DEPARTMENT OF VETERANS AFFAIRS

ADVISORY COMMITTEE ON DISABILITY COMPENSATION

July 14-15, 2020

MINUTES

Members Present:

Thomas J. Pamperin, Acting Chairman
Al Bruner
Bradley Hazell
Joyce Johnson
Evelyn Lewis
James Lorraine
Michael Maciosek
Jean Reaves**
Robert Wunderlich

Members Not Present:

Jonathan Roberts
Robert Sprague

Staff Present:

Janice Stewart, Management Analyst, Designated Federal Officer (DFO) for Advisory Committee on Disability Compensation (ACDC), Veterans Benefits Administration (VBA)
Claire Starke, Alternate DFO, ACDC; Program Analyst, VBA
Tonita Cannon, Program Analyst, Budget Office, Compensation Service, VBA
Jane Che, Director, Veterans Affairs Schedule for Rating Disabilities (VASRD) Program Management Office (PMO), Compensation Service, VBA*
Dean Christopher, Director (Acting), Product Management & Delivery, Compensation Service, VBA**
Clinton L. Greenstone, Acting Executive Director, Clinical & Network Management, Deputy Executive Director, Clinical Integration, Office of Community Care, Veterans Health Administration (VHA)**
Rodney Grimm, Program Analyst, Legislative Staff, Compensation Service, VBA*
Keith Hancock, Program Analyst, Legislative Staff, Compensation Service, VBA*
Patricia Hastings, Post-Deployment Health Services, VHA*
Earl Hutchinson, Director, Medical Disability Exam Quality & Program Management Office, Compensation Service, VBA**
Kathleen Lawless, Management Analyst, Contracting Officer's Representative,

Budget Office, Compensation Service, VBA**
Gary Reynolds, Medical Officer, VASRD PMO, Part 4, Regulations & Implementation, Compensation Service, VBA*
Eric Shuping, Director, Post-9/11 Era Environmental Health Programs, VHA*
Ioulia Vvedenskaya, Medical Officer, VASRD PMO, Part 4, Regulations & Implementation, Compensation Service, VBA*

*July 14 only
**July 15 only

The Advisory Committee on Disability Compensation (ACDC) met in public session on July 14-15, 2020, by Teleconference.

Tuesday, July 14, 2020

Opening Remarks/Member Intros

Ms. Stewart called the Committee to order at 8:55 a.m. She made some administrative remarks and turned the meeting over to Acting Chairman Pamperin. The Acting Chairman reminded members that ACDC was due to submit its next biennial report at the end of September. He announced that staff was trying to arrange a visit from a senior VA leader at the Committee's September meeting. He asked members to introduce themselves.

Travel Admin

Ms. Cannon discussed with Committee members steps for receiving compensation.

VASRD/Diabetes

Dr. Vvedenskaya gave the diabetes update. A diabetes work group had been formed two years previously and had examined the current code, ratings criteria, identified weak points, performed background research on whole-disease and symptom-by-symptom approaches, and developed a plan outlining the philosophy for developing new rating criteria. Dr. Vvedenskaya had put the group's activities on hold after its last meeting in January 2019 because of other, more pressing priorities. Compensation Service leadership would inform her as to when the work group's activities should resume.

Acting Chairman Pamperin asked if it was reasonable to assume that the work group would not reactivate until 2022, when it was anticipated the first iteration of the ratings schedule would be finished. Dr. Vvedenskaya suggested Ms. Che would be in a better position to answer that question.

The Acting Chairman added that he was unclear what Dr. Vvedenskaya meant by looking at the disease as a whole as opposed to symptom-by-symptom. Dr. Vvedenskaya replied that diabetes was a complex disease affecting many body systems, so it was necessary to

decide the most beneficial approach to the Veteran, a holistic one or one that teased out specific areas. Acting Chairman Pamperin asked if the symptom-based approach was currently the preferred one. Dr. Vvedenskaya confirmed that it was.

Dr. Maciosek asked if the Veteran would need to be re-rated as the disease progressed. Ms. Che explained that VA took the progression of disease into account. The Acting Chairman pointed out that a new rating would require the Veteran to reopen the prior claim. Ms. Che and Dr. Vvedenskaya agreed that a rating change did in fact require action on the claimant's part.

