to competent mental health care that is individualized to the patient. While the data shows VA mental health care is making a positive impact on those who use it, there is still room for improvement. More studies must be conducted to find more innovative ways to treat mental health conditions. VA has conducted research pertaining to areas such as service animals and emerging technologies, but other therapeutic alternatives need to be studied.

Unfortunately, we have all heard the stories of veterans who turned to VA in their time of crisis and were denied the inpatient mental health care they urgently needed. Congress must fully fund VA inpatient mental health clinics so lack of beds is never a reason a veteran takes his or her life. Additionally, Congress and VA must expand peer-to-peer support programs, which have been successful in helping veterans cope with mental health conditions by partnering them with fellow veterans who have overcome similar challenges and received specialized training to help others do the same. In instances where VA is not able to provide immediate assistance, or a veteran requesting assistance does not meet protocol for receiving inpatient care, VA must ensure veterans in need are given the opportunity to talk to and receive assistance from a peer support specialist. It is common practice in the private sector for hospitals and medical facilities to have professionals on call to assist patients who check into the emergency room, such as in cases of sexual trauma. If VA trains more peer-to-peer support specialists, VA medical centers would be able to have scheduled, on call veterans to assist others in mental health crises.

The VFW continues to hear from veterans that VA needs to hire more mental health care providers. This shortage of providers has been continually highlighted by Government

Accountability Office (GAO) and VA Office of Inspector General (OIG) reports in past years. Specifically, the VAOIG's yearly determination of occupational staffing shortages across the VA health care system has placed psychologists among the top five VA health care professions' staffing shortages. This is due in large part to a general lack of mental health care professionals in the United States (U.S.)

As the largest single provider of health education in the country, and second only to Medicare and Medicaid in funding graduate medical education (GME), VA has a significant role in training the next generation of health care professionals. To further increase VA's role in training America's health care workforce, the *Veterans Access, Choice and Accountability Act of 2014* authorized VA to add 1,500 additional GME residency slots over five years. However, a Medicare imposed cap on GME slots has limited VA's academic affiliates from accepting additional slots. The VFW urges Congress to remove this barrier by exempting VA residencies from the statutory ceiling on hospital residency programs.

Congress must also authorize VA to recruit medical professionals being trained at VA medical facilities throughout the country. The nationwide shortage of mental health care providers has forced private sector providers to begin recruiting health care professionals before they complete their residency programs, which provides candidates job security and ensures they are able to quickly begin their careers. Meanwhile, VA is required to wait until residents complete their training before offering employment opportunities. Congress must remove this barrier and authorize VA to begin recruiting the health care professionals it trains, giving VA the opportunity to retain the mental health professionals in which it invests time and resources.

Traumatic Brain Injuries (TBI): According to DOD's Defense and Veterans Brain Injury Center, more than 330,000 service members were diagnosed with TBI between 2000 and 2015. VA has made significant progress in diagnosing and treating TBI-related conditions since the start of the wars in Iraq and Afghanistan. VA reports nearly 80,000 veterans were treated by its integrated Polytrauma System of Care in 2015, and estimates a more than 30 percent increase in demand within two years. VA must continue to expand its services to ensure veterans who suffer from conditions associated with TBI are afforded the specialized care they need. Specifically, the VFW urges VA to expand its Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care to ensure all veterans with a TBI have an individualized plan to maximize their independence and restore physical and cognitive functions.

Additionally, VA and Congress must continue to commission research on the effects TBI has on cognitive and behavioral functions and develop treatment programs for any and all research that shows promise in improving health outcomes and quality of life for affected veterans. The VFW also believes veterans must not only receive health care for conditions that are found to be related to blast injuries, but VA should establish these conditions as

presumptive for compensation, as many service members go untreated while in service, so there is no medical evidence of the condition in their military health records.

Military Sexual Trauma: In 2014, 20,300 members of our military reported being sexually assaulted––a number that remained unchanged since 2010. Military Sexual Assault is not a gender specific issue. It happens to and affects both men and women in uniform. Nearly 11,000 of them were men and 9,600 were women service members. All told, these service members were assaulted more than 47,000 times. These are just the reported numbers.

Sexual violence is an issue the VFW does not take lightly. It has a significant and long term impact on our veterans, service members and our military––from retaliation within the military against victims to deter reporting and its impact on camaraderie within a unit, to the physical and mental health ailments that result from the trauma. That is why the VFW firmly believes Congress and DOD must take measures to prevent sexual assault and sexual harassment and ensure victims receive the care and services they need.

According to reports from Human Rights Watch, over half of the individuals who have reported sexual assault within the military have experienced retaliation. Such retaliation by supervisors often leads to victims being punitively discharged for unrelated actions which are categorized as personality disorders, rendering them ineligible for VA benefits. This not only deprives sexual assault victims from the benefits they have earned, it also significantly hinders their ability to succeed after leaving military service. The VFW calls on Congress to work with DOD to ensure veterans who were wrongfully given bad paper discharges after being sexually assaulted have a fair shot at having their discharges upgraded.

The VFW urges Congress to ensure DOD's Sexual Assault Prevention and Response Office (SAPRO) has the resources and assets it needs to improve prevention within DOD. The Centers for Disease Control and Prevention have empirically proven ways to work toward preventing sexual assault, but without the budget and assets required, SAPRO will be unable to use these data driven approaches to bring the unsatisfactory numbers of assault down.

Lastly, the VFW requests Congress work with VA to improve mental health for veterans who survived sexual violence and trauma. For example, sexual assault victims say they feel uncomfortable speaking about their experiences in a group setting with veterans discussing their combat related PTSD. While these veterans wish to talk about their PTSD from sexual trauma, they feel more comfortable doing so in a private setting amongst other sexual assault survivors.

Whether PTSD or any other mental health conditions stem from combat in Afghanistan or rape, veterans deserve the treatments that work best for them. Yet, VA struggles to arrange group therapy sessions for sexual trauma survivors, simply due to the lack of patients

willing to partake in group therapy. Though there may only be one, two, or three veterans wanting group therapy, it does not mean they should be denied access or placed in uncomfortable group therapy sessions. That is why the VFW calls on Congress to expand VA's telemedicine authorities to ensure sexual assault patients within VA have the opportunity to talk comfortably in a virtual group setting of people who endured the same traumas.

Women Veterans

Women veterans are the fastest growing population within the military and veteran community. There are currently two million female veterans, and their population is expected to exceed that of the entire active duty, reserve and guard components by 2030. Of the women who have served in Iraq and Afghanistan, more than 160 of them have paid the ultimate sacrifice and, as of 2016, women service members are able to serve in any career field they desire. Now more than ever, as their population and roles in the military continue to increase, it is important we address gender specific needs.

It is important we do not neglect the fact that there are certain gender specific needs for both men and women. Our nation's women veterans are younger than the average male veteran. They are more likely to have served in Gulf War or Post-9/11 eras than in previous conflicts. Female veterans are also more likely to come from diverse racial backgrounds. They are also more likely to have a service-connected disability and are more likely to use VA health care when compared to their male counterparts.

