MOAA™
Military Officers Association of America

STATEMENT

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA

LEGISLATIVE PRIORITIES

for

VETERANS' HEALTH CARE and BENEFITS

1st Session, 114th Congress

before the

SENATE and HOUSE VETERANS' AFFAIRS COMMITTEES

May 20, 2015

Presented by

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EXECUTIVE SUMMARY

VETERANS' HEALTH CARE

Assured Access to Health Care and Capacity Building

- Assure aggressive implementation of the Veterans Access, Choice and Accountability Act of 2014 to ensure eligible veterans who request outside care are referred in a timely, professional manner.
- Support initiatives to deliver mental health services, including rural tele-health, seamless referral of high-risk service members to VA providers prior to discharge.
- Expand and improve suicide prevention outreach and screening for veterans, including members of the Reserve Components.
- Assure sufficient resources for VA to train and educate community mental health providers on the unique cultural needs and expectations of military veterans.
- Work to resolve discrepancies in VA and DoD reporting of military sexual assaults of service women and men and ensure VA-DoD military sexual assault/sexual assault prevention measures and care coordination provide positive outcomes to individuals seeking support.
- Build on initiatives to assure women veterans receive appropriate, quality and equitable medical and support services, focusing on expanding community relationships to establish strong networks for women veterans seeking healthcare, employment, financial counseling and housing.
- Extend the final report deadline of the Commission on Care established in Section 202 of the VACAA from "not later than 180 days after the date of the initial meeting of the Commission" to "12 months."

Seamless Transition and Accountability

- Demand completion of a DoD-VA Integrated Electronic Health Record (iEHR) as soon as possible.
- Ensure accountability and standardization of the VA and DoD wounded warrior policies and programs, and sustain funding for program execution, research, staffing, and other resource requirements to achieve seamless transition between the DoD and VA systems.
- Ensure greater collaboration and standardization of VA and DoD resource sharing programs.
- Oppose proposals that would combine VA and the Military Health Care System/TRICARE on the premise of creating efficiencies or alleged cost-savings to accommodate budget pressures from the federal deficit or because of the Patient Protection and Affordable Care Act (P.L. 111-148).
- Preserve full funding of VA's health system and ensure an annual independent review of the agency's entire health account by the Government Accountability Office.
- Support additional funding for collaborative, mid-long-term research between VA and DoD with emphasis on mental-behavioral and physical health, including catastrophic injuries and long-term disability care and support services.
- Oppose higher drug co-payment fees for VA services.
- Extend eligibility for the Caregiver Support Program to caregivers of veterans of all eras.
- Authorize adult children of survivors entitled to CHAMPVA to be carried on their parent's insurance up to age 26.

Veterans Independent Budget for FY 2016 – 2017

- Implement the major recommendations associated with the IB's "critical issues" in the FY 2016 – 2017 Report

VETERANS' BENEFITS

Advance Appropriations

- Extend two-year advance appropriations authority to all VA accounts.

Disability Claims and Backlog

- Initiate review and implementation of best practices in case management to improve efficiency and monitor initiatives directed at improving quality and accuracy.
- Require VA to assess and report its capacity to handle current and future claims volume, in terms of staffing levels and administrative support including IM / IT capabilities.
- Monitor employee performance standards and work-credit system, and support adequate incentives for quality and accuracy, not just production quotas.
- Monitor relationships between VA and other federal agencies to ensure that records necessary to deciding claims are exchanged in a timely manner and protected from loss or destruction.
- Ensure that the Veterans Benefits Management System (VBMS) is provided resources to develop into a comprehensive, paperless, and rules-based platform.
- Ensure that the VBA is given sufficient staffing to meet the rising demand on claims from veterans after 13 years of conflict.
- Require VA to provide standardized and targeted training to employees, and test all employees on the skills, competencies, and knowledge required to do their jobs.
- Continue and expand national "challenge" training as well as VA training for veterans' service organization representatives to ensure that veterans' claims are developed to their optimum.
- Authorize service connection for "blue water" Navy Vietnam veterans who contract a VA-listed disease presumed caused by exposure to Agent Orange.
- Authorize Agent Orange presumption for USAF C-123 veterans who handled and shipped the defoliant to Vietnam. A recent Institute of Medicine Report (IOM) confirmed their exposure.
- Provide greater focus on non-ratable claims (such as dependency claims) as well as appeals.
- Improve access to National Guard / Reserves medical records.
- Consider and favorably report out bi-partisan Senate legislation (Senators Heller and Casey) to improve the VA claims processing system.

Joint VA/DoD Integrated Disability Evaluation System (IDES) Program

- Conduct a joint oversight hearing with the Armed Services Committees to review the IDES program and VA's other pre-discharge programs – Benefits Delivery at Discharge and Quickstart - and evaluate what more may need to be done to support our wounded warriors as they transition to civilian life.
- Direct the Department of Veterans Affairs to work with the Departments of Defense, Homeland Security, Health and Human Services and Commerce to enable U.S. Coast Guard, U.S. Public Health Service Officers and NOAA Corps officers, respectively, to have access to the IDES program.

Veteran Transition, Readjustment and Employment

- Re-authorize the VOW to Hire Heroes Act including the Veterans Retraining Assistance Program (VRAP) to support older veterans' re-integration in the workforce.
- Require all service members going through the improved Transition Assistance Program (TAP) "GPS" to take the education track in order to gain a basic understanding of training and education opportunities available to them under the Post-9/11 GI Bill.
- Re-authorize the additional Vocational Rehabilitation and Employment provisions in the VOW to Hire Heroes Act to support the accelerated drawdown of service members under sequestration.

GI BILL PROGRAMS

Oversight, Outcomes, Transparency

- Expand the VetSuccess On Campus program and make the application / selection process transparent.
- Amend the educational counseling provisions in Chapter 36, 38 U.S. Code to mandate such counseling via appropriate means, including modern technologies, and permit veterans to opt out. Raise the $6 million cap in the counseling provision to meet the enormous demand of new GI Bill enrollments.
- Require all academic programs receiving funding under the GI Bill be Title IV compliant under Department of Education rules.