Earnings Loss Studies Executive Overview

Dr. Reynolds gave the overview. The Earnings Loss Study (ELS) was at the point where VA was getting access to survey data, which gave VA a fraction of the Veteran population relative to longitudinal earnings data. For selected codes, it provided a large enough sample size to perform reasonable analysis. VA hoped to be able to conduct an economic analysis on at least 50 codes in the current year. Part of the problem was that VA had no control over the bureaucratic process. Once a request left VA, it was subject to an approval process involving the Census Bureau, Social Security Administration, Internal Revenue Service, and/or the Department of Labor. Dr. Reynolds expected to have the survey data access relatively soon. The ultimate goal was to take the information quantifying the effect of a condition on the capacity for earning and incorporate it as the occupational impairment component for each diagnostic code.

Acting Chairman Pamperin asked why VA did not create a sample size with just mental health disorders. Dr. Reynolds said the general rating formula was more or less a clinical determination because mental health disorders typically presented themselves in a limited number of ways.

Dr. Lewis asked Dr. Reynolds to clarify sample size in terms of limitations. Dr. Reynolds explained that for the first ELS there had been eight diagnostic codes, only two of which had a large enough sample size to be statistically relevant. This time, there would be more survey data to draw from, which would enlarge the sample size to accommodate at least the top 15 codes. Dr. Lewis asked why VA did not make sure it got a statistically significant sample size. Dr. Reynolds pointed out that VA was using existing data, and that it was not practical for it to conduct a study by itself. Dr. Lewis argued that practicality was irrelevant if VA was not obtaining the necessary information. Dr. Reynolds noted that VA had the ability to rank the codes in order of utilization and would be asking for those codes first.

Dr. Lewis said she would appreciate further discussion of the issue. Dr. Maciosek and Mr. Bruner agreed that it would be helpful to discuss the ELS in greater detail at a future meeting. Dr. Reynolds offered to provide a status summary in advance of the meeting, which would give the Committee an opportunity to formulate questions.

Mr. Hazell noted that at a previous ACDC meeting, the Committee had proposed comparing disabled Veterans with disabled civilians instead of nondisabled Veterans. He asked if there had been any more research on that, and whether the Office of General Counsel (OGC) had been contacted to ensure that the necessary criteria would be satisfied. Dr. Reynolds

said OGC had not been contacted; at this point, his team was still trying to get the data, and the concerns Mr. Hazell raised were several steps down the road. Mr. Hazell said his main concern was that it was taking a long time to get the data, and there was a chance it still might not meet the criteria. Dr. Reynolds took note of the question and promised to have an answer by the next ACDC meeting.

The Committee recessed from 10:06 a.m. to 10:15 a.m.

Hypertension Agent Orange (A/O) Presumptive

Mr. Grimm gave the presentation. In establishing a new presumptive A/O disease, VA considered the entirety of scientific evidence, including reports of the National Academies of Science, Engineering, and Medicine (NASEM), to make an informed decision. The Department of Veterans Affairs Expiring Authorities Act of 2018 extended VA's requirement to consider NASEM reports until September 30, 2020.

Hypertension was a disease involving higher than normal blood pressure and could lead to such diseases as coronary artery disease, kidney disease, and stroke. Its etiology was unknown in 90-95 percent of cases. It was estimated that one in three U.S. adults, or around 70 million, had hypertension. Twenty percent of hypertensives were unaware of their condition.

Dr. Lewis asked what level of blood pressure was considered hypertensive. Mr. Grimm said that the hypertensive range included anyone with a systolic blood pressure greater than 140 and/or a diastolic blood pressure greater than 90. Dr. Hastings corrected him, saying that in 2017 the American Heart Association, American College of Cardiology, and nine other health organizations lowered the threshold to a systolic of 130 and/or a diastolic of 80.

