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FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

PROPOSED LEGISLATION

JULY 11, 2017

Chairman Isakson, Ranking Member Tester and members of the Committee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today on the legislation being considered by the Committee. There is no doubt that the bills addressing the Choice program could have a significant impact on the delivery of health care services to veterans going forward. Additionally, many of the bills on the agenda can improve access to critical services needed by veterans.

The "Veterans Choice Act"
The "Improving Veterans Access to Community Care Act"
S. 1279, the "Veterans Health Administration Reform Act"

There are three bills that directly address the next iteration of the Choice Program. We appreciate the Committee's significant efforts in this matter and the Senators for sponsoring the legislation being considered during today's hearing. To better construct a debate on their merits, we will address the bills together in one discussion.

PVA strongly supports the concept of developing an integrated, high-performing network that would seamlessly combine the capabilities of the Department of Veterans Affairs (VA) health care system with both public and private health care providers in the community. This approach has gained consensus among stakeholders, including the most recent and current VA Secretaries,

the Independent Budget (IB), most major Veteran Service Organizations (VSO), the Commission on Care, and congressional leadership. As stakeholders continue to coalesce around this concept, though, the dynamics that govern the boundaries of this network need to be thoroughly explored.

These three bills collectively demonstrate the need for scrutiny—how the network is developed and governed is limited only to the imagination. The devil is in the details; they are critical and will have a dramatic impact on VA's future health care landscape. Our philosophy is that the development of VA's network of providers should be locally driven, contemplating demographics, demand and availability of resources within that particular area. It is more, though, than just filling access gaps. Quality, both within VA and in the community, is inextricable from this analysis. It should be a critical factor in determining whether VA should continue to offer a service or if it should capitalize on segments of the community that are already delivering that service with excellent results. Similarly, just because VA is offering poor quality in a particular service line does not automatically mean there is a second choice available in the community. VA is obligated to raise the quality in its own house in those circumstances.

A well-balanced network that supplements service gaps in VA's system sets a natural boundary for the network. It is efficient and preserves VA core competencies and specialized services such as spinal cord injury and disorder care.

Establishing appropriate eligibility standards will be an integral part of a sustainable network. This is the most significant point on which these three proposals diverge. Chairman Isakson's draft proposal, the "Veterans Choice Act," provides unfettered choice to all veterans enrolled in the VA health care system. However, it remains unclear how this proposal would be funded. The cost is staggering, and the impact on VA and its ability to serve veterans who most need care is predictable. The Commission on Care's economists found that the cost of unmitigated choice throughout a loosely-managed network, a concept most closely reflected by the "Veterans Choice Act," would yield a price tag of well over $1 trillion over a decade. In a case such as this proposal, it will not be enough to simply say that VA has enough resources to manage this option. That is an absolutely false assumption.

In recent months, proposals such as billing veterans' other health insurance for service-connected care, Medicare subvention, and elimination of Individual Unemployability payments to service-connected disabled veterans over the age of 62 have been floated to potentially offset the $3 billion price tag of the Choice Program. If the administration had to consider taking from the most vulnerable groups of veterans to meet this projected cost, where can we expect to find the money for this expansion? What money would be left to sustain VA's foundational services, let alone general health care services for the veterans who choose VA as their provider?

Alternatively, Ranking Member Tester's draft proposal, the "Improving Veterans Access to Community Care Act," and Senator Crapo's bill, the "Veterans Health Administration Reform Act" (S. 1279), structure eligibility standards in line with PVA's vision of employing a clinically-based determination. This is also the path the Secretary wishes to take. This approach requires us to confront the difficult question of how a decision is reached in the absence of arbitrary, but clear, delineations for eligibility. As we mentioned, variations in how liberally access is granted to community care providers can have a drastic impact on cost.

These two proposals call for case-by-case determinations and include a variety of parameters for VA practitioners to consider when consulting with the veteran. Providers should be able to sit down with a veteran and consider circumstances such as access and availability of services and the urgency of that veteran's situation. The veteran should also have the opportunity to voice concerns over how a certain care plan will adversely or inadvertently impact him or her. Access to transportation, geographic distance and travel time can often present unreasonable obstacles to care for veterans. For example, a 30-mile trip to a VA facility might seem reasonable on paper, but a doctor administering a treatment plan that requires the veteran to commute three times per week may have good grounds to object to that determination.

