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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2003

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

FEBRUARY 13, 2002

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DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2003

WEDNESDAY, FEBRUARY 13, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Evans, Filner, Gutierrez, Buyer, Carson, Reyes, Snyder, Moran, Rodriguez, Lynch, Simpson, Berkley, Hill, Udall, Davis, Miller, and Boozman.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The hearing will come to order.

I want to thank all of our witnesses for agreeing to appear today. I also want to extend a very special welcome to the newest members of the Committee on Veterans' Affairs: Jeff Miller of Florida and John Boozman of Arkansas on the majority side; Stephen Lynch of Massachusetts and Susan Davis of California on the minority side.

This committee has a long history, as I think everyone knows, of addressing veterans' issues in a bipartisan manner, and I believe we must continue that tradition if we are to be effective in the future.

the Administration's budget proposal for the Department of Veterans Affairs represents the largest increase in spending ever proposed in terms of total dollars, $6 billion over last year for a total of $58 billion.

In the most critical area, veterans' health care, the Administration is requesting 22.7 in direct appropriations, in addition to 1.4 billion that is expected to be available through collecting co-payments and third party insurance payments, an increase of 1.4 billion in appropriated dollars, also a record in terms of total dollars.

We all recognize and commend the efforts of the Secretary in fighting for this increase and his commitment to providing the best possible care for our Nation's veterans.

Yet despite these large increases, the Administration itself acknowledges that their proposal does not contain enough appropriated dollars to provide care for all of the veterans who are expected to seek care from the VA next year. According to the VA's calculations, an additional $1.1 billion would be needed.

To cover this shortfall, the Administration is proposing a new $1,500 deductible that would applied to Category 7 veterans in order to increase collection and decrease the number of veterans seeking health care through the VA. In fact, the VA has indicated that one result of this proposal will be that 121,000 veterans will leave the VA health care system. At a time when health care costs continue to rise and our veterans population continues to age, Congress should not endorse a policy designed to discourage veterans from obtaining health care from the VA. With all due respect, Mr. Secretary, I believe this proposal is a non-starter, and I will oppose it.

Ironically, last month the President signed legislation, H.R. 3447, now Public Law 107–135, which contains a provision requiring the VA to lower co-payments for near-poor veterans who live in high-cost areas of the country. Thus, I question whether this new $1,500 deductible proposal fits the policy we so recently enacted into law.

It seems to me that the answer is not to turn away veterans and their families, but to provide sufficient resources to the VA in order to meet their needs. Last year, working in a bipartisan manner, the committee was able to increase health care funding significantly, although not by as much as I or others, including the members of the Independent Budget who will testify later, would have preferred.

We succeeded last year by presenting a serious, detailed, and bipartisan estimate of the legitimate needs of the VA health care system. We should do the same this year. Rather than seek a solution that turns away veterans, we must work together to build a budget proposal based on the principle, "leave no veteran behind."

Let me point out that by keeping veterans inside the VA health care system, we will be investing health care funds in a system that clearly has one of the world's most advanced patient safety programs, one in which the cost of the care may well be 25 to 30 percent less costly than comparable care in the private sector.

Judging by the rising enrollments, it also appears that veterans are voting for their favorite health care provider, they're voting with their feet, by seeking VA care in record numbers.

In fact, despite their funding limitations, the VA provides excellent health care for almost 5 million veterans and their families.

As a member of the Committee on Veterans' Affairs for over 20 years, I have had the privilege of meeting with thousands of the more than 220,00 VA employees, and they are indeed a unique national resource. Unlike health care systems, most of the employees in the VA choose to work there out of a commitment to serving and its veterans. And not coincidentally, many of them are veterans themselves.

Our goal, therefore, must be to put federal health care dollars where veterans are receiving their care. VA already has the authority to collect payments from veterans and third party insurers, and they must continue their efforts to do a better job at that. The Secretary has indicated his desire to do just that.

At the same time, we may need to examine current laws and policies that prevent VA from collecting for the cost of care if enrolled veterans are members of HMOs or are covered by Medicare. We need to see if there are ways to offset some of the cost of their

care through innovative approaches to these obstacles. The health care provider actually providing the care should be the one getting the money.

We must also take action to ensure that VA's hospitals, outpatient clinics, research centers, and other facilities are properly maintained. Last year, our committee reported out H.R. 811, and the House later approved it, to provide $550 million in emergency funding to repair, retrofit, and rehabilitate crumbling VA health care facilities.