Women's Health Care: VA reports that more than 447,000 women veterans used the VA health care system in fiscal year 2015, which is a 123 percent increase since fiscal year 2003. VA has worked to improve their gender specific care for this population of veterans, but more work needs to be done. In 2016, the VFW conducted a survey of nearly 2,000 female veterans as a way to identify the most important issues they are facing in VA. Over the past year we have worked with VA and the Veterans' Affairs Committees to address outreach, which is a key recommendation from our report, but other issues still need to be addressed.

According to VA reports from 2015, 66 percent of women veterans were assigned to Designated Women's Health Primary Care Providers (DWHP). VA and the Center for Women Veterans have worked to increase those numbers, and the VFW asks Congress to provide VA with the tools they need to continue expanding access to providers with necessary gender specific specialization. VFW surveys have found that women veterans overwhelmingly prefer to receive their health care from women primary care providers, and are more likely to be satisfied with their VA health care experience when they receive care from female providers. That is why the VFW has urged VA to allow women veterans to choose the gender of their provider when enrolling into health care.

While the DWHP program is expanding and providing above satisfactory care to patients, the VFW understands there is still a need for trained gynecologists within VA. Gynecology is sex-specific care that has traditionally been understaffed at VA medical centers across the country. While some doctors are able to provide certain treatments and procedures that a gynecologist specializes in, it is important to increase the number of doctors trained in this specialty.

Studies have found that women who deployed to combat may have higher rates of abnormal pap smears. As time goes on, more studies are starting to reveal what researchers believe to be higher rates of infertility and complications during pregnancy for female combat veterans as well. With this in mind, the VFW urges Congress to demand a thorough research study by VA to evaluate infertility and reproductive health issues for women veterans who have deployed to combat zones during the Gulf War as well as the recent conflicts in Iraq and Afghanistan. This data should then be used by Congress and VA to provide more competent care to veterans who become pregnant, have complications during pregnancy, experience a loss of pregnancy, or have difficulty conceiving.

Our women veterans also reported concerns regarding gender specific competencies in other clinics. For example, veterans are concerned they often face problems finding prosthetic options suitable for women, leaving them with no choice but to use uncomfortable products that do not fit properly. In orthopedics, veterans reported that doctors fail to treat them with their gender in mind. To ensure all VA health care programs are equitable among men and women veterans, the VFW urges Congress to work with the Center for Women Veteran's to conduct greater oversight of women veterans programs, expand outreach campaigns, gain more insight directly from women veterans themselves, and identify barriers or gaps in VA care and services for women veterans.

The VFW applauds VA and Congress for their work to provide more access to gender specific health care providers for women veterans. While overall progress has been made, gender specific mental health care is still lacking. In VFW surveys, female veterans have voiced concerns over what they view as a lack of gender specific training for mental health care providers. Congress and VA must work to ensure every VA medical center has mental health care providers who are well trained in conditions such as post-partum depression and conditions that stem from menopause or sexual trauma.

Identity and Outreach: The VFW applauds VA's Center for Women Veterans and their initiative to expand their efforts in recognition and outreach to women veterans. It is disheartening, however, for the VFW to hear time and again from women veteran VFW members going to VA appointments where employees continue to confuse them for spouses or caregivers and even challenge their veteran status. Veterans of all genders, races and creeds have honorably served our country. VA must properly train its workforce to treat women veterans with the respect and dignity they have earned and deserve.

In the past, VA noticed a much lower utilization and awareness of benefits among older women veterans compared to their younger counterparts. In one of the VFW's surveys, we found older women veterans were less likely to report receiving disability compensation, but equally as likely to have been injured or made ill as a result of their military service. Similarly, older veterans were less likely to report that they use VA health care, but equally as likely to report being eligible for VA health care than their younger counterparts. We were also concerned that several respondents who reported being 55-years-old and older believed they did not rate the same benefits as their male counterparts, which is an egregious misperception that must be addressed.

No veteran should be left to wonder what, if any, benefits they are eligible to receive. Furthermore, it must be clear that women veterans have earned the exact same benefits as male veterans. That is why the VFW urges Congress and VA to continue improving its outreach to women veterans and conduct targeted outreach to older women veterans to ensure they are aware of all the benefits and services VA provides.

Caregivers: Family caregivers who choose to provide in-home care to veterans who were severely disabled in the line of duty truly epitomize the concept of selfless service. They choose to put their lives and careers on hold, often accepting great emotional and financial burdens. They do so recognizing that their loved ones benefit greatly by receiving care in their homes, as opposed to institutional settings. The VFW strongly believes that the contributions of family caregivers cannot be overstated, and that our nation owes them the support they need and deserve. Unfortunately, the Program of Comprehensive Assistance for Family Caregivers is unjustly limited to caregivers of severely wounded post-9/11 veterans.

The VFW commends the Senate Committee on Veterans' Affairs for its efforts to correct this inequity through the *Veterans First Act*, which would have expanded the caregivers program to wounded veterans of all eras. Unfortunately, the bill did not pass the full Senate and the House Committee on Veterans' Affairs failed to act on similar legislation. The VFW frequently hears from our members about eligibility for this important program. Their message is clear: veterans of all eras deserve caregiver benefits. As an intergenerational veterans' service organization that traces its roots to the Spanish American War, this is not surprising.

Our members are combat veterans from World War II, the Korean War, the Vietnam War, the Gulf War, and various other conflicts, in addition to more than 200,000 veterans from the wars in Iraq and Afghanistan. They rightly see no justifiable reason to exclude otherwise deserving veterans from program eligibility simply based on the era in which they served. Accordingly, we strongly urge you to swiftly consider and pass a bill to end this inequity.

Preventive Medicine & Services: The VFW recently learned that current law requires VA to charge veterans for prescriptions, with a limited exemption for severely disabled veterans. Due to this statutory mandate, veterans using VA and the uninsured are currently the only people in the U.S. who have to pay for preventive medications and services.

The U.S. Preventive Services Task Force recognizes 11 categories of effective preventive medications, which range from aspirin to folic acid. Aspirin is used to reduce risk of cardiovascular disease, which is the number one cause of death in the U.S. and significantly impacts the veteran community. Aspirin is also used for prevention of preeclampsia, a condition found in some pregnant women. Folic acid and iron are categorized as preventive medication for pregnant women to reduce risk of serious birth defects and prevent anemia.

VA currently carries these medications in its formulary. However, given that veterans who turn to VA for their health care needs tend to be lower income, more sickly, and higher users of medical care, they elect to forgo many of these potentially lifesaving medications simply because they cannot afford to pay the pharmacy cost shares VA is required to charge. Congress must end this inequity to ensure veterans have access to effective preventive medicine.

The VFW urges the Committees to swiftly consider and pass the *Veterans Preventive Health Coverage Fairness Act*, which would ensure veterans have access to effect preventive medicine, whether they suffer from hindbrain TBI conditions and need vitamin D to prevent bone fractures, or need medication to prevent breast cancer they are likely to develop as a result of exposure to toxic water at Camp LeJeune.

Reproductive Health Care: Due to the widespread use of improvised explosive devices during the wars in Iraq and Afghanistan, both female and male service members have suffered from spinal cord, reproductive, and urinary tract injuries. Many of these veterans hope to one day start families, but their injuries prevent them from conceiving.