Providers should have the ability to help educate veterans and make decisions in the context of the patient's specific circumstances. They should be able to take action when it is clear that VA offers a needed service, but a particular veteran's situation requires a higher level of expertise than what that doctor or facility can offer. Arbitrary standards should not prevent a doctor from sending a veteran out to the community when the need is urgent and VA is not prepared to administer the care in a timely fashion.

Some veterans might have reservations about their provider, i.e. VA, having the final say in whether they are eligible to utilize the Choice Program, but it is a marked improvement over the current process where bean-counting bureaucrats make decisions behind closed doors for veterans who appear to be just another number in the queue. A more pointed concern is the past institutional bias exhibited by VA employees for administering care directly in VA at all costs. VA has long had authority to contract for care, but in prior years employees demonstrated a reluctance to utilize this tool to the point that it eventually prevented timely access to care for many veterans. This behavior, though, was largely attributed to mid-level bureaucrats making decisions driven by how the funding was administered. The current funding arrangement under the Choice Program produced a welcome side-effect of removing the incentive to avoid contracting care out to the community. Over the last two years, VA's institutional behavior has been modified to a degree, and it has become more comfortable with contracting for care when the need exists.

Once the clinical parameters are determined, eligible veterans will have meaningful choices among the options developed within the high-performing network and the ability to schedule appointments that are most convenient for them. When you pair this decision-making process with a well-managed, integrated network and the structural flexibilities discussed above, it becomes possible for VA to be a competitive and sustainable enterprise.

We applaud Senator Tester's explicit provision extending medical malpractice protections under 38 U.S.C. § 1151. This is an especially important signal to veterans that Congress and VA are not abandoning oversight and responsibility for the quality of care delivered in the community. When veterans receive treatment at a VA medical center, they are protected in the event that some additional disability or health problem is incurred. Under § 1151, veterans can file claims for disability as a result of medical malpractice that occurs in a VA facility or as a result of care delivered by a VA provider. This protection currently does not attach to a veteran during outsourced care. The veteran must pursue standard legal remedies instead of VA's non-

adversarial process. Adding insult to literal injury, veterans who prevail in a private action are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. These include treating the resulting injuries as service-connected conditions, such as a botched spinal surgery resulting in paralysis. It also includes access to adaptive housing and adaptive automobile equipment benefits should the veteran require these features. Furthermore, the limits on these monetary damages vary from state to state leading to disparate results for similarly-situated veterans. To keep all veterans on equal footing, we insist that this provision be incorporated in any legislation that moves forward. We recognize that there will be questions on the mechanics of this protection and to what extent this provision would expand VA's liability exposure. We stand ready to have that conversation and to assist the Committee in sorting through these issues.

S. 1279 offers a unique idea for expanding choices for veterans by allowing VA practitioners to refer Medicare-eligible veterans to Medicare providers. It also encourages greater information sharing efforts between the two systems. In addition to capitalizing on an already-existing network of providers, this adjustment to the law could reduce instances of fragmented care for veterans who normally use VA for primary care but take advantage of Medicare to receive specialty care for a non-service-connected condition close to home. We certainly recognize the value in shifting some of the financial burden that would otherwise be absorbed by VA on to the Medicare rolls, but we are concerned that a turf war between these two financially-stressed systems will likely result. An additional concern is also the potential for Congress to simply reduce funding for VA in an amount that corresponds to any cost savings realized instead of allowing VA to reinvest that money in its own medical services.

These three proposals contain the tools necessary to achieve an end-state at VA where veterans have meaningful choices and quick access to quality care. As the Committee moves toward a final bill, we will continue to support measures that encourage VA to retain ownership and responsibility for care provided to veterans, no matter where it is received. VA's role in care coordination, no matter how expansive the network, must be clear. It is one of the most important features that makes VA care not only competitive with the private sector, but in many segments better. Simply listing in statute that a third-party administrator is responsible for "managing the network" is not enough to identify where that responsibility lies.