While I am pleased to see an increase in the Administration's major medical facility construction request, I continue to be concerned that we are failing to properly maintain the aging infrastructure of the VA health care system.

I would continue to urge our colleagues in the other body to move this legislation, and I tried—and I know you did, as well, Mr. Secretary, repeatedly, to get them to move—and would hope the Administration would continue this year to try to procure that amount.

Last year was indeed a productive year for the committee.

Working together with the leadership of our subcommittees, subcommittee chairmen Mr. Moran, Mr. Simpson, Mr. Buyer, our vice chairman, Mr. Bilirakis, and the ranking members, who have worked very hard, we were able to enact into law, and the President signed, five significant new bills.

Several others, again, are still pending over on the Senate side and several we hope to act on in this committee. This year, we must and we will aggressively seek to have these new laws swiftly and faithfully implemented with full funding from the Congress.

Of particular urgency are the provisions of H.R. 2716, now Public Law 107–95, the Homeless Veterans Comprehensive Assistance Act of 2001.

Every night, as we all know, more than 250,000 homeless veterans are sleeping on the streets—on any given night, the equivalent of 17 infantry divisions, more than the entire United States Marine Corps.

It is absolutely imperative that the VA move rapidly to open the 10 new domicillaries authorized by our legislation, establish the new technical assistance grant programs, and work with HUD to implement the new Section 8 low-income housing voucher program. We don't have a minute to spare, and, again, we have an obligation, and again, we'll be pushing hard so that no veteran will be left behind.

We also approved legislation, H.R. 1291, now Public Law 107–103, the Veterans Education and Benefits Expansion Act of 2001, providing an historic increase for the Montgomery GI Bill program, and we must ensure that it, too, is fully funded.

Finally, as I mentioned before, we also approved H.R. 3447, now Public Law 107–135, the Department of Veterans Affairs' Health Care Programs Enhancement Act of 2001, which, in addition to lowering out-of-pocket hospitalization costs for lower income veterans, requires the VA to establish new programs providing chiropractic care and service dogs for severely disabled veterans.

This new law also creates new incentives and recruitment programs to attract and retain nurses within the VA. We look forward

to the testimony on whether the budget proposal accommodates all of these new and expanded programs.

Another important issue presented to the Congress by this budget concerns the Administration of employment assistance to job-seeking veterans. The GAO and numerous others have examined the Veterans' Employment and Training Service (VETS) and agree that it is an agency mired in mismanagement, as evidenced by their lack of vision, accountability, and results.

the Administration has proposed that it be transferred to the Department of Labor and that the funding be made available for competitive grants. Whether the Congress is ultimately persuaded that this is the appropriate step, it is my belief that on this issue as well, Congress cannot simply do nothing.

I am pleased that our subcommittee on Benefits Chairman Mike Simpson and Ranking Member Silvestre Reyes have already held a hearing on the need for reform of this program, and that they have pledged to look very carefully at all that needs to be done to deliver effective job-finding assistance to our veterans. They need and deserve the support of all of us in their quest.

Mr. Secretary, I want to commend you for your stewardship of the Department during the past year. You have been honest, you've been approachable, and you've been effective.

More importantly, you have seized the helm and laid a very clear course for the Department. I urge my colleagues to pay careful attention to the Secretary's statement and look forward to working with you to ensure that we leave no veteran behind.

I yield whatever time remains to Ranking Member Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman, and good morning, Mr. Secretary. Welcome to you and your colleagues. We look forward to your testimony today.

The VA has many serious problems, but when the VA has problems, so do the veterans of this country. Mr. Secretary, you have not made these problems, but they have found you. And if they are not resolved quickly, they could become your legacy.

The VA has a budgetary shortfall this year; they have acknowledged it. But I think it's even bigger than reported. Today we're examining a new budget for veterans, but it is, in my opinion, a major disappointment.

We are told it provides $25 billion in so-called resources for medical care; $800 million of these resources are for retirees' benefits costs. These costs are being shifted to the VA from the Office of Personnel Management. It's clear that OPM never has considered these costs as veterans' medical care resources.

Many times statements are made about veterans being our main concern. We all ought to appreciate these sentiments. But that's too little. It won't solve the problems we all know exist. What we do for veterans is far more important than what we say about them.

VA needs about $26 billion in appropriations for medical care next year. Some say we can't afford it—that appropriating $26 billion for our veterans will increase the deficit. It will increase the

budgetary deficit by less than 8/10 of 1 percent. Not only can we afford it, we must afford it.