The VFW applauds Senator Murray and other members of the Committees for their hard work to secure passage of legislation authorizing VA to use assisted reproductive technologies to provide infertility treatments or cover the cost of adoptions so severely wounded veterans who have service connected infertility conditions can finally accomplish their dreams of starting a family.

VA recently issued an interim final rule to begin providing in vitro fertilization (IVF) options to eligible veterans. The VFW is glad to see VA has moved quickly and that veterans will receive fertility treatments under this authority in 2017. VA also estimated that as many as 500 veterans and their spouses could receive adoption reimbursement and IVF services in 2018. However, VA's new authorities are temporary and veterans who are unable to receive IVF or adopt a child by the end of fiscal year 2017 will be left to bear the full cost of adoption

or enhanced fertility treatment options. For that reason, the VFW strongly urges Congress to make these important authorities permanent.

Homelessness: VA, the Department of Labor and the Department of Housing and Urban Development (HUD) have made significant strides toward ending veteran homelessness, but much work remains.

Veterans with dependent children face diverse burdens accessing their earned benefits, including access to health care. Currently, VA has three pilot programs which offer child care service while a veteran attends his or her medical appointment. These programs have been successful in increasing access to care and benefits. Veterans who have used the program tell the VFW that they may have not been able to complete their prescribed treatments if it were not for child care. Homeless veterans are likely to forgo treatment, particularly inpatient treatment, due to the lack of child care. The VFW firmly believes that child care service would also improve access to employment training and counseling services that homeless veterans need to make certain they are able to maintain meaningful employment that will enable them to keep their homes and stay off the streets. That is why the VFW urges Congress to make the child care pilot program permanent and expand it to VA medical facilities throughout the country.

The VFW also encourages Congress to work with VA to provide more separate living arrangements for veterans with children and veterans who have survived sexual trauma. Congress and VA must work together to better understand that individuals face homelessness for different reasons, and their needs to overcome homelessness are equally unique.

For veterans on the verge of being homeless, there is currently little VA can do. Several benefits require veterans to be on the streets before they are deemed eligible for benefits. Many veterans who are on the verge of homelessness know they are being evicted, and nearly half of homeless veterans report temporarily staying with friends or family. This is why the VFW recommends Congress work with VA and HUD to ensure homeless veterans who are facing eviction or temporarily staying in another person's home are afforded the opportunity to obtain assistance.

Veterans fortunate enough to obtain HUD-Veterans Affairs Supportive Housing (HUD-VASH) vouchers also face difficulties. The VFW's Service Officers have reported in various cities that their homeless veterans sometimes prefer sleeping under a bridge rather than living in the unsafe neighborhoods their vouchers are eligible for. With a high percentage of veterans suffering from poor mental health, the VFW does not believe they should be forced to struggle with their PTSD in some of the most unsafe neighborhoods in the country. Additionally, sexual trauma survivors should not be forced to choose between homelessness and a neighborhood where their homes have been broken into and they are harassed on the

streets. The VFW urges Congress, VA and HUD to work with local VA facilities and community resources to ensure HUD-VASH vouchers put veterans in safe and secure housing.

Through surveys, the VFW is aware homeless veterans are significantly more likely to be dissatisfied with VA employment benefits and the Transition Assistance Program. Congress and VA must recognize certain veterans face considerable barriers to employment and need more inclusive case management and support services. To address this issue, Congress created the Vocational Rehabilitation and Employment (VR&E) program. VR&E also provides other support, such as counseling and assistance finding meaningful employment appropriate for their disabilities. The VFW views VR&E as a cornerstone of VA services. That is why we urge Congress to expand VR&E eligibility requirements by authorizing VA to classify homelessness as a qualifying barrier to employment, without regard to service-connection or when a veteran was discharged from military service.

Telemedicine: With geographic distance remaining a significant barrier to care for many veterans, the use of telemedicine technology has emerged as a highly effective method of providing veterans with timely and convenient care. Current law, however, restricts VA health professionals from practicing telemedicine across state lines unless both the provider and the veteran are located in federally owned facilities.

Consequently, veterans who are enrolled in out-of-state VA Medical Centers may be forced to travel significant distances to access telehealth services. Congress must pass legislation to authorize VA health care professionals to practice telemedicine across state borders, so a veteran's physical location can no longer limit his or her ability to use VA telehealth services.

Nursing Home Eligibility: The VFW also calls on Congress to expand eligibility for VA nursing home care to ensure all veterans enrolled in VA health care have access to a full continuum of VA health care services. Current law limits VA nursing home care to veterans who are service-connected at 70 percent or above or seeking nursing home care for a service-connected disability. However, the demand for VA nursing home care is increasing as the veteran population continues to age and veterans who do not meet limited eligibility criteria are forced to forgo nursing home care or bear the full cost.

VA nursing home care is considered the "safety net" for VA health care services such as residential care, respite care, hospital-based home care, adult day health care, homemaker/home health aide services and other extended care programs. VA also agrees that the difference in eligibility for nursing home care and inpatient hospital care are inconsistent with the principles of sound medical practice. Congress must expand eligibility for VA nursing home care to all veterans enrolled in VA health care and ensure VA has the appropriate resources to meet demand.

Hepatitis B Screening: In developed countries like the U.S., Hepatitis B is a preventable, highly treatable long term illness. A 2014 study by the American Association for the Study of Liver Disease concluded that Hepatitis B infection was twice as common in the veteran population as in the general population, and that VA screening for the infection was "suboptimal." That is why the VFW urges Congress to ensure VA takes steps to improve Hepatitis B screening, follow-up testing and treatment among veterans.

Health Equity: VA's Offices of Patient Care Services and Health Equity are tasked with assisting minority veterans to overcome unique challenges when accessing quality health care. Currently those offices estimate over one million veterans from these communities experience lower status of health. For example, heart disease, intimate partner violence, end-stage renal disease, and many other health concerns are more prevalent amongst various minority and LGBT veterans.

It is deplorable that veterans who have honorably served this nation must overcome health care inequities and disparities simply because they belong to a minority. The VFW urges Congress to work with VA in an effort to ensure no veteran is ignored. Veterans all swore the same oath, regardless of their ethnic background or sexual orientation.

Veterans Treatment Courts: According to the most recent data from the Bureau of Justice Statistics, over 130,000 veterans are incarcerated in state and federal prisons, representing approximately eight percent of the total prison population. While the VFW realizes that veterans who are convicted of crimes must suffer the consequences, we also recognize that many veterans commit crimes due to undiagnosed or undertreated conditions that stem from their military service. In those instances, it is invaluable for veterans to have advocates to represent them before the legal system to make certain they receive needed treatments instead of being required to serve prison time. Veterans Justice Outreach Specialists are the first line of defense when a veteran enters the legal system. This group of lawyers, social workers, and specialists work to ensure veterans facing legal issues are taken care of with the respect they deserve.

The VFW urges Congress to expand the amount of Veterans Justice Outreach Specialists to help more justice-involved veterans navigate the legal system, and hopefully attain outcomes that are best suited for their individual needs. The VFW is confident that increasing the number of veterans' advocates in our court system will help our nation's veterans receive the proper legal help they need to continue moving forward in life.