We will yet again raise the most important questions for our members: What are Congress and VA doing to ensure that as the Choice Program expands, VA's foundational services remain competitive? What steps are being taken to deal with scenarios where access to care in specialized services is dismal, but there are no comparable services offered in the community to fill the void? Is VA focused on ensuring that VA specialized services are staffed appropriately based on demand, or is it more focused on providing ever-greater convenience to veterans who already have options? We have stated on multiple occasions before this Committee that care delivered in the community is an essential component of VA's health care system. But it is simply that, a component. This Committee needs to demand comprehensive answers to these questions, on the record, instead of settling for platitudes and vague promises to "take care of that later." A member of the Commission on Care warned against designing a health care system

that is "optimized for people who do not rely on veteran-specific health care."[1] The Commissioner captured our perspective, as representatives of the highest per-capita users of VA and its specialized services, when he stated, "[w]e must design our veteran health care system for those who *need* it most, not for those who *want* it least."[2]

S. 115, the "Veterans Transplant Coverage Act"

PVA supports S. 115, the "Veterans Transplant Coverage Act." This legislation gives VA the authority to provide organ transplants to veterans from a live donor regardless of veteran status of the donor or the facility they are in. Under the current Choice program, veterans in need of organ transplants are denied due to the program's eligibility requirement. If a living donor is not a veteran, the transplant coverage is denied if the surgery is not performed at a VA facility. However, due to the very access problems that prompted the Choice program—long distance travel, inaccessible transportation, etc.—these veterans are unable to receive the care they so desperately need. Whether or not a veteran receives a necessary organ transplant should not depend on who or where the donor is.

S. 426, the "Grow Our Own Directive: Physician Assistance Employment and Education Act of 2017"

PVA supports S. 426, the "Grow Our Own Directive: Physician Assistance Employment and Education Act of 2017." This bill would set up a five year pilot program to provide education assistance to veterans training as physician assistants (PAs) in VA. The goal is to train veterans with medical or military health experience to be readily employable physician assistants at VA. Section 2 of the bill explains the prioritization of veteran participants who are in the Intermediate Care Technician Program and those individuals who plan to work in medically underserved states with a high population of veterans. To meet these goals the bill provides funding and support staff to the Office of Physician Assistance Services. It would also require VA to establish a strategic plan to recruit and retain PAs and adopt the standards leading to competitive pay for PAs employed by VA. Currently the vacancy rate of PAs at VA is 25 percent, the third largest shortage throughout the health care system. Recruiting and retaining PAs at VA is critical to improving access to high quality care. Further, this bill will provide job opportunities for veterans with medical work histories that are hard to translate to the civilian sector.

S. 683, the "Keeping Our Commitment to Disabled Veterans Act of 2017"

PVA supports S. 683, the "Keeping Our Commitment to Disabled Veterans Act of 2017." This legislation would extend the requirement to provide nursing home care to certain veterans with service-connected disabilities to December 31, 2018. Without an extension, VA reimbursement of nursing home care will end December 31, 2017.

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[1] Blecker, Michael. "Explaining decision not to sign the Report of the Commission on Care." Letter to Commission on Care. 29 June 2016. Available at https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commissioner-Alternative-Viewpoints-06302016.pdf. (Last accessed July 7, 2017).

[2] *Id*. (Emphasis added).

S. 833, the "Servicemembers and Veterans Empowerment and Support Act of 2017"

PVA strongly supports S. 833, the "Servicemembers and Veterans Empowerment and Support Act of 2017." This legislation would expand VA coverage of counseling and treatment for military sexual trauma (MST). This bill would codify the idea that MST does in fact include the experience of "cyber harassment of a sexual nature." Currently, these victims are ineligible for VA counseling and benefits. The experience of cyber harassment is varied for its victims and distressingly unclear in our laws. But the intent of a perpetrator, as in any sex crime, is the assertion of power over someone and the degradation of their humanity. Most often the harassment takes the form of "revenge porn," nude or sexual photos or videos, taken with or without consent, and used to harm its subject. The possessor of the material may blackmail, control and/or threaten the victim. Often it is used for humiliation by sending the material to the victim's family or coworkers, or, like 'Marines United,' to build up a culture of male camaraderie by degrading and threatening the safety of their female peers.

The goal of cyber harassment is to cause maximum distress. While someone may not be interpersonally exploitable, that effort can be exacted through social media, to greater and longer lasting effect. To be the victim of cyber harassment of a sexual nature is to be exploited by thousands of people, forever unknowable. Such an experience denies any hope of accountability or acknowledgement of injustice.

Recent qualitative analyses of mental health effects on the civilian victims of cyber harassment of a sexual nature consistently reveal very serious effects; high prevalence of PTSD, anxiety, depression, suicidal ideation and increased likelihood of physical assault. Only 34 states and the District of Columbia have laws criminalizing the practice of cyber harassment. The Uniform Code of Military Justice does not directly address this issue. Veterans who are victims of this kind of sex crime will often have no recourse. This bill is a greatly needed step to ensure VA is able to meet the needs of those who served honorably and came home carrying wounds ignored for too long.