Education Recommendation (#11) of the Military Compensation and Retirement Modernization Commission Report

- Authorize sunsetting the Montgomery GI Bill – Active Duty (Chapter 30, 38 USC) and the Reserve Educational Assistance Program (REAP) (Chapter 1607, 10 USC) as recommended by the MCRMC.
- Consolidate GI Bill programs under a single platform in Title 38 structured under a principle of scaling benefits according to the length and type of service performed:
    - Recruits who initially enter the National Guard and Reserve would receive the lowest benefit level.
    - Reservists called to active duty (Title 10) for aggregates of 90 days or more would receive a portion of the new GI Bill (Chapter 33, 38 USC) as currently authorized.
    - Service members who complete 36 months of qualifying active duty would receive the maximum benefit under Chapter 33.
    - To achieve seamless integration of GI Bill programs the MGIB-Selected Reserve should be re-codified from Chapter 1606, 10 USC and embedded as a sub-chapter in Chapter 33, 38 US Code.
    - Reservists in medical hold status (Section 12301(h), 10 USC) should continue to earn new GI Bill entitlement during such service
- Oppose MCRMC recommendation to terminate the housing stipend portion of GI Bill service extension contracts for benefit transfers signed prior to January 1, 2017.

SURVIVORS' and DEPENDENTS' BENEFITS

Survivors' Fry Scholarship Usage Period

- Extend the usage period under the Survivors' Fry Scholarship program from 15 – 20 years or authorize other means for beneficiaries using the program to take full advantage of their benefits.

Dependency and Indemnity Compensation (DIC) Equity

- Establish the annual DIC rate at 55% of the compensation rate for a 100% service-connected veteran.

Caregivers of Catastrophically Disabled Veterans

- Increase the income replacement rate for survivors of catastrophically disabled veterans.

Retain DIC on Remarriage at Age 55

- Establish age-55 for retention of Dependency and Indemnity Compensation upon the remarriage a surviving spouse thereby bringing the benefit in line with rules for the military SBP program and <u>all</u> other federal survivor benefit programs.

CHAMPVA Dental

- Allow survivors qualified for CHAMPVA health care to enroll in a proposed CHAMPVA dental program.

NATIONAL GUARD AND RESERVE VETERANS

Reemployment Rights and the Office of Special Counsel

- Ensure a continuing, robust role for the federal Office of Special Counsel (OSC) on USERRA claims brought by members of the National Guard or Reserve who are federal employees. Recommend an oversight hearing to consider how best to use the OSC to pursue USERRA claims in the Federal workforce in partnership with the Department of Labor – VETS office.

Service members Civil Relief Act (SCRA)

- Enact legislation that would make mandatory arbitration agreements in certain financial contracts unenforceable under the SCRA.
- Authorize civil fines for violations of the SCRA; criminal penalties in egregious cases of violation of the statute; and, recovery of reasonable attorneys' fees by service members from SCRA violators.

Honoring as Veterans Certain Career National Guard and Reserve Members

- Enact legislation to establish that career Reservists eligible for or in receipt of non-regular retired pay, government health care and other earned veterans' benefits, but who never served under active duty orders may be honored as "veterans of the Armed Forces of the United States."

CHAIRMAN ISAKSON, CHAIRMAN MILLER, RANKING MEMBERS BLUMENTHAL AND BROWN, on behalf of the more than 380,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's major legislative priorities for veterans' health care and benefits this year.

MOAA does not receive any grants or contracts from the federal government.

VETERANS' HEALTH CARE

Assured Access to Health Care and Capacity Building

MOAA is grateful to the Committees and Congress for unwavering support of our nation's veterans over the longest protracted conflicts in our nation's history. We are grateful, too, for final passage of two key bills: the Veterans Access, Choice and Accountability Act of 2014, or VACAA (P.L. 113-146) and the Clay Hunt Suicide Prevention for American Veterans (SAV) Act (P.L. 114-2). These laws represent an important step in addressing the tremendous toll on our veterans their families.

Mental Health Care and Suicide Prevention. While a number of significant initiatives and programs have been put in place to address the physical and mental health and wellness of our troops, veterans and family members, we are still losing far too many individuals to suicides-- arguably the most critical health care issue facing leaders today at all levels in the VA.

MOAA requests the Committees build upon the Clay Hunt SAV Act by directing the VA to develop and implement a comprehensive set of measures to evaluate mental health care services furnished by the Department, including measures to assess the:

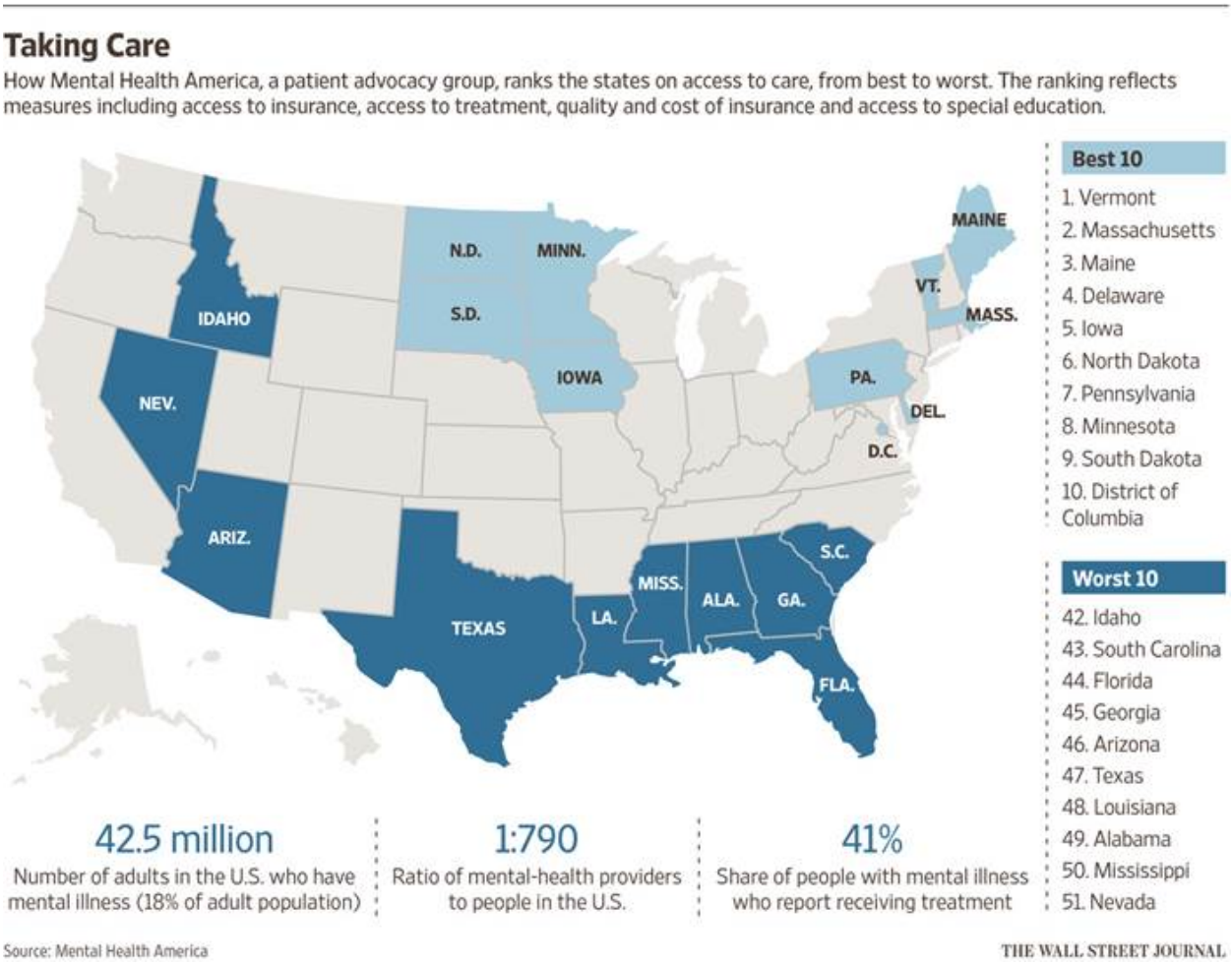
- Timeliness of mental health care delivery,
- Satisfaction of patients who receive mental health care services,
- Capacity to furnish mental health care, and
- Availability of alternative and complementary evidence-based therapies.

The VA has made steady progress in hiring additional providers across the health care spectrum in order to improve access to health care and services, to reduce wait times, enhance quality of health care, and to identify and reach at-risk veterans. But more needs to be done.

The entire country is struggling with a lack of available and accessible specialty and mental-behavioral health providers.

A recent *Wall Street Journal* article (February 16, 2015) illustrated the fact that access to mental-health providers is uneven across the country. Many veterans are locating to areas that have insufficient numbers of these providers.

[Graphic follows on p. 7]



Congress and VA must remain committed to doing all that is possible to explore ways to increase the number of providers across the country through additional education incentives, reimbursement programs for medical and mental health treatment, and ultimately to establish parity in care for physical and mental health conditions.

Community Mental Health Providers Need Training. A critical aspect of improving mental health care access for our veterans is awareness of their unique needs. Most community-based mental health providers are not well prepared to take care of the special needs of veterans according to a recent study (Dec. 2014) by the RAND Corporation that was commissioned by the United Health Foundation in collaboration with MOAA.

Based on a national survey of mental health providers, RAND found few community-based providers met criteria for military cultural competency or used evidence-based approaches to treat problems commonly seen among veterans.

MOAA believes it's crucial that civilian mental health providers acquire the training and perspective they need to guide their practice in the care of our military and veteran population. The RAND study recommends organizations that maintain registries or care provider networks include information about mental health practitioners' ability to properly treat the special needs of military and veteran populations.

Women Veterans. Today, women veterans represent 10 percent of the total 22 million U.S. veteran population—a segment that is expected to grow by nearly 18 percent by 2040. According to the VA, women make up about 15 percent of the veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn. This is a huge demographic shift for the VA—one that requires immediate and sustained attention.

More than 61% of Post-9/11 women veterans receive health care in the VA. The most frequent medical diagnoses include musculoskeletal conditions, mental health disorders, nervous system conditions, genitourinary, digestive system, endocrine and metabolic disorders and respiratory conditions. The top three mental health conditions for women include PTSD, hypertension and depression. Unfortunately, about 1 in 5 women seen in VA medical facilities screen "yes" for military sexual trauma (MST).

Choice Card. Veterans who have been waiting for care for more than 30 days or who live more than 40 miles driving distance – a recent change from geographic distance – from the nearest VA facility may request outside care by calling a special number on the card and discussing treatment options with a VA-contracted call center. Care scheduled outside the VA comes with limitations on the scope of care, time and other restrictions.

53,828 Choice card authorizations for care and 43,044 appointments have been scheduled through April 25, 2015.

In part because of modest early demand, the administration's budget request for FY 2016 requested standby authority to re-allocate some of the $10 billion provided by Congress for the Choice Card program to other in-house needs. MOAA does not support the request for flexible use of Choice Card funding, though that may be needed at some point.

Some of the factors we believe may be impinging on Choice card demand include:

- Veterans' preference for "one-stop" care directly from the VA;
- A lack of community-based providers, especially specialty care, in small or rural communities;
- Insufficient outreach and marketing of the Choice Card program to providers, veterans and VA employees;
- A lack of training and information tools for call-center workers;
- Inconsistent support by the VA across all networks for the Choice Card program;
- Gaps in procedures such as reimbursement for civilian Rx written for veterans

Strategic Plan for Purchased Care. MOAA believes the Choice Card program presents a timely opportunity for VA to develop a strategic approach to fee-basis care in the VA.

Outsourced care has been around for years but has not been well-planned or coordinated system-wide, nor tied into an overall strategy to maximize efficient use of VA resources.

The VACAA established a two-step process to improve VA's long range planning process. First, it calls for an independent assessment of VA's health care delivery system. Second, it establishes a Commission on Care to "examine the access of veterans to health care from the Department of

Veterans Affairs and strategically examine how best to organize the VHA, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act."