Exposures and Other Environmental Hazards

The brave men and women who wear our nation's uniform are asked to serve in the

roughest and most dangerous environments on earth. They without question serve their country with the utmost faith because they know the freedoms that make this country great are at stake. When they are injured or made ill as a result of such service, a grateful nation owes these selfless warriors the care and benefits they need to cope with such disabilities.

Blue Water Navy: The VFW strongly supports S. 422 and H.R. 299, the Blue Water Navy Vietnam Veterans Act of 2017, which would expand disability compensation benefits to veterans who were exposed to Agent Orange while serving in the territorial seas of the Republic of Vietnam in support of ground operations during the Vietnam War.

Currently VA relies on what the Court of Appeals for Veterans Claims has called an "arbitrary and capricious" interpretation of inland waterways, which unjustly denies veterans who served aboard ships in the coastal waters of Vietnam the benefits they deserve. The VFW calls on Congress to swiftly pass the Blue Water Navy Vietnam Veterans Act of 2017.

Korean DMZ: The U.S. government authorized the testing and use of toxic herbicides, including Agent Orange, to improve the observation and fields of fire for American service members patrolling along the demilitarized zone (DMZ) and deny hostile forces concealment provided by vegetation.

Due to direct exposure to these toxic herbicides, Korean DMZ veterans now suffer from diseases and illnesses that have been directly linked to the toxic chemical defoliant Agent Orange. While many of these veterans are provided presumptive disability compensation for their service-connected disabilities, hundreds of them are unjustly required to prove individual exposure, which is almost impossible to do nearly 50 years after the incident.

Currently, VA presumes that veterans who served along the Korean DMZ from April 1, 1968 to August 31, 1971 were exposed to Agent Orange, making the disability claims process significantly easier and faster because such veterans are not required to present evidence of individual exposure. However, such dates contradict evidence obtained by the VFW and with congressional records.

When Congress passed PL 108-183, the Veterans Benefits Act of 2003, the Senate and House Committees on Veterans' Affairs used evidence obtained by committee staff and information provided by DOD to authorize VA to provide benefits to veterans who served along the Korean DMZ between September 1, 1967, and August 31, 1971, which incorporates the earliest use of toxic herbicides along the Korean DMZ, and accounts for the half-life of such toxins. When aligning its compensation regulations regarding presumptive herbicide exposure for veterans who served along the Korean DMZ to PL 108-183, VA unjustly elected to begin the presumptive date seven months after Congress suggested. Doing so denied a

streamlined path to benefits for the hundreds of veterans who served along the Korean DMZ between September 1, 1967 and April 1, 1968. These veterans suffer from the same malaises as those who served along the Korean DMZ after April 1968, but face an uphill battle obtaining the benefits they deserve.

The VFW has worked with members of Congress to correct this injustice, but VA has ignored the evidence and refused to reconsider its decision. That is why the VFW urges Congress to amend PL 108-183 and require VA to begin the presumptive date on September 1, 1967.

The VFW also believes that the end date recognized by VA and DOD and established by Congress does not accurately account for the half-life of Agent Orange in the soil of sprayed areas. DOD asserts that use of Agent Orange near the Korean DMZ ceased in 1969. When Congress and VA set presumption dates for Korean DMZ veterans, they expanded the end date beyond 1969 to account for residual exposure. Although the half-life of 2,3,7,8 TCDD – a human carcinogen found in Agent Orange – may be between one year and three years on soil surfaces, studies conducted by the Environmental Protection Agency and the Department of Agriculture have determined that TCDD is resistant to biodegradation and can remain in soil interiors for up to 12 years.

A similar study conducted by the Canadian company Hatfield Consultants Ltd., in collaboration with the government of Vietnam, found a "hot spot" of TCDD contamination at a former U.S. Special Forces base in the Aluoi Valley in 1997. The soil found on this abandoned base continued to exceed Canadian health standards more than 30 years after initial spraying of Agent Orange in the area. VA must ensure its regional offices are aware that soil interiors remained toxic long after August 31, 1971. Doing so would ensure veterans who served along the Korean DMZ after August 1971 and whose duties required them to excavate soil that was previously sprayed with Agent Orange are not wrongfully denied the benefits they deserve.

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

The VFW is glad to see that nearly 100,000 veterans have enrolled in VA's burn pit registry. The VFW is also anxiously awaiting the results of the National Academies of Science's study on the burn pit registry which will serve to determine whether veterans exposed to airborne hazards from burn pits experience certain pulmonary conditions. The VFW urges VA and Congress to act swiftly on recommendations from this important study.

VA must also take measures to improve the Airborne Hazards and Open Burn Pits Registry. For example, a similar registry operated by Burn Pit 360 allows the spouse or next of kin of registered veterans to report the cause of death for veterans. VA must add a similar feature to its registry to ensure VA is able to track trends. Other improvements include streamlining the registration process, updating duty locations, and eliminating technical glitches to ensure veterans are able to register.

While the VFW is glad to see VA has commissioned independent research on the burn pit registry, more independent research is necessary. That is why the VFW supports establishing a Congressional Directed Medical Research Program (CDMRP) specifically for burn pits. The CDMRP for Gulf War Illness has shown some progress in identifying causes, effective treatments and biomarkers for gulf war illness and the VFW is confident a similar program for burn pits will help exposed veterans finally determine whether their exposure to burn pits during combat is associated with their negative health care outcomes.

Gulf War Illness: A recent IOM study found medical research has not made progress in identifying the cause of Gulf War Illness, and that future research is unlikely to produce more clarity. However, what is certain is that more than 200,000 Persian Gulf War veterans suffer from conditions that cannot be explained by medical or psychiatric diagnoses, such as chronic widespread pain, cognitive difficulties, unexplained fatigue, and gastrointestinal problems. While the VFW supports IOM's recommendation that VA's top priority must be to identify effective treatments for Gulf War Illness, we do not believe that future medical research should focus on the connections between brain and body function. The VFW believes that future research efforts must continue to study all symptoms and conditions associated with Gulf War Illness. That is why the VFW urges Congress to continue to properly fund the Gulf War Veterans' Illnesses Research Program CDMRP.

Additionally, veterans who have served in the Southwest Asia Theater of military operations since August 2, 1990, including Operation Iraqi Freedom and Operation New Dawn are eligible for a Gulf War Registry health exam. This comprehensive exam evaluates exposure and medical history to identify possible long term health problems that may be related to environmental exposures during their military service. While veterans who served in Afghanistan after 2001 are eligible for VA's Airborne Hazards and Open Burn Pit Registry, they are not eligible for the Gulf War Registry health exam. The VFW believes that Afghanistan veterans served under circumstances similar to those served in Iraq. That is why we urge VA and Congress to expand eligibility for the Gulf War Registry health exam to veterans of the war in Afghanistan.