Dr. Lewis noted that hypertension was particularly prevalent in the African-American population, and asked if there was any effort to drill down into various demographics. Dr. Hastings agreed that certain subsets of Veterans required an additional look and cited the Vietnam Era Health Retrospective Observational Study (VE-HEROeS) and Vietnam Mortality Study, which were expected to yield a wealth of demographic data. Acting Chairman Pamperin asked whether the Million Veteran study would address this issue. Dr. Hastings said she believed so but promised to follow up with a definitive answer. Dr. Lewis agreed that that would be helpful.

NASEM, in the 2006 update of its publication Veterans and Agent Orange, first placed hypertension in the category of a "limited or suggestive evidence of an association" with A/O exposure. The Secretary declined to establish presumption on the basis of the recommendations of a VA task force.

Updates in 2008, 2010, 2012, and 2014 retained hypertension in the "limited or suggestive" category. In its 2018 update, NASEM concluded that there was sufficient evidence of an association between hypertension and A/O exposure. Dr. Hastings added that this ratings change was primarily due to the results of a study conducted out of her office, and that the Secretary wanted to wait for the results of the VE-HEROeS and Vietnam Mortality Study before determining whether to establish a presumption.

Compensation Service estimated that if a presumption were established, 800,000 Vietnam Veterans would be newly eligible for service connection for hypertension; 50 percent of those would file in the first year, and 70 percent would file within five years. It further estimated that 8,700 survivors would be eligible for benefits, and that 50 percent of those would file within the first year.

Acting Chairman Pamperin asked whether the estimate of 800,000 newly eligible Veterans included those who were already receiving benefits on other grounds. Mr. Grimm said it did.

In April 2019, costs were estimated to be $768 million in fiscal year (FY) 2020 and $7.98 billion over the next five years. After the Nehmer decision, the costs were now estimated to be $1.46 billion in FY2020 and $10.4 billion over the next five years.

VE-HEROeS had completed, and its results were being analyzed. The Vietnam Mortality Study was expected to conclude by fall 2020.

Dr. Lewis said she thought it had already been established that hypertension was an herbicide-related disease, citing NASEM's 2018 update. Dr. Hastings clarified that there was an association, but not necessarily a causal link. Acting Chairman Pamperin pointed out that causation had been the core issue in the Nehmer lawsuit; a VA regulation was held to be invalid because causation had not been proved. Dr. Hastings acknowledged that it was difficult to prove causation, and that many presumptions were based solely on association. The Secretary considered the basis for NASEM's determination tenuous and limited, and hoped for more data from VE-HEROeS and the Vietnam Mortality Study.

Dr. Maciosek asked whether the evidence considered in determining a presumption included any toxicology studies with animals. Dr. Hastings said there was a large component that looked at animal studies, and that VA staff included an accomplished toxicologist.

Dr. Hastings said she had to leave to attend another meeting but offered to follow up with the Committee on any questions it might have.

<u>COVID-19</u>

Ms. Che gave the briefing. Compensation Service was drafting an Interim Final Rule that would create a new diagnostic code and rating criteria to evaluate active coronavirus disease as well as its residuals, and a regulatory basis for granting service connection for COVID-19 based on symptoms and positive viral tests. The new rule would allow for service connection to be established presumptively for COVID-19. Its target effective date was June 8, 2021.

In the meantime, Compensation Service was drafting a Policy Letter to advise VA Regional Offices to process COVID-19 claims analogous to West Nile Virus and with a "COVID-19" special issue until the Interim Final Rule was published. Policy Letter implementation was scheduled for July 28, 2020.

Acting Chairman Pamperin said he thought the rating schedule was adequate to rate residuals. Ms. Che said Compensation Service was confident VA would be able to provide benefits under the current ratings criteria, but it wanted to make sure that it had a separate and brand-new diagnostic code just for coronavirus. The Acting Chairman praised Compensation Service for being proactive. Ms. Che added that the goal was to get the Interim Final Rule published as quickly as possible.

Camp Lejeune

Mr. Hancock gave the presentation. Camp Lejeune is a Marine Corps training base in North Carolina. From the 1950s to the 1980s, its drinking water was contaminated with volatile organic compounds, including perchloroethylene, trichloroethylene, vinyl chloride, and benzene. Over one million individuals were potentially exposed.