Related, Ranking Member Brown and Chairman Miller's H.R. 216 establishes in the VA a Chief Strategy Officer to advise the Secretary on long-range planning and implications. It requires the VA to develop a five-year planning, program and budgeting process similar to that used in the DoD; and, requires a quadrennial review of the strategy to meet the nation's commitment to veterans and supporting resource requirements.

MOAA believes the VACAA and H.R. 216 provide an excellent framework for development of an overall strategy for VA health care delivery, including integration of all elements of purchased care: local provider contracts, the Patient Centered Community Care (PC-3) contracts, and the Choice Card program.

MOAA recommends the Committees:

- ***Assure aggressive implementation of the Veterans Access, Choice and Accountability Act of 2014 to ensure eligible veterans who request outside care are referred in a timely, professional manner.***
- ***Support initiatives to deliver mental health services, including rural tele-health, seamless referral of high-risk service members to VA providers prior to discharge.***
- ***Expand and improve suicide prevention outreach and screening for veterans, including members of the Reserve Components.***
- ***Assure sufficient resources for VA to train and educate community mental health providers on the unique cultural needs and expectations of military veterans.***
- ***Work to resolve discrepancies in VA and DoD reporting of military sexual assaults of service women and men and ensure VA-DoD military sexual assault/sexual assault prevention measures and care coordination provide positive outcomes to individual seeking support.***
- ***Build on initiatives to assure women veterans receive appropriate, quality and equitable medical and support services, focusing on expanding community relationships to establish strong networks for women veterans seeking healthcare, employment, financial counseling and housing.***
- ***Extend the final report deadline of the Commission on Care established in Section 202 of the VACAA from "not later than 180 days after the date of the initial meeting of the Commission" to "12 months."***

'Seamless Transition' and Accountability

MOAA is grateful for the Committees' continuing concern to achieve seamless transition of service members into the Department of Veterans Affairs (VA). Thanks to your efforts, significant progress has been made in policy, program, and service enhancements to treat and support our most vulnerable wounded, ill, injured, and disabled populations. Yet, much more remains to be done.

The VA and Department of Defense (DoD) acknowledge they can't meet all the needs of those who have worn the uniform of the country and must rely on community and other partners to complete the mission of successful transition outcomes.

Veterans, military members, and their families often voice concern and frustration navigating the VA and DoD bureaucracies. For example, after initial high-level attention, the departments relegated oversight of wounded warrior care coordination to lower levels of their respective organizations.

The Military Compensation and Retirement Modernization Commission (MCRMC) report (January 2015) highlighted the deficiency in departmental coordination and recommended "improved collaboration between the DoD and VA by enforcing coordination on electronic medical records, a uniform formulary for transitioning service members, common services, and reimbursements." This echoes MOAA's longstanding concern over DoD-VA collaboration shortfalls on a number of fronts.

We believe strongly that VA and DoD collaboration is not only vital to achieving seamless transition, an institutional state the Committees have worked vigorously to achieve for over a decade, but is also crucial to the long-term sustainability of the All-Volunteer Force (AVF), as well as our sacred duty as a nation.

Integrated Electronic Health Record (iEHR). One particularly disappointing area is the inability of VA and DoD to develop and implement a truly interoperable, joint iEHR. As in years past, this initiative continues to be stymied by bureaucratic and systemic issues such as the desire to maintain individual technology systems, policies and requirements, leaving providers and patients frustrated and limiting the capability of delivering continuity of care while increasing potential health risks to our veteran population.

With further expansion of VA purchased care programs and contracts, it is more essential than ever that providers, in and outside these health systems, have the essential information to care for veterans and service members. With the enormous demand for mental health care and other medical services arising from the drawdown of forces, interoperability, collaboration, and communication are especially important to break the rising number of suicides among veterans, and address the growing need for mental-behavioral health services.

MOAA feels strongly that an iEHR should remain a top priority on Congress' agenda. We urge the committees and Congress to hold the VA and DoD Secretaries accountable for achieving full interoperability of medical records. We believe the iEHR is central to achieving long-lasting transformation and modernization goals.

MOAA recommends the Committees demand completion of a DoD-VA integrated Electronic Health Record (iEHR) as soon as possible.

VA-DoD Resource Sharing. The MCRMC report also identified issues related to resource sharing between the departments. The commission "found numerous, ongoing weaknesses exist in joint collaboration and cost-effectiveness between the care services of VA and DoD."

The commission noted inconsistencies in collaboration and non-standardized health policies and practices in such areas as formulary schedules and drug purchasing; billing, payment, expenditures, and reimbursement; contract/agreement negotiations; and construction management.

MOAA supports improved collaboration and standardization in the two resource sharing programs. While we would likely consider supporting a standard formulary system, we would however insist that VA use the Defense Department's list of formulary drugs to ensure service members transitioning out of the military are able to continue their medications seamlessly, rather than be restricted by the more limited list of drugs currently available in VA's formulary schedule.

MOAA is concerned about the impact of the Patient Protection and Affordable Care Act (P.L. 111-148) on VA's health system and beneficiaries. Some may see the implementation of the law as an opportunity to consolidate or dismantle the VA health care system. MOAA strongly supports preservation of the VA health care system to meet the unique needs of those who have borne the battle.