Fort McClellan: From 1943 to its closure in 1999, Fort McClellan, Alabama, was home to thousands of soldiers in the Women's Army Corps, the Army's Military Police Corps, and the Army's Chemical Corps. It was forced to close in 1999 due to investigations by the Alabama

Department of Public Health, the Alabama Department of Environmental Management, the Agency for Toxic Substances and Disease Registry, and the U.S. Environmental Protection Agency, which discovered evidence of Polychlorinated Biphenyl (PCB) contamination in Fort McClellan's neighboring town, Anniston.

The VFW has heard from several veterans suffering from deteriorating health conditions that are consistent with exposure to PCBs that they are unable to obtain the care and benefits they need because their service at Fort McClellan is not considered presumptive exposure to toxic substances. The VFW calls on Congress to commission more research on the health effects associated with exposure to PCBs at Fort McClellan and to ensure exposed veterans have access to the care and benefits they deserve.

Camp LeJeune: The VFW is pleased VA has begun to provide presumptive disability compensation benefits to veterans who suffer from eight medical afflictions associated with exposure to contaminated water at Camp Lejeune between 1953 and 1987. This is a major step towards ensuring veterans who suffer from health conditions that stem from their military service on Camp Lejeune receive the health care and benefits they deserve.

Thanks to efforts by the Senate and House Veterans' Affairs Committees, VA is authorized to provide no-cost health care to veterans and their families for 15 health care conditions that have been found to be associated with exposure to contaminated water on Camp Lejeune. However, VA only expanded presumptive disability compensation benefits for six of the 15 conditions. As a result, veterans who served 30 or more days at Camp Lejeune between 1953 and 1987 and have been diagnosed with esophageal cancer, breast cancer, renal toxicity, female infertility, lung cancer, bladder cancer, hepatic steatosis, miscarriage, and neurobehavioral effects are eligible for no-cost VA health care, but have an uphill battle obtaining disability compensation benefits. The VFW urges Congress and VA to review the medical research linking these conditions to the contaminated water at Camp Lejeune and determine if VA's presumptive list is accurate.

Woomera: In the 1950s and 1960s, a contingent of American military personnel was stationed in the Woomera prohibited area which includes Woomera Air Force Station and Maralinga, South Australia. The station was in the close vicinity of nuclear weapons testing conducted by the United Kingdom and Australia governments during the same time period. Veterans who were stationed at Woomera Air Force Station now suffer from diseases associated with radiation exposure. However, Woomera is not recognized by VA as an area of known radiation exposure. As a result, these veterans are denied service connection and medical treatment for disease associated with such exposure. The VFW urges Congress to pass legislation to provide health care and benefits to veterans who served in Maralinga, South Australia, and Woomera Air Force Station who were exposed to radiation from nuclear testing.

Capital Infrastructure

For more than 100 years, the government's solution to provide health care for our military veterans has been to build, manage and maintain a network of hospitals across the nation. This model allows VA to deliver care at 1,753 facilities, but has left it with more than 5,600 buildings and 34,000 acres, many of which are past their building lifecycle. Many of these facilities need to be replaced, some need to be disposed of, others need to be expanded, and all of them need to be maintained. The process to manage this network of facilities is the Strategic Capital Infrastructure Plan (SCIP). SCIP identifies VA's current and projected gaps in access, utilization, condition, and safety. It then lists them in order based on the gap's priority. In VA's FY 2017 Budget Submission, the 10-year full implementation plan to close these gaps is estimated to cost $52 to $63 billion.

Major Construction: Congress and VA needs to realign the SCIP process to allow VA to enter into public-private partnerships and sharing agreements to right size VA's footprint. Congress must also continue to fund VA major construction projects that are partially funded, and VA must begin the advanced planning and design of those projects it knows it will need to fund through the traditional appropriations process. Currently, VA has 24 major construction projects that are partially funded, some of which were originally funded in FY 2004, that need to be put on a clear path to completion. There are an additional three projects that are in the design phase. Outside of the partially funded major projects list are major construction projects at the top of the FY 2017 priority list that would correct seismic deficiencies. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long term.

VA will need to invest more than $3.5 billion to complete the 24 partially funded projects. Two of the five projects on the priority list are seismic deficiencies, two are the core mission of VA–– a mental health clinic and a spinal cord injury center––and one is an addition to an existing facility. The total cost of these two projects is $1.2 billion.

The VFW recommends that Congress appropriate $1.5 billion for major construction in FY 2018. This amount will fund either the "next phase" or fund "through completion" all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

To ensure VA is able to complete major construction projects on time and on budget, the VFW believes VA must move its construction process entirely to an Integrated Design Bid Build (IDBB) model. This will allow VA to shorten the overall length of major construction projects, by overlapping the three phases of the project. Additionally, using the IDBB process would allow state of the art medical technology to be in use during its prime years, meaning VA would get more use out of expensive medical equipment.

The largest added benefit of the IDBB process is it saves time over the entire length of the project. Currently the three phases of building––the design, the bidding, and the building–– happen sequentially. Integrating the three phases allows for some overlap of the different phases and shortens the entire length of the project, sometimes by years.

The other added benefit of the IDBB is bringing the contractors on board during the design phase of the project, which allows the builders and the designers to interact as a team and helps prevent future conflicts during the building phase. Teamwork in the design phase alleviates problems up front, which saves time and ultimately money.

Minor Construction: In FY 2017, Congress appropriated $372.1 million for minor construction projects. Currently, there are still hundreds of minor construction projects that need funding to close all current and future year gaps within ten years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion in minor construction over the next decade.

In VACAA, Congress provided $5 billion to increase health care access by increasing medical staffing levels and investing in infrastructure. VA has developed a spending plan that will obligate $511 million for 64 minor construction projects over a two-year period.

While this infusion of funds has helped, there are still hundreds of minor construction projects that need funding for completion. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. The VFW recommends that Congress continue to properly fund VA's minor construction budget requests.

Leasing: Historically VA has submitted capital leasing requests that meet the growing and changing needs of veterans. While VA has requested adequate resources, Congress must find a streamlined process to authorize and appropriate such leasing projects. Unfortunately, current congressional rules require the Veterans' Affairs Committees to offset the full ten year cost of leases in the first year. This makes authorizing leases nearly impossible. There are currently six major medical leases from FY 2016 that Congress has yet to authorize. Delays in authorization of these leases have a direct impact on VA's ability to provide timely care to veterans in their communities. Congress must authorize pending leases and reform the authorization process.

Nonrecurring Maintenance: Even though nonrecurring maintenance (NRM) is funded through VA's Medical Facilities account, and not through a construction account, NRM is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the long term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors. Nonrecurring maintenance 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.

Just to maintain the status quo, VA's NRM account must be funded at $1.35 billion per year, based on the estimated Plant Replacement Value (PRV). The Administration's past budget requests have fallen short of the PRV guideline, but its request for FY 2017 shows that they have started to request funds much closer to the actual need. However, the VFW believes it will take more than the baseline $1.35 billion per year to reduce the more than $20 billion of identified gaps within NRM. As VA works to close these gaps, VA and Congress must make it a priority to maintain what exists, finish what has been started, and chart a long term plan to effectively close future gaps.