I look forward to hearing your testimony this morning, Mr. Secretary, and thank you, Mr. Chairman, for yielding the time.

The CHAIRMAN. Thank you very much, Mr. Evans.

We will have to break shortly, regrettably, for two votes.

Chairman Moran, I understand you have an opening statement?

Mr. MORAN. Mr. Chairman, I'll just have my opening statement put in the record, and I'll take the opportunity to question the Secretary at the appropriate time. Thank you.

[The prepared statement of Congressman Moran appears on p. 69.]

The CHAIRMAN. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. I also have a statement for the record, and I want to welcome the Secretary here this morning.

[The prepared statement of Congressman Reyes appears on p. 69.]

The CHAIRMAN. Thank you, Mr. Reyes. Mr. Buyer.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. I would like my statement submitted for the record.

The CHAIRMAN. Without objection, so ordered.

[The prepared statement of Congressman Buyer appears on p. 71.]

Mr. BUYER. I want to thank you, and let me thank Dr. Murphy for an issue we worked on after September 11 on how we can move education from on how to treat casualties of chemical, biological, radiological, moving that piece into the VA. As a nexus, we have 122 VA hospitals affiliated with medical schools across the country.

Dr. Murphy did a very good job of helping put together a bill that's going to move through Congress. So I want to thank her for doing that.

It's easy to take swipes at the VA. It's really easy. But when you get in it, you find there are a lot of people who are working very hard. I want to congratulate you for your historic increase in this budget and I think this conference committee working together with you, we can go a long way.

I yield back.

The CHAIRMAN. Thank you, Mr. Buyer. Dr. Snyder? Or Mr. Boozman?

I want to thank, again, my colleagues for coming out. We have to be voting, and we'll return.

I'd like to just introduce our very distinguished witness, and then when we come back we'll go right to his testimony.

The Honorable Anthony J. Principi, Secretary of Veterans Affairs. Secretary Principi has a long history of service to our Nation and in just his first year at the helm, he has brought all his knowledge, energy and enthusiasm to the cause of supporting our Nation's 25 million veterans and their dependents.

Secretary Principi has a wealth of knowledge, having previously served as Deputy Secretary of the VA in the first Bush administration.

He was chairman of the Federal Quality Institute in 1991 and chairman of the Commission on Servicemembers and Veterans Transition Assistance established by Congress in 1996.

He has extensive private sector experience as well, having served as president of QTC Medical Services, senior vice president at Lockheed Martin IMS, and as a partner in the San Diego law firm of Luce, Forward, Hamilton & Scripps.

He also knows his way around Capitol Hill, having served as chief counsel and staff director of both the Senate Armed Services and Veterans' Affairs Committees.

Secretary Principi is a graduate of the Naval Academy, he is a combat-decorated Vietnam veteran, and Seton Hall law school graduate—that's in my state, of course, and we're very proud of it. Secretary Principi has served our Nation proudly, and we are very happy to have him here this morning.

And again, I apologize for this recess, but we will get right to your testimony upon returning.

Secretary PRINCIPI. Thank you, Mr. Chairman.

The CHAIRMAN. We are in a brief recess.

[Recess.]

The CHAIRMAN. The hearing will resume.

Mr. Secretary, you've already been introduced. We do hope you will proceed, and we look forward to your testimony.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY FRANCES MURPHY, M.D., MPH, ACTING UNDER SECRETARY FOR HEALTH; JUDGE GUY McMICHAEL, III, ACTING UNDER SECRETARY FOR BENEFITS; COL. ROBIN HIGGINS, UNDER SECRETARY FOR MEMORIAL AFFAIRS; TIM S. McCLAIN, GENERAL COUNSEL; AND MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT

Secretary PRINCIPI. Thank you, Mr. Chairman, Mr. Evans, members of the committee. I'm pleased to be here today to discuss the President's 2003 budget proposal for the Department of Veterans Affairs.

I want to thank you, Mr. Chairman, and Mr. Evans, and all the members of the committee for the very, very tremendous advocacy on the part of our Nation's veterans and for my department and all you do for us.

We sometimes differ in approach, but that's what this process is all about: to find the right approach and to do what's right for our Nation's veterans. We look forward to working with you and the ranking member and the members of the committee to that end.

The fiscal year 2003 budget request for the Department of Veterans Affairs does, indeed, reflect the largest increase ever proposed for veterans' discretionary programs. Despite today's national emergency, a time when increases in discretionary spending averaged about 2 percent, VA's discretionary spending increased by 7 percent.

I am proud of this budget, and I'm grateful to the President for his support.