MOAA's recommends the Committees:

- ***Ensure accountability and standardization of the VA and DoD wounded warrior policies and programs, and sustain funding for program execution, research, staffing, and other resource requirements to achieve seamless transition between the DoD and VA systems.***
- ***Ensure greater collaboration and standardization of VA and DoD resource sharing programs.***
- ***Oppose proposals that would combine VA and the Military Health System/TRICARE on the premise of creating efficiencies or alleged cost-savings to accommodate budget pressures from the federal deficit or as a consequence of the Patient Protection and Affordable Care Act (P.L. 111-148).***

CHAMPVA Young Adult. The Patient Protection and Affordable Care Act (P.L. 111-148) established that adult children may be carried on their parents' insurance up to age 26 under specific circumstances. All other health plans now authorize such coverage, including TRICARE and the Federal Employee Health Benefit plan. For young adults up to age 26 who could be carried on their CHAMPVA-eligible surviving parents' coverage, a technical correction to Title 38 is needed. ***MOAA urges the committees to favorably report out S. 170 (Senator Tester, D-MN), H.R. 218 (Ranking Member Brown, D-FL), and H.R. 220 (Rep. Fortenberry, R-NE).***

MOAA's recommends the Committees:

- **Preserve full funding of VA's health system and ensure an annual independent review of the agency's entire health account by the Government Accountability Office.**
- **Support additional funding for collaborative, mid-long-term research between VA and DoD, with emphasis on mental-behavioral and physical health, including catastrophic injuries and long-term disability care and support services.**
- **Oppose higher drug co-payment fees for VA services.**
- **Extend the eligibility for the Caregiver Support Program to caregivers of veterans from all eras. (MOAA strongly supports S. 1085, a bipartisan bill sponsored by Senators Murray (D-WA) and Collins (R-ME)).**

Veterans Independent Budget. MOAA is a strong proponent of the Veterans' Independent Budget (IB) for Fiscal Years 2016-2017. Our staff regularly consults with our partners in the Veteran Service Organization community. We urge the committees to carefully consider the IB's recommendations in deliberating VA budget requirements, especially in the areas highlighted in our below listed recommendations.

VETERANS BENEFITS

VA Advance Appropriations

MOAA is grateful to the committees and Congress for extending advance appropriations authority to veterans benefits programs in the FY 2015 Appropriations Act. This change in law will ensure that

beginning in fiscal year (FY) 2016, veterans and military families have certainty in the benefits they've earned and deserve, regardless of shutdowns or gridlock in Congress.

Advance funding provides certainty for veterans benefits including compensation for illnesses and injuries while serving in the military such as combat wounds, hearing loss and PTSD. It also assures advance funding of pensions for those permanently disabled while serving in the military, education benefits including the new G.I. Bill, and spousal support for deceased veterans.

To assure coordinated service delivery year-over-year to our nation's veterans, MOAA recommends the Committees consider extending two-year advance appropriations authority to all VA accounts.

Disability Claims and Backlog

MOAA continues to support a comprehensive, integrated strategy for improving the claims-management system with primary emphasis on quality decisions at the initial stage of the process.

The VA is to be commended for significant progress in attacking the claims backlog despite an enormous increase in the number of claims filed by veterans and more "issues" within each claim.

However, despite a coordinated attack plan, it seems doubtful the VA will eliminate the claims backlog this year as the Department had projected.

VA defines the backlog as initial claims awaiting decision for more than 125 days. Commendably, the backlog has dropped from 611,073 in March 2013 to 161,519 (as of May 2, 2015), a 73.5% reduction. Claim-based accuracy has improved slightly over the past year from 89% to almost 91%.

Several initiatives, such as clearing out the oldest claims inventory, encouraging fully developed claims, and national training, have reduced the pending claims inventory.

To continue the progress made to date and approach VA's goal of ending the backlog of initial claims in 2015, investments in "people, process, and technology" must continue.

Simplifying claims regulations, getting results faster in claims processing, and using best practices in claims management must continue so that VA is prepared for current and future claims demand. At the same time, the VA must ensure that faster results don't impede quality decision making.

- *Simplify the claims process*. Making the claim process simpler for veterans, family members, VSOs, and VA together
    - Fully implement "digit to digit" technologies, which eliminates re-keying of claims by VSOs.
    - Streamlining claims for survivors whose spouse would qualify for DIC based on how long the veteran has received a 100% VA rating (38 USC § 1318 sets 10 years, but could be less if veteran left service less than 10 years ago).
    - Outreach to survivors who qualify for eBenefits accounts, and extending eBenefits accounts if there are some survivors who can't sign up for one, to allow them better access to assistance from the VA.

- *Identify presumptions that would help expedite claims* – examples include conditions secondarily related to TBI and extending Agent Orange presumption to USAF C-123 veterans.
- *Medical records.* Communicating exactly which records are submitted from DoD to VA electronically, and "federalizing" deployment health records of the Guard and Reserve. For example, we understand that deployed health records are kept separately from the rest of the Service Treatment Record, so that portion, when the service member is on active duty, could be sent to VA.
- *Veterans Benefits Management System (VBMS).* Workload management tools like VBMS need to be VSO friendly to ensure electronically-processed claims are promoted.
- *Communications.* Consistent communications by VA to VSOs and veterans (incorporates issues as disparate as remote access, getting good information over the telephone, responses to FOIA requests, etc.).
- *Surge capacity.* VA should report on its ability to plan for future claim surges in terms of its support for IT, Full-time Equivalent Employees (FTEs), and contracted employees.
- *TAP Engagement*. Support increased VSO involvement in TAP GPS.

By identifying best practices in claims management among high-performing regional offices, VA will ensure consistency in its decisions, leading to greater trust of the system and easier identification of systemic problems.

In concert with standardized and specialized training, simplification of VA regulations and policies would enable veterans working with their VSO to understand the evidence necessary to decide their claim and increase accuracy and efficiency.

Now that VA is tracking both issue-based and claim-based accuracy, it should become apparent which types of decisions are creating problems or are delayed due to unclear evidence requirements. For example, one of the most complicated types of claims to rate is residuals of traumatic brain injury. When policy was clarified and 22 hours of training was mandated, the accuracy level of these claims increased to greater than 92%.