VA's SCIP program clearly identifies the current and projected 10-year gaps in delivery of health care. What is missing is a long term strategy to effectively close these gaps in the most veteran-centric and cost effective way. This must include a strategic plan for removing unutilized or underutilized space, so VA can invest the funds used to maintain these building into facilities that can provide direct care for veterans. Facilities will need to be replaced, improved and reduced over the years, and the method used to decide when and how to move forward with these projects must be comprehensive. VA can no longer afford to build a new facility and within three years have a need to expand the same facility because VA did not properly forecast the need. Nor should VA feel compelled to maintain a specialty that is so underutilized that it becomes cost prohibitive.

Veterans Benefits Administration

Workload: The past year has seen an interesting shift in priorities within the Veterans Benefits Administration (VBA). While the total number of claims it is responsible for working[1] has decreased by 154,900 from 1,511,554 to 1,356,654, the disability claims workload increased by 36,699 from 352,666 to 388,365 during the same period.

We believe that this reflects management decisions to stop focusing resources solely on reducing the disability workload in order to achieve the former Secretary's goal of processing all disability claims within 125 days. Instead, VBA appears to be taking a more measured and nuanced approach to its total workload. For example, dependency claims numbered 213,278 a year ago; today dependency claims have been reduced to 96,978. A year ago 71 percent of dependency claims were over 125 days old; today, 52 percent are over 125 days old. While there are still far too many dependency claims pending in regional offices, the VFW commends VA for its effort to help all veterans, not just those with disability claims. This shift in priorities is also reflected in the appeals work pending in

regional offices.

Quality of Claims Processing: VA measures quality two ways: claims-based and issue-based accuracy rates. Claims-based accuracy judges whether there is a substantive error in a veteran's claim. Using this methodology, VA reports an 89.4 percent accuracy rate. This is slightly lower than at the same time last year. Issue-based accuracy determines whether any decision made within the claim was in error. So, if a claim has five issues and only one is wrong, than the decision isn't wrong, it's 80 percent right. Using this methodology, VBA reports a 95 percent accuracy rate, down slightly more than 1 point from last year.

The VFW conducts random reviews of VA rating decisions when performing staff visits to VFW offices. These reviews reveal error rates similar to VBA's claims-based rate.

The VFW strongly believes VBA must publish detailed quality reports. These reports are a necessary tool to demonstrate the effects of any improvements to its processes. This will allow VBA to set achievable goals to improve the quality of its decisions.

While discussions with VA officials and contractors who have studied VBA quality data indicate that the former Secretary's goal of 98 percent accuracy is statistically unachievable, continued efforts to achieve incremental improvement in both measures are to be encouraged. Continued advances in rules-based decision making, as well as improved training and accountability, will improve quality without an undue impact on resources.

Next, VA's National Work Queue (NWQ) moves work around VA based on capacity through the Veterans Benefits Management System (VBMS) digital work environment. The VFW understands and supports the concept of the NWQ. It makes sense for VA to shuffle its business processes to offices that have the capacity to complete the work in a timely manner. However, when VA proposes a rating decision and posts it for review, they do not return the claim to the regional office where the claim originated––depriving the accredited VFW Service Officer familiar with the claim the opportunity to review it for accuracy before the claim is finalized.

This makes no sense to the VFW, especially considering that our resources are customer-facing and aligned to serve the veterans in a particular community. VA has proposed workarounds like zip code filtering or station filtering to help organizations like the VFW track local work, but the VFW believes the simplest solution is to just allow the accredited representative who initiated the claim to review any pending rating decisions. Since accredited representatives from organizations like the VFW are the final quality check on disability ratings, VA is losing an opportunity to avoid unnecessary errors and,

consequently, appeals.

Appeals: In January of 2017, VA reported that it had over 329,000 appeals pending. While appeals may take 1,000 days to go from Notice of Disagreement (NOD) to Board of Veterans Appeals (BVA) decision, 223,000 (68 percent) of those cases pending in VA regional offices wait an average of 430 days for the issuance of a Statement of the Case (SOC). While VA has made progress during the past year, reducing appeals pending in the regional offices by 29,000, the appeals crisis is destined to continue for years absent increased staffing at both the BVA and VBA, and appeals reform.

There are a number of reasons for the increase in the number of pending appeals over the years. VA argues that the increase in appeals was a result of the increased number of decisions made in the past several years. While that is a factor, it only accounts for half of the increase documented in the past two years. The other half of the increase is the result of management decisions to focus on initial claims because VA lacked the resources and workforce to devote adequate attention to both.

To address these problems, the VFW would like to offer what we believe are two creative solutions:

- First, VBA should establish model criteria for staffing appeals teams. This should be based on an analysis of data, including optimum caseloads per DRO or appeals team support staff. Simply put, VA has never studied how long an appeal should take to process under the current appeals regime in a properly staffed and functioning unit. This must happen in order to understand what proper staffing levels are required.
- Second, any increase or reallocation of staff to appeals processing would inevitably create a learning curve. To mitigate this, we suggest utilizing retired annuitants at both VBA and BVA to expand experienced personnel to process appeals. These suggestions, along with proper funding from Congress and a commitment from VA to prioritize appeals processing, would go a long way towards reducing the time it takes to complete an appeal.

Another example of inefficient VBA management is the systemic failure to issue timely SOC to appellants. It is in the best interest of both the veteran and VA to legally resolve an appeal at the earliest opportunity. Once VA issues a SOC, a veteran has the remainder of the one year appeal period or 60 days, whichever is longer, to submit a Form 9. New evidence received on the 61st day following issuance of a SOC may start a new claim; however, VA cannot reopen the appeal. Since roughly half of all appellants do not return a Form 9 within the allotted period, it is to the advantage of VA to issue the SOC as quickly as possible. This could potentially reduce the number of appeals by half.

VA's shift in 2016 to focus all its workload has produced a decrease in appeals pending in the regional offices. It appears that VA has begun issuing SOC's in greater numbers. That one category of appeals has decreased by over 12,000 in the past year.

Finally, VA has consistently failed to train, encourage and monitor the use of difference of opinion authority by DROs. This authority allows the Decision Review Officer (DRO) to conduct a de novo review of the evidence of record and, if they choose, grant some or all of the benefit sought on appeal on their own initiative, without the need of new evidence.

Historically, DROs have received scant training in the use of their expanded authority. As a consequence, many DROs rarely exercise their difference of opinion authority. Since management, both in the regional office and in VBA, has ignored appeals, this problem has not been addressed. In fact, in 2014 VBA leaders said that they were considering eliminating the DRO position because it was ineffective in reducing appeals.

The VFW strongly believes that the DRO position should be revitalized by determining which DRO's nationwide are outliers and need more training in the use of the difference of opinion authority.

To reiterate, the only variable that VA has indirect control over is the rate of appeal. All the other factors, listed above, are and have been well within the ability of VA to manage. That it has failed to do so says much more about inadequacies and failures in management than it does about the inefficiencies built into the appeals process.

Appeals Reform: During the 114th Congress, the VFW, along with the other VSOs, VA and Congress, came to agreement on the VA Appeals Modernization Act of 2016. This legislation would create three lanes for veterans to choose from when filing an appeal. These lanes are:

1. Center (claims) lane (The starting point for all claims)
   Under this lane all claims are processed much as they are today: A claimant submits a claim. VA develops the claim to completion and refers it for decision. VBA makes a decision and notifies the claimant.