The Environmental Protection Agency placed Camp Lejeune on the National Priorities List in 1989. The Department of Defense (DoD) created a registry to notify Veterans of possible exposure. The Agency for Toxic Substances and Disease Registry (ATSDR) issued a public health assessment, and with funding from DoD, was conducting a series of epidemiology studies. ATSDR also led a Community Assistance Panel for Veterans and Family Members.

In 2012 legislation was passed requiring VA to provide health care to Veterans who served on active duty at Camp Lejeune and reimbursement of medical care to eligible family members for one or more of 15 specified illnesses or conditions.

To be eligible, a Veteran had to have served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987. The Veteran did not need to have one of the 15 health conditions, nor did s/he need a service-connected disability. VA healthcare related to any of the 15 qualifying health conditions was at no cost to the Veteran. Camp Lejeune Veterans were enrolled in VA healthcare in Priority Group 6, unless they qualified for a higher priority group.

As of June 30, 2019, VA had enrolled 63,702 Camp Lejeune Veterans, 3,449 of which were treated specifically for one or more of the 15 specified Camp Lejeune-related medical conditions.

The Camp Lejeune Family Member Program was launched in October 2014. Family members received care by civilian providers, and VA reimbursed, as the last payer, out-of-pocket medical costs associated with the 15 conditions. Family members could request reimbursement for expenses incurred up to two years prior to the date of application.

On March 14, 2017, VA published a Final Rule creating a presumption of service connection for eight diseases associated with exposure to contaminants in the water at Camp Lejeune. The presumptions were mostly forms of cancer, but also included anemia and Parkinson’s disease.

As of June 1, 2020, VA had completed 73,732 claims. The grant rate was 73 percent for presumptive issues and seven percent for non-presumptive issues. The primary reason for denials was no diagnosis.

Acting Chairman Pamperin noted that the number of claims would suggest a seven percent application rate, which was significantly below the typical claim rate for Veterans. Mr. Hancock refused to speculate as to why that would be but mentioned that there were quite a few claims received before the presumptive was established, and that a significant number of claims were in the appeals pipeline. Dr. Shuping also had no explanation but insisted that VA made an effort to inform Veterans of the availability of benefits.

VBA currently had 882 pending legacy appeals on Camp Lejeune contaminated water (CLCW); the Board of Veterans' Appeals had 556 such appeals. Since February 2019, 838 CLCW claims had been completed under the Appeals Modernization Act (AMA); 203 claims were pending.

Mr. Bruner expressed concern that the outreach was primarily reaching individuals who were already in contact with the VA. Dr. Shuping promised to check up on any external outreach efforts and report back to the Committee. Dr. Lewis said she would like to see a demographic breakdown of who had filed the claims. Mr. Hancock promised to provide such data.

Evidence of garrison-based environmental exposures was increasing. Firefighting chemicals, or perfluorinated compounds (PFAS) were a high-profile issue with congressional interest. There was widespread interagency collaboration on the issue, including the ATSDR Community Assistance Panel and a VA-DoD Deployment Health Working Group.

Acting Chairman Pamperin mentioned a fire aboard the Bonhomme Richard in San Diego Harbor, which was expected to burn for several days. Dr. Shuping said he was aware of the incident but did not know if PFAS chemicals were being used. He pointed out that such chemicals were indeed useful in fighting fires, and that it was important to strike the right balance. The Acting Chairman asked whether DoD had a dynamic protocol for cataloging events like this on a routine basis so that it knew who participated. Dr. Shuping said there was a relatively new program called the Individual Longitudinal Exposure Record (ILER).

Burn Pits Overview

Mr. Hancock gave the overview. At the end of FY2019, there were almost five million Veterans on the rolls for compensation due to burn pit exposure receiving an estimated $85 billion in annual total payments.

There were no established regulatory or statutory presumptions for determining benefits based on burn pit exposure. Claims were adjudicated on a case-by-case basis. Requirements for disability compensation included 1) a current disability, 2) an event, injury, or disease in service, and 3) a link or nexus between disability and service. There was a low threshold for verifying exposure. Fact sheets were provided to VA examiners to ensure medical opinions were fully informed. Registry exams or other post-deployment health records were considered as additional evidence.