MOAA recommends the committees:

- ***Initiate review and implementation of best practices in case management to improve efficiency and monitor initiatives directed at improving quality and accuracy.***
- ***Require VA to assess and report its capacity to handle current and future claims volume, in terms of staffing levels and administrative support including IM and IT capabilities.***
- ***Monitor employee performance standards and work-credit system, and support adequate incentives for quality and accuracy, not just production quotas.***
- ***Monitor relationships between VA and other federal agencies to ensure that records necessary to deciding claims are exchanged in a timely manner and protected from loss or destruction.***
- ***Ensure that the Veterans Benefits Management System (VBMS) has resources to develop into a comprehensive, paperless, and rules-based platform.***
- ***Ensure that the VBA receives sufficient staffing to meet the rising demand on claims from veterans after 13 years of conflict.***
- ***Require VA to provide standardized and targeted training to employees, and test all employees on the skills, competencies, and knowledge required to do their jobs.***
- ***Continue and expand national "challenge" training as well as VA training for veterans' service organization representatives to ensure that veterans' claims are developed to their optimum.***

- ***Authorize service connection for "blue water" Navy Vietnam veterans who contract a VA-listed disease presumed caused by exposure to Agent Orange. Favorably report out H.R. 969 (Rep. Gibson, R-NY) and S. 681(Sen. Gillibrand, D-NY).***
- ***Authorize Agent Orange presumption for USAF C-123 veterans who handled and shipped the defoliant to Vietnam. A recent Institute of Medicine Report (IOM) confirmed their exposure.***
- ***Provide greater focus on non-ratable claims (such as dependency claims) as well as appeals.***
- ***Improve access to National Guard / Reserves medical records***
- ***Consider and favorably report bi-partisan Senate bill, S. 1203 sponsored by Senators Heller (R-NV) and Casey (D-PA to improve the processing of VA claims and further reduce the backlog.***

Joint VA/DoD Integrated Disability Evaluation System (IDES) Program

The VA-DoD Integrated Disability Evaluation System (IDES) is intended to simplify the process for disabled service members transitioning to veteran status, improve the consistency of disability ratings, and improve customer satisfaction. IDES operates at 139 Military Treatment Facilities (MTFs) worldwide and covers 100 percent of service women and men referred to Medical Evaluation Boards for fitness determinations.

VA's strategic goal for the IDES program is to award disability benefits to qualifying service women and men within 30 days of discharge from military service. VA seeks to close the gap between final military pay and receipt of VA compensation under the program.

Last year, the VA made only modest progress in delivering on its stated goal.

The VA's *Performance and Accountability Report for 2014* shows that the number of IDES participants receiving benefits within 30 days of separation rose from 16% in 2013 to 35% in 2014 (p. 42). In itself, that's a 100% gain in performance, but is well short of the VA's target of 68% of IDES participants getting benefits within 30 days of separation.

The report notes the conversion of IDES processing to a paperless environment and actions to "reduce rework" at IDES activity sites.

In the previous *Performance and Accountability Report (2013)*, the VA reported that vocational rehabilitation and employment (VR&E) counselors had been placed at 75 IDES locations as of the end of 2013 to support service members' transition into meaningful civilian careers. The current report, however, is silent on whether VR&E counselors have been allocated to more MTFs or whether some counselors cover more than one MTF.

Overall VR&E participation dropped to 123,223 in 2014, compared to 135,815 in 2013, a 9.3% reduction. The decline seems to suggest that VR&E counselors have not been deployed to many more MTFs.

MOAA remains concerned about access to the IDES by wounded and ill members of the National Guard and Reserve, who in some cases are advised to bypass the IDES and to take their service-related conditions directly to the VA after separation.

MOAA recommends that the Committees conduct a joint oversight hearing with the Armed Services Committees to review the IDES program and VA's other pre-discharge programs – Benefits Delivery at Discharge and Quickstart - and to evaluate what more may need to be done to support our wounded warriors as they transition to civilian life.

MOAA also recommends the Committees direct the Department of Veterans Affairs to work with the Departments of Defense, Homeland Security, Health and Human Services and Commerce to enable U.S. Coast Guard, U.S. Public Health Service Officers and NOAA Corps officers, respectively, to have access to the IDES program.

Veteran Transition, Readjustment and Employment

MOAA recommends the Committees:

- ***Re-authorize the VOW to Hire Heroes Act, which expired on Dec. 31, 2013.***
- ***Require all service members undertaking the improved Transition Assistance Program (TAP) "GPS" to take the education track to ensure a basic understanding of training and education opportunities available to them under the Post-9/11 GI Bill.***
- ***Vocational Rehabilitation and Employment (VR&E) – Re-authorize the additional VR&E provisions in the VOW to Hire Heroes Act to Dec. 31, 2017 or later to support the accelerated drawdown of service members under sequestration.***

GI BILL PROGRAMS

MOAA is very grateful to Chairman Miller for his leadership in championing legislation to establish in-state tuition rates for non-resident student veterans enrolled in public colleges and universities. Chairman Miller's bipartisan bill was included as a provision in the Veterans Access, Choice and Accountability Act (P.L. 113-146) signed into law on Aug. 7, 2014.

MOAA also was pleased to see that the VA, in collaboration with other federal agencies, created GI Bill comparison and complaint tools to aid veterans in making informed decisions before using their benefits and, if necessary, reporting any problems experienced with their education or training program or the administration of their benefit.

MOAA recommends the Committees:

- ***Expand the VetSuccess on Campus program and make the application and selection process transparent. In 2013, VetSuccess expanded to 94 campuses from 32 the previous year. The program should be ramped up as rapidly as possible so that more veterans can get academic and career counseling support.***
- ***Amend the educational counseling provisions in Chapter 36, 38 U.S. Code to mandate such counseling via appropriate means, including modern technologies, and permit veterans to opt out. Raise the $6 million cap in the counseling provision to meet the enormous demand of new GI Bill enrollments.***
- ***Require that all academic programs receiving funding under the GI Bill be Title IV compliant under Department of Education rules. The FY 2014 National Defense Authorization Act (P.L. 113-66) includes provisions mandating Title IV compliance for DoD educational assistance programs for service members and their spouses.***

Towards A 21st Century GI Bill Architecture

The Military Compensation and Retirement Modernization Commission (MCRMC) Final Report cited earlier offered a set to recommendations to streamline GI Bill programs. The MCRMC recommendations are consistent with longstanding MOAA priorities to address educational benefit programs overlap and duplication.

The MCRMC found that "Education benefits are strong recruiting and retention tools. The 2014 Blue Star Families Military Family Lifestyle Survey determined that approximately 74 percent of Service member respondents indicated they joined the military to receive educational benefits. The number of veterans using GI Bill benefits increased 67 percent, from 564,487 to 945,052 students, between FY 2009 and FY 2012."