2. Difference of Opinion review lane
   Once a decision is made by VBA, a claimant may elect to receive a higher level review from VBA. Under VA's proposal, this is not done by a Decision Review Officer but by someone who is at least one grade higher than the previous decision maker.

3. Appeals lane
   A claimant may elect to appeal once they receive a decision by VBA (either a center

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

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

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

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

Concerns

While the VFW is supportive of this legislation and asks the Committees to quickly pass it, there are issues that will need to be worked through during the rule writing process.

They include:

Duty to Assist

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

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

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

Docket Flexibility

Currently the BVA is limited to only one docket. Under this proposal, BVA would have to maintain at least two dockets in order to have the flexibility to more efficiently work its cases. At the very least, the BVA would need a separate docket for the fast, no hearing/evidence lane so that those appeals are decided as rapidly as possible. In addition, BVA would need at least a second docket for those appeals requiring hearings.

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

New Evidence

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

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

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

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

Higher Level Review

Under 38 CFR 3.2600, claimants may elect a review by a DRO. This individual has the authority to conduct a de novo review of the evidence, order additional development as needed, and make a decision. No deference is given to the prior decision. Under the appeals reform proposal, a difference of opinion review is provided, which is similar to the current DRO process. However, the reviewer would not be required to be a DRO but can be anyone of a higher grade detailed to make the review. It is also likely that this reviewer will not receive separate training and will have this assignment as an adjunct duty.

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

Further, VA intends to make these reviews based solely on the evidence of record and preclude the authority to order additional development, except for duty to assist errors. This presents the same problems for a claimant at a difference of opinion review as it does for evidence submitted at a BVA hearing described above. Any evidence submitted during a

difference of opinion hearing would not be subject to the duty to assist. Once a decision is made, how might a claimant receive assistance by VA as required by the current duty to assist provisions of the law? This problem is not resolved by the language of this proposal. The VFW believes that the difference of opinion reviewers should be able to remand a claim for additional development based on evidence received during the difference of opinion review.

Claims in Different Lanes at the Same Time

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

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

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

Private Medical Evidence: The VFW strongly supports amending Title 38 United States Code (U.S.C) to require VA to accept sufficiently complete private medical evidence provided by veterans when filing disability claims. VA already has the authority to do so under section 5125, but in our experience, rarely exercises it. In our view, there is absolutely no reason why a veteran should have to wait additional weeks or months for an examination from a VA physician if evidence provided by a non-VA physician is sufficient to make a determination. Redundant examinations slow down the process, not only for the veteran who does not need them, but also for other veterans who legitimately do. The VFW calls on Congress to reintroduce and pass the Quicker Veterans Benefits Delivery Act, which would require VA to accept private medical evidence, so long as it is "competent, credible, probative, and containing such information as may be required to make a decision on the claim for which the report is provided."

ECONOMIC OPPORTUNITY

Veterans have long outperformed their civilian counterparts in the workforce. After suffering setbacks due to the economic downturn in 2008, employment numbers from Department of Labor show veterans once again have lower rates of unemployment than non-veterans. The VFW believes this it due to investment in transitional resources, such as the Post-9/11 GI Bill and employer making efforts to hire quality veteran candidates.

However, the VFW knows certain cohorts of veterans continue to face significant barriers to securing quality employment opportunities. That is why Congress must remain vigilant in guaranteeing military transitional programs and veterans economic development programs remain relevant and effective.

The VFW believes improving access to education and relevant workforce skills while in the military remains a critical priority to ensure a smooth transition into the civilian workforce. The VFW also believes veterans should have easier access to resources to start small businesses, in addition to the full suite of economic benefits currently available.

The VFW has worked closely with Congress to consistently improve veterans' economic development programs through initiatives like in-state tuition for veterans and the Transition Assistance Program participation mandate. But these were just the next logical steps in fostering a successful transition for our service members into the workforce. Below are our continued recommendations to improve on these successes.

Transition Assistance Program: In 2016 the Department of Labor (DOL) worked with the VFW to make adjustments to their Transition Assistance Program (TAP). After years of reviewing qualitative data the VFW collected in our own survey of thousands of transitioning service members, as well as data from DOL, the department decided to move away from providing a vast amount of information, which confused individuals going through the program, and to start focusing more on practical work during TAP.

In doing this, DOL put over 180,000 participants through these workshops. Not all individuals going through TAP were required to go through them, but those who did and later took DOL's Transition GPS Participant Survey responded that 96 percent of them agreed or strongly agreed that lessons from the workshops would be used in their transition planning. Another 94 percent of respondents agreed or strongly agreed that the workshops increased their confidence in their transition planning.

While this is a good start, and the VFW is confident that DOL will continue to improve TAP, there is still work that needs to be done. Our survey was launched in 2014 and transitioning service members have consistently responded saying TAP is too short. Many survey participants have also expressed a desire for a more concise, consolidated way to access the information taught during TAP.

The VFW urges Congress and DOL to work on better dissemination of information in a technologically savvy way desirable to the average transitioning veteran. Material presented during TAP needs to be readily available in short, concise and effective ways through various platforms.

Fortunately, the VFW believes the transition experience is improving for service members. Veterans' overall unemployment has remained below the national average; more companies are hiring and retaining veteran employees; and, most importantly, the agencies responsible for transition training are heeding the advice of the veterans' community. The VFW is encouraged by the plans to annually review and update the TAP curriculum with stakeholder input. We are encouraged that DOD, VA, and DOL have worked to make the curriculum publicly available after military service. And we are also encouraged the military is offering service members an opportunity to prepare for their transition early on.

Education: Aside from outperforming their civilian counterparts in employment, new studies show that veterans are also outperforming their civilian counterparts in education. Veterans have not only higher grade point averages, but higher graduation rates as well. This is why the VFW urges Congress to protect the integrity of the Post-9/11 GI Bill as a gateway for veterans to a successful civilian career.One aspect of Post-9/11 GI Bill that should be changed is the way eligibility is determined for veterans who serve in combat. Currently, only veterans who serve 36 months on active duty after September 11, 2001, qualify for the benefit at the 100 percent rate, regardless of whether they served in combat or not. This fails to include individuals who served in combat and received a medal of valor such as the Purple Heart, Bronze or Silver Stars. As the nation's oldest and largest major organization of war veterans, we strongly believe veterans who deployed to combat as part of the Global War on Terrorism should fully qualify for Post-9/11 GI Bill benefits.

Current era veterans receive five years of VA medical care if they deployed to an area of combat operations. We urge Congress to similarly amend the Post-9/11 GI Bill to fully honor the combat service of all Post-9/11 combat veterans.

The current eligibility system is especially inequitable for combat Guard and Reserve veterans. The Post-9/11 era saw unprecedented numbers of Guardsmen and Reservists deploy in harm's way. Typically, they were activated only for short training periods before their deployments, saw combat, and were deactivated shortly after returning home. After recognizing the value of high tempo Guard and Reserve components, DOD elected to establish total force policies to optimize integration of active duty and reserve personnel to accomplish its mission. However, DOD lacked the authority to involuntarily mobilize Guard and Reserve service members is support of preplanned, non-emergent, missions.