Mr. Hazell asked if Committee members could have access to the fact sheets. Mr. Hancock promised to have them distributed.

ILER would provide a record of exposure for individuals that would improve the efficiency and quality of exposure-related health care, epidemiology, research, and benefits determination. Full Operating Capability was expected in September 2023.

An Airborne Hazard and Burn Pit Center of Excellence was established in New Jersey in May 2019, which conducted clinical research related to airborne hazards focusing on respiratory conditions and other health concerns.

Dr. Lewis asked if the Committee could have the results of some of the studies the Center of Excellence was conducting, and what the Center was doing with that data. Dr. Shuping said he could get the Committee that information.

VA initiated a request to the National Academy of Medicine (NAM) to study health effects from airborne hazards and open burn pits with a focus on respiratory conditions. Completion was expected in August 2020.

Dr. Lewis asked if the NAM study was a follow-up to the previous study on the same topic. Dr. Shuping said it was somewhat of a follow-up, but while the first study focused primarily on burn pits, this one looked at a broader range of exposures. Dr. Lewis asked that both studies be made available to the Committee. Dr. Shuping said those studies were actually available to the public on the NAM website. Dr. Lewis said she was aware, but that it would be more convenient if members did not have to look up the data themselves. Dr. Shuping promised to obtain that information.

In the National Defense Authorization Act (NDAA) of 2019, Section 355 mandated a study on phasing out open burn pits. Section 1050 required outreach and education regarding the Airborne Hazards and Open Burn Pit Registry. NDAA 2020 mandated DoD to provide a plan to phase out the use of burn pits. Another provision in the bill called for DoD to provide VA and Congress a list of all burn pit locations. Section 704 required VA to ensure that any Periodic Health Assessment include an evaluation of whether a Servicemember had been stationed at a location where a burn pit was used or had been exposed to other toxic airborne chemicals.

Dr. Lewis asked if the Periodic Health Assessments were for active personnel or those who had gotten out. Mr. Hancock said Section 704 was specific to DoD and only applied to Servicemembers. Any Veteran who had been near a burn pit could sign up for the Airborne Hazards and Open Burn Pit Registry. Various efforts were underway to research and study exposed Veterans. Dr. Lewis asked if there was any Veteran equivalent to the Periodic Health Assessment. Mr. Hancock said there really was not.

As of July 1, 2020, there were 1,611 National Pending Claims Inventory claims based on burn pit exposure. Since June 2007, 2,818 Veterans claiming disabilities based on burn pit exposure had been granted compensation, and 9,728 had been denied. The most common reason for denial was the lack of a link between the current disability and the exposure.

Dr. Lewis mentioned a Veteran who had filed a claim with the Department of Labor, which had determined that there was a connection between her symptoms and burn pit exposure. Mr. Hancock said VA had several different research efforts ongoing and was willing to consider all evidence. He added that without a presumption, VA was pretty bound to the medical opinion provided by the examiner.

Mr. Hazell asked if it was possible to track to the ratio that specific compensation and pension examiners were giving negative nexus opinions versus those giving favorable ones. Mr. Hancock said he did not think there would be a way to do that without going through every case and reviewing each examination. Acting Chairman Pamperin said he thought that was a little beyond the scope of the Committee.

The top seven conditions granted based on burn pit exposure, in order of frequency, were bronchial asthma, allergic rhinitis, sleep apnea, bronchitis, maxillary sinusitis, migraines, and eczema.

Adjournment

The Committee recessed for the day at 12:14 p.m.

Wednesday, July 15, 2020

Opening Remarks/Member Intros

Ms. Stewart reconvened the meeting at 9:00 a.m. She made some administrative remarks and turned the meeting over to Acting Chairman Pamperin. The Acting Chairman asked how many people listened to the previous day's session. Ms. Stewart said that staff had tallied 39 lines connected to the conference call at one point.

Public Comments

Since its last meeting, ACDC received several written comments from the public. Acting Chairman Pamperin said he would read two of them at this point and the others at 11:00.