The MCRMC concluded: "Duplicative education assistance programs should be sunset to reduce administrative costs and to simplify the education benefit system. Both MGIB and REAP provide similar benefits to the Post-9/11 GI Bill. Yet Service members are enrolling and paying $1,200 for MGIB, while the Post-9/11 GI Bill is a more valuable benefit for most Service members because there is no enrollment or fees. REAP and the Post-9/11 GI Bill both provide education benefits to activated RC members. Sunsetting MGIB-AD and REAP would also be consistent with historical implementation of new educational programs. **In the past, when GI Bills were created, they replaced existing benefits. Such replacement did not take place when the Post-9/11 GI Bill was enacted."** (Emphasis added).

The MCRMC's major recommendations on a cohesive GI Bill platform are consistent with MOAA's own views expressed to the Committees during the joint hearings over many years.

Unfortunately, the MCRMC fails to address the need to integrate the MGIB – Selected Reserve under a single GI Bill platform, another longstanding MOAA recommendation.

Benefits authorized under the MGIB – SR (Chapter 1606, 10 USC) were last raised in 1999, except for annual COLAs. Over the past 16 years, the apparent reason for the steep drop in the MGIB – SR's educational buying power (compared to the MGIB-Active Duty) is that program funding competes with annual National Guard and Reserve discretionary pay and benefits accounts.

Since 1999, MGIB-SR rates benefits have plunged from nearly 50 cents to the dollar compared to MGIB-AD rates to less than 22 cents to the dollar.

MOAA questions the recruitment value of a benefit that continues to offer less and less incentive to join the Guard or Reserves.

MOAA endorses the MCRMC Report on GI Bill consolidation and recommends that the new GI Bill be structured under a principle of scaling benefits according to the length and type of service performed.

- ***Recruits who initially enter the National Guard and Reserve would receive the lowest benefit level.***
- ***Reservists called to active duty (Title 10) for aggregates of 90 days or more would receive a portion of the new GI Bill, as is currently authorized.***
- ***Service members who complete 36 months of qualifying active duty would receive the maximum benefit.***
- ***To achieve a streamlined GI Bill, REAP and the MGIB- AD should be sunset and the MGIB-SR should be re-codified from Chapter 1606, Title 10 to Chapter 33, 38 US Code.***
- ***Reservists in medical hold status (Section 12301(h), 10 USC) should continue to earn GI Bill entitlement during such service as their active component counterparts do.***

GI Bill Transferability. The MCRMC Report also recommends cancelling the housing stipend for dependents who have received transferred benefits in conjunction with a service extension or reenlistment contract.

MOAA recommends the DoD and the Armed Services Committees examine the career retention aspect of GI Bill transferability policies.

MOAA strongly opposes the MCRMC proposal to terminate the housing stipend portion of existing GI Bill transfer contracts as that would break faith with military families who have earned that benefit in exchange for agreeing to serve 10 years in the Armed Forces under current DoD transfer policies.

SURVIVORS' and DEPENDENTS' BENEFITS

Survivors' Educational Benefits. MOAA is very grateful to the Committees and Congress for enactment of Fry Scholarships for surviving spouses of those who died in the line of duty after Sept. 10, 2001.

This long-sought MOAA legislative priority was included as a provision in the Veterans Access, Choice and Accountability Act (P.L. 113-146) and signed into law on Aug. 7, 2014. As of Jan. 1 this year, eligible surviving spouses may enroll in any public college or university program or employment training program at very low or no cost and receive a housing allowance and an annual book stipend to help them prepare for a career.

Some eligible survivors lost their military spouse more than ten years ago in Iraq or Afghanistan. They will have only a few years to complete their studies under the Fry Scholarship before the 15-year usage period tolls.

MOAA recommends that the Committees extend the usage period under the Survivors' Fry Scholarship program from 15 – 20 years or authorize other means for beneficiaries using the program to take full advantage of their benefits.

Dependency and Indemnity Compensation (DIC) Equity. DIC is set at a flat rate for all eligible beneficiaries. MOAA believes the DIC rate should be pegged at the same percentage as survivors of disabled civil service employees. Their compensation is set at 55% of their disabled retirees' compensation for federal workers. The GAO report on Military & Veterans' Benefits (GAO 10-62) found that *"DIC payments are almost always less than workers' compensation payments for survivors of federal employees who die as a result of job-related injuries."* ***MOAA supports establishing the annual DIC rate at 55% of the compensation rate for a 100% service-connected veteran.***

Caregivers of Catastrophically Disabled Veterans. Catastrophically disabled veterans, whose spouses serve as primary care givers, receive additional allowances due to the severity of their service-connected multiple disabilities. These full-time caregivers, however, are precluded from earning a retirement or Social Security benefits in their own right. When the veteran dies, the survivor's income is reduced to the same DIC rate that other surviving spouses of veterans receive when the death was service connected. The percentage of replacement income can be as little as 15%. The income replacement of other federal survivor benefit plans is close to 50% of the benefit upon which they are based. ***MOAA recommends the committees increase the income replacement rate for survivors of catastrophically disabled veterans.***

Retain DIC on Remarriage at Age 55. Legislation enacted in 2003 allows eligible military survivors to retain DIC upon remarriage after age 57. Congressional staff advised MOAA at the time that the only reason age-57 was chosen was due to insufficient funds, not for any policy purpose. ***MOAA recommends legislation to authorize retention of DIC upon remarriage at age 55. That would align the benefit with all other federal survivor benefit programs.***

CHAMPVA Dental. ***MOAA supports permitting survivors qualified for CHAMPVA health care to enroll in a CHAMPVA dental program. If modeled on the TRICARE Retiree Dental Plan, this proposal would have no PAYGO requirement since it would be fully funded by enrollees' premiums.***

NATIONAL GUARD AND RESERVE VETERANS

National Guard and Reserve members straddle the demands of military service and civilian commitments. Dual-status veterans toggle between more frequent activations, civilian employment, career management challenges, and increased military training requirements while continuing to serve in the National Guard or Reserves. All the while, they strive to maintain a quality family life.