At the request of DOD, Congress amended section 12304 of Title 10 U.S.C. to provide DOD

the authority to involuntarily mobilizes Guard and Reserve service members for deployments in support of preplanned missions––12304b orders. However, Congress failed to ensure veterans involuntarily mobilized under this new authority are granted the same benefits and services as other Guard and Reserve service members who are called to serve on active duty, including eligibility for VA education benefits such as the Post-9/11 GI Bill. Congress must correct this oversight immediately.

Another coding issue taking away from education benefits is the mobilization authority under section 12301(h) of Title 10 U.S.C. Reservists and Guardsmen who are injured or ill under while on active duty are placed on 12301(h) to receive treatment, yet under 12301(h) orders they do not accrue GI Bill benefits. It is unjust for situations where a Reservist may deploy to combat, become injured and rehabilitate at military hospitals and not earn time toward education benefits. The VFW asks Congress to award individuals deployed under 12304b as well as those activated under 12301(h) orders the time they earned toward their education benefits.

The VFW is also concerned about predator institutions who seek to take advantage of loopholes to pad their pockets at great expense to the federal government and endangering the viability of the Post-9/11 GI Bill. Currently, third party training programs that contract with public schools are able to charge unlimited fees since public schools have no set dollar amount cap. Two years ago it came to light that some contracted flight training programs were charging exorbitant fees, which far exceeded the cost of an average in-state education. These institutions used their relationship with public school to charge up to $100,000 for flight training.

The VFW understands that flight training is expensive. However, these institutions charged exorbitant fees because they could, not because they needed to. Now the VFW has obtained evidence that private schools are partnering with these contractors and public schools to do the same. The VFW believes this loophole must be closed by placing a reasonable cap on the amount the Post-9/11 GI Bill covers for training programs that are affiliated with public institutions of higher learning. Doing so would ensure such training programs can continue, without endangering the integrity of the Post-9/11 GI Bill.

Vocational Rehabilitation and Employment (VR&E): Service members who have been wounded or injured, or have fallen ill desire to return to civilian life as a productive member of society. VR&E is the bridge to get them there.

To improve VR&E programs, VA must conduct a comprehensive work measurement study ensure VA has appropriate staffing levels, VR&E counselors have the necessary skills and competency levels to fully assist veterans, and extend the tracking of success rates further into employment to ensure full reintegration. The VFW believes VA must hire additional counselors to meet this standard and then evaluate if the current 1:125 is truly an effective

ratio, especially for counselors who assist veterans with severe cases of PTSD and TBI. Counselors must be able to invest the time necessary to achieve a higher standard of success for veterans seeking meaningful employment. The VFW also believes VA must change its current veterans' success rate tracking model from a 60-day threshold to the end of the veteran's probationary period at his or her job.

Additionally, the VFW strongly supports Vocational Rehabilitation for Life. The VFW firmly believes time restrictions on the VR&E program prevent veterans who have been discharged for more than 12 years receiving the training they need to adjust to a changing workforce. Recent economic conditions have demonstrated exactly why our disabled veterans must always have access to this critical program. Industries evolve and some jobs go away. The VFW believes America has an obligation to ensure service-disabled veterans can secure meaningful careers, regardless of how long they have been out of the military. Eliminating the current 12-year delimiting date will ensure VA can uphold this obligation.

Licensing and Credentialing: When we recruit Americans to serve in the military, we promise them skills and experience employers will value. With this in mind, it seems incomprehensible that our veterans continue to struggle to find comparable civilian careers in fields such as health care, transportation and various mechanical jobs.

The VFW recognizes this is predominantly a state issue, and we will continue to work at the state level to advance the acceptance of military training and experience. However, Congress must ensure DOD training service members to standards deem acceptable to state licensing and credentialing boards.

Upon transition from the military many service members and veterans will need to take licensure and certification tests in order become credentialed. Currently, veterans may use their Post-9/11 GI Bill to pay for these tests, however, they are charged a full month of benefits for each test. This is not the case under the Montgomery GI Bill, which subtracts only the exam fee from the overall entitlement. Licensing and examination fees are typically much less expensive than a full month of tuition and fees, making the Montgomery GI Bill method more favorable for the veteran. Yet, not all veterans are eligible for the Montgomery GI Bill. Congress must correct this issue by either deducting the actual cost of the exam from Post-9/11 GI Bill beneficiaries or prorating eligibility. This would allow veterans to retain the earned maximum amount of educational benefits to achieve other academic and professional goals in the future.

Veterans Small Business: Veterans have multiple options for their path toward a successful transition back to civilian life. The path of higher education and training is supported by programs like the GI Bill and VR&E, and the path to immediate employment is supported by Department of Labor. Considerably fewer government resources exist for veterans seeking entrepreneurship. The VFW strongly believes veterans aspiring to be

business owners should be supported.

An issue the VFW feels needs to be addressed is the federal protection status upon death of a disabled veteran business owner under the Service-Disabled Veteran-Owned Small Businesses contracts. The VFW urges Congress to amend penalties pertaining to misrepresentation of these contracts to a reasonable period of time longer than five years. This must be done to allow families of recently deceased disabled veterans to maintain their small businesses in local communities.

USERRA: The VFW has long pointed out that many service members, veterans and their employers fail to understand their most basic rights and responsibilities under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Not knowing these legal rights causes many service members to unknowingly waive them by signing binding arbitration agreements upon employment. To change this, Congress must create a USERRA exemption for such agreements. We must also better educate veterans on their rights, and equip both service members and employers to understand USERRA.

Finally, The VFW has long supported veterans' hiring preferences within the federal workforce. At a time of federal hiring freezes and budget constraints, The VFW believes Congress must ensure the federal government serves as a model employer of veterans, working proactively to recruit, hire and retain the best possible veteran recruits.

POW/MIA Full Accounting Mission

In closing, I would be remiss if I did not mention how important America's POW/MIA mission is to the VFW and our nation's veterans, service members and families everywhere. It is a mission—it is a promise to those serving in uniform today—that no matter what, we will travel to the ends of the Earth to recover and return you home to your families.

The VFW's support of the Full Accounting Mission is 100 percent. We will always support full mission funding and personnel staffing for the Defense POW/MIA Accounting Agency and its supporting agencies, such as the Armed Forces DNA Lab and the military service casualty offices. We also seek your support to increase the necessary resources to expand recovery operations into North Korea—if and when it becomes safe to do so.

Recovering fallen Americans from long-ago battlefields is demanding and dangerous work, but it is the most sacred of missions. It is our government's fulfillment of a soldier's pledge to never leave a fallen comrade on the battlefield, which is a promise that spans all generations. I know supporting this mission is something we can all agree on.

In closing, I want to thank you again for the opportunity to represent America's largest war

organization today, and I look forward to any questions you may have.

[1]*Traditional Aggregate Spreadsheet; Monday Morning Workload Reports, February 1, 2016 and January 30, 3017. These numbers include compensation, pension and burial benefits as well as appeals pending in VA regional offices. Education claims are not included in these numbers due to their extreme seasonal volatility.*