The first letter was from Linda Northrup, who had been stationed at Camp Lejeune in early 1987. Shortly after leaving, she became pregnant with a daughter who was born with an arteriovenous malformation causing extensive health problems, but she did not meet the guidelines since she had not been conceived or born at Camp Lejeune. Acting Chairman Pamperin sympathized with Ms. Northrup's difficult situation. He pointed out that people had the opportunity to comment on proposed regulations, and encouraged Ms. Northrup, if she believed she had a legitimate claim, to file one. If her claim was denied, she had the right to an appeal.

The second comment was from Vincent P. Diem, an Army sergeant from 1994 to 1999. Mr. Diem asserted that official government agency reports and other credible documentation revealed various sources of contamination where he was stationed. He did not believe he had been exposed to contaminants or hazardous working environments after leaving the service. Since 2014, he had been hospitalized more than 16 times, had more than 30 active

problems identified in his VA health profile, and experienced three nearly fatal health crises. He was medically laid off from full-time employment in January 2015. None of the autoimmune diseases he had been diagnosed with were identified with his parents or extended family, but each of his three children had unique health conditions and concerns. Claims filed with VA beginning in December 2014 remained unresolved. Mr. Diem respectfully asked the Committee to begin to examine trends and patterns among Veterans based on their health profiles and not their prior duty assignments.

Acting Chairman Pamperin pointed out that the Committee had received information the previous day that DoD and VA were increasingly looking at environmental exposures. In September, ACDC would receive a briefing from VHA on its Million Veteran study. The Acting Chairman suggested that the Committee ask whether that particular study would address any of Mr. Diem's concerns.

Choice Treatment Records

Dr. Greenstone gave the briefing. The Veterans Choice Program (VCP) had actually ended on June 5, 2019. In its place was the Veterans Community Care Program (VCCP), which had been created by the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. In contrast to the earlier program, VCCP featured clear eligibility criteria, a longer implementation timeframe (one year), robust provider networks, efficient provider payment mechanisms, and enhanced care coordination.

The MISSION Act established six community care eligibility criteria: best medical interest of the Veteran, care or services noncompliant with VA's standards for quality, care or services not provided within designated access standards, grandfathered eligibility from VCP, lack of full-service medical facility, and required care or services not offered. Every VA Medical Center had a Local Community Care Department whose job it was to coordinate care for Veterans.

Numerous options were available for sharing clinical information, including fax and secure email. New modalities provided seamless options for community providers. HealthShare Referrals Manager was a web-based system allowing bidirectional exchange of health information. The Veterans Health Information Exchange (HIE) enabled bidirectional sharing of health information across a secure network. VA's transition to Cerner would continue to foster adoption of HIE standards common across the industry. VBA contractors and staff currently had access to Compensation and Pension Records Interchange (CAPRI) and Joint Longitudinal Viewer (JLV).

Acting Chairman Pamperin expressed the Committee's concern that rating specialists have access to records. Dr. Greenstone agreed that this was an important issue. The Acting Chairman asked if the VA electronic health record indicated an outstanding treatment record. Dr. Greenstone assured him that it did.

Dr. Maciosek asked if the system could be used to alert a Veteran that his/her VA records might be incomplete. Dr. Greenstone said it was an interesting suggestion, but that currently there was no specific trigger. Dr. Maciosek asked if there were any state privacy laws more

stringent than federal laws that might hinder VCCP. Dr. Greenstone said that had not been an issue so far.

The Acting Chairman noted that the Centers for Medicare & Medicaid Services (CMS) were incentivizing the use of electronic records, and asked Dr. Greenstone if he had an idea as to when records would go totally paperless. Dr. Greenstone said he did not know whether CMS would make electronic records mandatory at some point, but felt that most people appreciated the time, energy, and money saved through their use.

Evaluation Builder

The Committee had heard there were significant problems with some evaluation builders. It wanted to know if the problems had been resolved, and if not, what the mitigation strategy was, and whether VA was able to assess the scope of the problem and determine the cases affected.