S. 946, the "Veterans Treatment Court Improvement Act of 2017"

PVA firmly believes in the rule of law and that anyone convicted of a crime should be held accountable. Our criminal justice system, though, has long recognized the existence of aggravating and mitigating circumstances that play an important role in influencing the administration of penalties. While advocacy before a sentencing judge following conviction is critical, prosecutorial discretion is also vast. Veterans Justice Outreach Specialists can help veterans use their honorable service, as well as mitigating circumstances arising from that service, to ensure both the prosecutor and judge see more than just a rap sheet when making decisions.

If the specialist demonstrates that the veteran is entitled to health care or disability benefits, the judge or prosecutor might be able to fashion a sentence or plea offer that incorporates utilization

of these services in lieu of imposing solely punitive sanctions. It could also lead to an outright deferment of prosecution conditioned on the veteran exploring and obtaining all services available to him or her. This scenario is especially enticing to the judicial system given the constant struggle to find resources, particularly for in-patient substance abuse rehabilitation programs and mental health care.

For some veterans, this path might help them avoid being permanently stigmatized with a criminal conviction. For others, it might be the ticket that lifts them out of homelessness and the corresponding criminal recidivism, specifically with petty and/or vagrancy crimes. It is no secret that some veterans go years before realizing they were entitled to certain benefits that might have helped them avoid poverty and dejection. A court order pointing the veteran to the Department of Veterans Affairs can sometimes turn into a life-changing event. At the least, more veterans touched by this program will re-engage productively with society. That is a goal worth pursuing.

S. 1153, the "Veterans Acquiring Community Care Expect Safe Services Act of 2017"

PVA generally supports S. 1153, the "Veterans Acquiring Community Care Expect Safe Services Act of 2017," or "Veterans ACCESS Act." This legislation would deny or revoke the eligibility of a health care provider to be a community care provider if they have been fired from VA, violated their medical license, had a department credential revoked, or were imprisoned for one year or more.

S. 1261, the "Veterans Emergency Room Relief Act of 2017"

PVA supports S. 1261, the "Veterans Emergency Room Relief Act of 2017." This legislation would require VA to contract with urgent care providers and pay reasonable costs for care provided to veterans who are enrolled at VA and have received care there within the preceding two years. It would also establish cost-sharing amounts for certain veterans receiving care at a VA emergency room. We have consistently advocated for adding urgent care services to the standard medical benefits package to help fill the gap between routine primary care and emergency care. This is consistent with current health care trends, and greater utilization could provide a relief valve to VA emergency services, the Choice Program, and the system as a whole. It would help address issues of long distance travel for veterans needing immediate attention, and mitigate long term costs for VA by providing quick attention to medical needs that would otherwise compound in both cost and severity if the veteran were to wait to be seen at VA. Additionally, this has the potential to decrease the current burden at VA emergency rooms, freeing up capacity to properly address their patient loads.

We do, however, continue our opposition to any requirement that a veteran have received VA care within the preceding 24 months in order to qualify for emergency and urgent care benefits. The strict 24-month requirement is problematic for newly enrolled veterans, many of whom have not been afforded the opportunity to receive a VA appointment due to appointment wait times, despite their timely, good-faith efforts to procure one. This barrier has caused undue hardship on veterans and has resulted in some receiving unnecessarily large medical bills through no fault of their own. Additionally, this provision discriminates against healthier veterans who otherwise do not need as much health care as other veterans and may go more than two years without being

seen. This bill's authorization to impose cost-sharing should be enough to compensate for dropping the 24-month requirement as a cost control mechanism.

S. 1266, the "Enhancing Veteran Care Act"

PVA generally supports S. 1266, the "Enhancing Veteran Care Act." This legislation would authorize the Secretary of Veterans Affairs to enter into contracts with nonprofit organizations to investigate medical centers and report deficiencies. This legislation allows the Secretary to delegate the contracting authority for an investigation to the VISN director or the director of the medical center to be investigated. The Office of Inspector General has at times demonstrated a bureaucratic rigidity too cumbersome to address localized needs for investigation. This bill ostensibly aims to meet that need. While the Secretary is already able to contract with third party investigators, this bill extends that ability to lower leadership positions. We also believe it is an appropriate step to require the Secretary, Inspector General and Comptroller General of the United States be notified of an investigation for the purposes of coordination.