907,176 Guard and Reserve members (as of Mar. 31, 2015), have served on operational active duty since Sept. 10, 2001 and roughly 350,000 have served multiple tours. Sustained reliance on citizen-warriors for more than 13 years has no precedent in American history. Reliance on the operational reserve is likely to continue after the Afghanistan conflict, albeit at a reduced level.

With the drawdown of the active force, the Guard-Reserves will constitute more than 50% of the nation's military capability. Moreover, Congress enacted a new call-up authority in the FY 2012 National Defense Authorization Act that permits the services to call up as many as 60,000 reservists for up to one year to perform pre-planned, budgeted missions without a national emergency declaration.

Ever greater reliance on the Reserves means that it will be critical for the Congress to ensure that reservists' re-employment rights after call-ups are robust, transparent to all stakeholders and vigorously enforced. Similarly, personal financial protections need to be updated to reflect the sea change in the use of the G-R in our armed forces.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Pending legislation in the last session of Congress provides a framework for the Committees' consideration of upgrades to the USERRA.

These changes would:

- Allow the United States to serve as a named plaintiff in all suits filed by the Attorney General, while preserving the right of the aggrieved person to intervene in such suits, or to bring their own suits where the Attorney General has declined to file suit. It would also allow the Attorney General to investigate and file suit to challenge a pattern or practice in violation of the USERRA.

- Allow for the suspension and debarment of federal contractors that repeatedly violate the rights of members of the uniformed services provided for under USERRA.

- Provide the Special Counsel with authority to subpoena attendance, testimony, and documents from federal employees and federal executive agencies in order to carry out investigations related to USERRA.

- Authorize the Attorney General to issue civil investigative demands in investigations under USERRA. It would not include the authority to compel oral testimony or sworn answers to interrogatories.

MOAA continues to support a robust role for the federal Office of Special Counsel (OSC) on USERRA claims brought by members of the National Guard or Reserve who are federal employees. We recommend an oversight hearing to consider how best to use the OSC to pursue USERRA claims in the Federal workforce in partnership with the Department of Labor – VETS office.

Service members Civil Relief Act (SCRA)

Forced Arbitration Clauses. MOAA and our partners in The Military Coalition (TMC) wrote to Senators Lindsey Graham (R-SC) and Jack Reed (D-RI) in the last session of Congress expressing our collective support for their bipartisan bill on "forced arbitration."

The senators' legislation would have guaranteed that our military service members can enforce the rights already granted to them under the SCRA.

A 2006 DoD report concluded: "Service members should maintain full legal recourse against unscrupulous lenders. Loan contracts to Service members should not include mandatory arbitration clauses or onerous notice provisions, and should not require the Service member to waive his or her right of recourse, such as the right to participate in a plaintiff class. Waiver isn't a matter of 'choice' in take-it-or-leave-it contracts of adhesion" (Department of Defense, 2006).

Congress has already passed laws to ban forced arbitration for disputes brought by auto dealers; certainly our nation's service members should be afforded the same protections on other types of contracts.

MOAA supports legislation that would make mandatory arbitration agreements in certain financial contracts unenforceable under the SCRA.

MOAA also recommends the Committees endorse legislation that would impose civil fines for violations of the SCRA; criminal penalties in egregious cases of violation of the statute; and, recovery of reasonable attorneys' fees by service members from SCRA violators.

Honoring as Veterans Certain Career National Guard and Reserve Members

National Guard and Reserve members who complete a full Guard or Reserve career and are receiving or entitled to a military pension, government health care and certain earned veterans' benefits under Title 38 are not "veterans of the Armed Forces of the United States," in the absence of a qualifying period of active duty.

Due to military accounting and funding protocols, many reservists actually have performed operational missions during their careers but orders often were issued under other than a Title 10 active duty authority.

MOAA strongly supports H.R. 1384 (Rep. Walz, D-MN) and S. 743 (Sen. Boozman, R-AR) to establish that career Reservists eligible for or in receipt of military retired pay (at age 60), government health care and other earned veterans' benefits, but who never served under active duty orders can be honored as "veterans of the Armed Forces of the United States." No new benefits are authorized under the legislation.

Conclusion

MOAA is grateful to the Members of the Committees for your leadership in supporting our veterans and their families who have borne the battle in defense of the nation.

Biography of Robert F. Norton, COL, USA (Ret.)
Deputy Director, Government Relations

Bob Norton joined the MOAA Government Relations team in 1997, specializing in National Guard / Reserve, veterans' benefits and VA health care issues. He co-chairs The Military Coalition's (TMC) Veterans' Committee and is MOAA's representative to TMC's Guard and Reserve Committee. In 2000, Bob helped found the Partnership for Veterans Education, a consortium of TMC, higher education associations, and other veterans groups that advocates for the GI Bill. Bob served on the statutory Veterans Advisory Committee on Education from 2004-2008.

Bob entered the Army in 1966 and was commissioned a second lieutenant of infantry in August 1967. He served in South Vietnam (1968-1969) as a civil affairs platoon leader. He transferred to the U.S. Army Reserve in 1969.

Colonel Norton volunteered for full-time active duty in 1978. He served in various assignments on the Army Staff and the office of the Secretary of the Army specializing in Reserve manpower and personnel policy matters.

Bob served two tours in the Office of the Assistant Secretary of Defense for Reserve Affairs, first as a personnel policy officer (1982-1985) and then as the Senior Military Assistant to the Assistant Secretary (1989-1994). Reserve Affairs oversaw the call-up of more than 250,000 members of the Guard / Reserve in the first Gulf War. Colonel Norton retired in 1995 and joined the MOAA Government Relations staff in 1997.

Colonel Norton holds a B.A. from Niagara University and an M.S.Ed. from Canisius College. He is a graduate of the U.S. Army Command and General Staff College, the Army War College, and the Harvard Kennedy School of Government senior officials in national security course.

His military awards include the Legion of Merit, Defense Superior Service Medal, Bronze Star, Vietnam Service Medal, and the Armed Forces Reserve Medal.