Mr. Christopher reported that the main citation issue after AMA release, where 4.124 was populating on every decision, had been resolved. Compensation Service was conducting a comprehensive review of all Veterans Benefits Management System (VBMS) fragments to determine the necessary updates, if any. Since citation fragments were provided by Compensation Service, the calculators were functioning correctly unless there was a request to change them.

Acting Chairman Pamperin asked what Mr. Christopher meant by citation fragments. Mr. Christopher explained that AMA mandated that each decision be annotated with the applicable law.

Mr. Hazell asked what the evaluation builder was, and how it was used. Mr. Christopher said there were three evaluation builders available: a legacy one written in Visual Basic and maintained by Compensation Service, a copy of the Visual Basic version embedded within VBMS-Rating (VBMS-R), and a Java version in VBMS-R. The Java version was the main system used. The Virtual Basic versions would likely be retired soon. The user would look at the available medical evidence and apply it to the data points on the user interface, and then the evaluation builder would generate an output based on the rating.

Acting Chairman Pamperin asked if consistency and accuracy of evaluations had been improved with the introduction of evaluation builders. Mr. Christopher said he was not aware if that had been measured. The Acting Chairman asked if the Committee could get some information on this. Ms. Stewart promised to obtain an update.

The Committee recessed from 9:56 a.m. to 10:10 a.m.

Disability Benefits Questionnaire (DBQ) Removal Update

Mr. Hutchinson gave the update. He explained that VBA had discontinued DBQs on the public-facing website for several reasons: Congress expanded VBA’s contract examination authority so that exams were now available nationwide. VBA’s statutory duty to assist, combined with the expanded contract exam coverage, made it unnecessary for Veterans to

incur the expense of an exam. The availability of DBQs created an industry characterized by abusive business practices that harmed Veterans. After Veterans had paid for these exams, they were often unusable by VA and delayed the claims process. Public DBQs were only 2.5 percent of all DBQs that VBA received. The cost of administering a public DBQ program far outweighed any potential benefit for Veterans. Lastly, the requirements of the Paperwork Reduction Act made it impossible for VBA to synchronize internal DBQs with external, or public, ones.

VBA's statutory duty to assist included providing each claimant a medical exam, at no cost to the claimant, if it was necessary to develop the claim. This duty included obtaining any medical evidence or records that the claimant identified. Discontinuing public DBQs had no impact on a Veteran's ability to submit medical evidence in support of his/her claim. Medical records from a Veteran's treating physician were more influential to the outcome of a claim than a DBQ completed by a business established for the purpose of profiting off of claimants for VA benefits. VBA's current claim process was streamlined to include the medical exam process and ensured the fastest possible route to an award of benefits without any of the risk inherent in antiquated public DBQs.

Acting Chairman Pamperin noted that Mr. Hutchinson had stated that public DBQs only accounted for 2.5 percent of all DBQs received, and of those public DBQs, only four percent were relevant to the Veteran's claim. Mr. Hutchinson said that the DBQs had been designed with the intent of being completed by a treating provider with knowledge of the Veteran's condition. Instead, the forms were being completed by for-profit businesses with less than scrupulous practices. Mr. Hutchinson's staff had reviewed over 4,000 publicly submitted DBQs, of which only four percent had reported a treating relationship with the Veteran.

Mr. Bruner stressed the importance of transparent information for the Veteran, which suffered when VBA took away the public-facing DBQs, and that the VA Inspector General (IG) and various federal and state agencies were in place to investigate fraud. Mr. Hutchinson said the fields contained within the DBQ forms came straight from the VASRD, which was as easy to pull up online as any DBQ would be.

Mr. Hazell asked how the DBQs lined up with the evaluation builder. Mr. Hutchinson said certain fields on the DBQ did feed the evaluation builder, which did its calculations based on some of the responses by examiners. The fields on the public-facing DBQ would not accurately feed the evaluation builder.