S. 1325, the "Better Workforce for Veterans Act of 2017"

PVA supports S. 1325, the "Better Workforce for Veterans Act of 2017." This legislation would improve the authorities of the Secretary to hire, recruit, and train employees at VA. In order to transform the culture and timeliness of care, Congress must enable VA to quickly hire a competent workforce with competitive compensation that ensures VA is a first-choice employer among providers.

The access to care issues plaguing Department of Veterans Affairs (VA) can almost always be traced back to staff shortages, and the systemic consequences of those shortages, within the health care system. The current 45,000 vacancies are a result of improper staffing decisions, a lack of sufficient resources, and the misallocation of existing resources. No reformation of staffing or capital infrastructure processes will increase access without appropriate resources.

No one is more affected by provider shortages than those veterans with complex injuries who rely on VA to treat their specialized needs. Unfortunately, VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans—veterans with spinal cord injury/disorder, blindness, amputations, and mental illness—as mandated by P.L. 104-262, the "Veterans' Health Care Eligibility Reform Act of 1996." As a result of this law, VA developed policy that required the baseline of capacity for Spinal Cord Injury/Disease System of Care to be measured by the number of available beds and the number of full-time equivalent employees assigned to provide care.VA was also required to provide Congress with an annual "capacity" report to be reviewed by the Office of the Inspector General. This reporting requirement expired in 2008, and was reinstated in last year's "Continuing Appropriations and Military Construction and Veterans Affairs Appropriations Act for FY 2017." This report, a critical tool of oversight, should be made available to Congress by September 30 of this year. We suspect this report will verify the willful disregard for staffing shortages that exist in our most critical specialties.

It is worth noting that the SCI/D System of Care is the only specialty service line with its own staffing mandate, implemented in 2000, as a standardized method of determining the number of

nursing staff needed to fulfill all points of patient care. VA has not met this statutory mandate. For years, PVA has identified chronic staff shortages, resulting bed closures, and denied admissions. Since 2010, VA has operated at only 60% of the capacity mandate. Further still, the mandate itself is 17 years old, and in need of an update to reflect the aging population of veterans. Such an update would provide a starker picture of unmet need for the most vulnerable population of veterans.

A modernized and effective human resources operation is vital to any organization, especially one as large as VA. The multiple authorities governing the VHA personnel system are incompatible with a high-performing health care system. Hiring managers and their employees must attempt to understand the end-to-end hiring process under four separate rules systems. This unnecessarily adds complexity to the hiring system which is difficult for both the potential employee and the human resources staff to navigate. The unnaturally slow hiring process also ensures VA loses talented applicants. It is not reasonable to expect a quality provider to wait up to six months for VA to process an application. Similarly, when an employee announces his or her forthcoming retirement or departure from VA, HR is unable to begin the recruiting or hiring process for that position until it is actually vacated. This not only causes an unnecessary vacancy, exacerbated by the lengthy hiring time, but it also prevents a warm handoff between employees and any chance for training or shadowing.

Mid-level management at the VISN level seems to have obfuscated all responsibility for clinical staff shortages, while maintaining themselves handsomely. The 21 VISNs, managed by directors and senior managers control the funding for all 1,233 VA health facilities, and are required to oversee the performance for their VA facilities and providers. Currently a nominal appointment, this structure was intended to decentralize decision-making authority and integrate the facilities to develop an interdependent system of care.

In 1995 the total number of VISN staff was 220. In fiscal year 2011, the total number of VISN employees had climbed to 1,340, a 509% increase, while bedside clinician and nurse staffing in specialized VA services plateaued, then fell behind demand. Meanwhile, the VA failed to request from Congress the resources to meet health care demand, particularly in specialized services such as spinal cord injury and disorder care and inpatient mental health.

PVA believes that veterans have suffered from VA's inability to be competitive with its private sector health care counterparts who do not face the same restrictions on pay and benefits. In the face of a nationwide provider shortage, and an aging generation of baby boomers, VA must be competitive now in order to have any chance of meeting the needs of veterans.

While the personnel challenges facing VA, are numerous, and often frustrating, it is important to remember these staffing issues and how they are resolved will have an immediate impact on the life and well-being of catastrophically injured veterans. For the thousands with complex needs, there is no private sector alternative where they can seek care until VA's access problems are solved.