Dr. Lewis cautioned that while the exams were available nationwide in theory, in practice they could still be difficult to access in some places, particularly rural areas. Mr. Hutchinson replied that VA had set a limit of 50 miles for Veterans to travel to receive a general exam, and 100 miles for a special one. He encouraged the Committee to report any instances when Veterans had to travel farther. Dr. Lewis added that she had worked with a Veteran who had had to travel an hour to receive an exam that would have been available at a place only 15 minutes away. Mr. Hutchinson promised to follow up with her.

Acting Chairman Pamperin asked Mr. Hutchinson if he had any information as to the number of cases referred and actively investigated for fraud. Mr. Hutchinson said he knew there were a number of investigations ongoing, but that IG could be quite tight-lipped.

Instances of fraud could be reported by a wide variety of sources, so it was hard to keep track of exact figures.

Mr. Wunderlich argued that the disclaimers on forms should make fraud easy to investigate and prosecute. Mr. Hutchinson pointed out that VA had no enforcement authority for that, and that it was not allowed by law to reject evidence. Mr. Wunderlich said he was speaking in terms of the IG.

Acting Chairman Pamperin said he understood the VASRD was available online, but a person who was not familiar with VA programs would have a hard time understanding how they were being evaluated. He asked if it would be possible to include an acknowledgement letter, development letter, and/or simple fact sheets explaining what was going on. Mr. Hutchinson said that had been proposed before, but there had not been much movement on it. He added that all accredited representatives still had access to the internal DBQ. The Acting Chairman asked if that included attorneys. Mr. Hutchinson said attorneys did not have access unless they had been accredited and had the appropriate code.

Dr. Johnson asked if fraud was presumed to be on the side of the provider, the Veteran, or both. Mr. Hutchinson said Compensation Service was not assuming anything; it merely questioned the practices of the individuals, organizations, and providers. He added that many of the worst offending organizations consisted of former VA employees. Acting Chairman Pamperin asked how large this industry was. Mr. Hutchinson said Compensation Service had referred over 100 providers and 30-40 organizations.

Mr. Bruner argued that VBA's decision to remove the public-facing DBQs might have gone over better if it had provided a guide for the Veteran filing a claim. Mr. Hutchinson promised to consider Mr. Bruner's suggestion. He added that VBA realized this was a controversial decision, but believed it was warranted considering the protection of the Veteran and the taxpayer and the cost to properly administer a public-facing DBQ program. Acting Chairman Pamperin said he understood VBA's position, but reiterated the Committee's concerns regarding transparency. Mr. Hutchinson said he would take those concerns back to VBA.

Public Comments

Acting Chairman Pamperin read the remaining written comments into the record.

The Committee had received two emails from Peter Van Dermark, who had filed a series of claims with the VA which he had deemed valid, but had nevertheless been rejected, often after he had been forced to wait for extended periods of time. The Acting Chairman said he did not know if Mr. Van Dermark had a representative, but that his communications clearly demonstrated the value of having one when filing a claim.

The next comment was from Kirk Valdez, who had gone to the hospital because of conditions that he believed arose from his exposure to toxins while in the service, and wanted to know why he was being charged a copayment. Acting Chairman Pamperin asked Ms. Stewart to obtain the relevant Social Security and claim numbers, and check with VHA to see whether copayments were, in fact, required. Ms. Stewart promised to report her findings to the Committee.

14
ACDC Minutes, July 14-15, 2020

The last letter was from Larry Miller, a retired Marine who encouraged the Committee to continue its heroic efforts for those with little time left.

Acting Chairman Pamperin added that the Committee had received a number of comments about Camp Lejeune and was working on a presentation regarding that issue for its September meeting.

Travel Admin

Ms. Lawless reiterated with Committee members steps for receiving compensation.

Committee Discussion on Biennial Report

Ms. Stewart said she had submitted inquiries as to what the Committee could and could not do in a virtual workgroup discussion. She expected to report back to the Committee by the end of the week.

Acting Chairman Pamperin encouraged members to submit their portions of the biennial report by the middle of August so that the Committee could edit the document collectively.

Adjournment

Acting Chairman Pamperin adjourned the meeting at 11:09 a.m.

Toby Walter
Neal R. Gross & Company
Preparer of the Minutes

Janice Stewart, Committee DFO

Thomas J. Pamperin
Acting Committee Chairman