Draft bill, the "Department of Veterans Affairs Quality Employment Act of 2017"

PVA supports the proposed draft legislation the "Department of Veterans Affairs Quality Employment Act of 2017." This legislation would improve the authority of the Secretary of VA to hire and retain physicians and employees at VA. PVA is particularly interested in a couple sections included in the bill. Section 3, which would require the Secretary to select at least 18, but no more than 30, employees to participate in a one year fellowship with a private sector company or entity that administers or delivers health care or other services similar to those provided within VBA and VHA. PVA generally supports this idea. In the current environment there could be a benefit to sending VA senior executives into the private sector to better understand best practices from both sides. At the same time, sending already limited resources and talent outside of VA could further undermine the existing training programs within the Department.

Section 4 would require the Secretary to conduct an annual performance plan of VA's political appointees. The plan would be similar to those employees who are members of the Senior Executive Service and would assess recruitment and retention of qualified employees, engagement and motivation, and performance and accountability. While surprised there is not already a performance plan for VA political appointees, PVA considers this a reasonable provision.

Section 5 would allow the Secretary to noncompetitively reappoint a former VA employee to any position within the Department as long as the position is not more than one grade higher than their former position and as long as the employee left the Department voluntarily within the prior two years and maintained necessary licensures and credentials. PVA has concerns about bringing back a former employee to a higher grade through a noncompetitive process. While PVA supports the intent to easily fill critical vacancies, we are not convinced hiring former employees through a noncompetitive process is the most appropriate path to filling those vacancies.

Section 6 would require the Secretary to create a single recruiting database to list any vacant positions the Secretary determines are critical to the mission of VA, or difficult to fill, or both. It would keep information on applicants not selected for initial positions but who are qualified for other positions in the department. The Secretary would be required to use the database to fill any vacant positions. PVA questions whether such a recruiting database is necessary. Presumably, the 'mission critical' positions the proposed database would house are currently residing in USAJobs.gov.

Section 7 would improve training for Human Resources professionals and include virtual training. The development and implementation of defined goals for recruitment and retention (to include promotions, continuing education, etc.) should be components of HR staff's performance plans. VA HR management staff are not accountable to direct service providers. PVA believes they should be held accountable. HR performance is not measured by the degree to which they meet hiring and recruitment goals. As a consequence, failure to fill a critical vacancy in a timely manner carries no adverse effect on the involved HR staff.

VA must be able to recruit and retain qualified staff by providing competitive compensation and opportunities for professional and technical development. The Association of American Medical Colleges estimates the United States will have a shortage of 130,600 physicians by 2025. Today, the most vulnerable populations, including rural communities and veterans with specialty needs, are the first to feel the effects. While VA recruitment efforts are improving, the inexcusably long process it takes to bring an employee onboard continue to turn away highly qualified candidates. VA must provide its human resources management staff with the resources and training necessary to correct these issues.

Mr. Chairman, thank you for the opportunity to offer our organizations views on these bills. We would be happy to answer any questions you or your colleagues may have.

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Gabe was raised in Homer City, Pennsylvania. He attended the University of Pittsburgh where he earned a Bachelor of Arts degree in Political Science and Economics. After college he joined the U.S. Army and received his commission from the Officer Candidate School at Fort Benning, Georgia. He subsequently completed Ranger School, Reconnaissance and Surveillance Leaders Course (RSLC), Airborne School, and Air Assault School and was later assigned to the 2nd Battalion, 506th Infantry Regiment (4th Brigade Combat Team) of the 101st Airborne Division at Fort Campbell, Kentucky. In 2008, he deployed to Afghanistan in support of Operation Enduring Freedom as an Infantry Platoon Leader operating out of a remote outpost in the mountains of Khost Province. During his year-long tour he earned the Combat Infantryman Badge and the Bronze Star.

After the Army, Gabe attended Wake Forest School of Law. During his time as a student he was actively involved in helping establish the Veterans Advocate Law Organization (VALOR), which has since become a school-sponsored legal clinic at Wake Forest serving veterans in Winston-Salem, North Carolina. Before joining PVA in 2015, he was a prosecutor in Florida. He is licensed to practice law in Florida, North Carolina, the U.S. District Court for the Western District of North Carolina and the Court of Appeals for Veterans Claims.

Gabe lives in Old Town Alexandria, Virginia with his wife, Cecelia, and daughter, Penelope.