We are requesting $58 billion for veterans' benefits and services, $30.1 billion for entitlement programs; and $27.9 billion for discre-

tionary programs. This is an increase of $6.1 billion over the 2002 enacted level.

Our budget increases VA discretionary funding by $3.1 billion over the 2002 level, including medical care collections.

Increases for specific programs are as follows: a 7 percent increase in medical programs, or $1.57 billion, and I've taken out the money on this transfer of funds for health care costs and retirement costs and $260-some-odd million for the deductible. The $1.57 billion is real, and it's very large.

A $17 million increase for burial services; $94 million for the administration of veterans' benefits; and a $64 million increase for capital programs and other grants, and departmental administration.

Our budget request also includes $197 million, as you know, for a new grant activity to replace programs currently administered by the Department of Labor.

I'm very pleased that we're working with the assistant secretary, Fred Juarbe, who heads the veterans' program for the potential transition of that program to see how we can enhance it and ensure it meets its intended benefit, and that is to ensure that veterans, all veterans and especially those who are separating from active duty, disabled veterans, and the veterans with severe employment handicaps receive the benefits they have earned through their service to our Nation.

Our request for medical care is for $25 billion, including the $1.5 billion in collections. With these funds, we will be able to provide care for nearly 4.9 million patients, 3.3 percent more than we expect to care for in fiscal year 2002.

Perhaps we're the victim of our own success in many ways, but the VA has seen extraordinary growth in our workload since open enrollment came about in the mid-1990s; 38 percent overall growth in workload in the number of Priority's 1–6 veterans who are coming to us for care, that's grown from 2.4 million to 3.4 million; and an addition in Category 7 veterans, a 500 percent increase since 1996.

At the current rate, Category 7, just one category alone, will comprise about 42 percent of the VA's patient enrollees by the year 2010. The annual rate of growth averages 30 percent over the last 6 years.

I might point out that when we started open enrollment in 1996, Category 7's were 3 percent of our enrollees, and today they are 33 percent.

With no changes, the cumulative Priority 7 cost will be $20 billion between 2003 and 2007.

I believe the reason for this tremendous increase is primarily because of the improved quality in VA health care. This is not my father's VA. It is a much improved health care delivery system with over 600 clinics throughout the country providing convenient access for our Nation's veterans to get to the VA health care system.

Of course, we've seen HMO failures, we've seen fluctuations in the economy. We have a tremendous pharmacy benefit. And I think all of these factors, and perhaps others, have led to this tremendous, tremendous growth in the number of veterans who have come to us for care.

I'm very proud that record numbers have come to the VA and have chosen VA as their health care provider. That's what we have tried to do, and we have been successful.

However, meeting their future needs will require extraordinary efforts on everyone's part. The President requesting, and the Congress approving, a record appropriation, will necessitate VA further improving our stewardship of the resources that have been entrusted to us on the part of our veterans.

I believe that we are doing our part. We need to do more, but we are working hard.

For example, we're making substantial improvements in billing and collecting from third-party insurers. We expect to collect more than $1 billion this year, and with continuing increases in 2003 and beyond.

We are taking steps to improve our documentation, our coding, and our functions of billing and collections, and we will look very seriously at consolidating those functions, not just in 21 networks, but centrally, to ensure that we're efficient and we're effective.

We're making difficult decisions through our CARES initiative.

As you know, I recently announced the decision to close one of the four medical centers in Chicago and to consolidate those services in the other three, primarily the west side facility, and to build a new SCI and a new Blind Rehab Center at our Hines facility and to look at greater joint cooperation between DOD and VA at our North Chicago facility.

However, for us to continue to treat all veterans, I believe that higher income veterans and primarily their insurance companies will have to share in the cost of providing care.

So the medical care budget does include a proposal for a $1,500 deductible for Priority 7 veterans, and I want to stress that this deductible does not apply to any service-connected disabled veteran.

It does not apply to any veteran pensions or any low-income veteran. It does not apply to any veteran in receipt of aid and attendance. It does not apply to any former POW.

It does not apply to any veteran who is at the VA receiving care for any exposure to environmental hazards, be it Agent Orange or Persian Gulf War Syndrome. It doesn't apply to the few World War I veterans who still come to us for care.

It only applies to those veterans who are non-service connected and have higher income, the fastest growing of our veteran population.

We want to do this in a way that ensures that we do have a safety net for those who become seriously ill in our Category 7's, and I want to also stress that this initiative does not deny care to anyone. We will keep our health care system open to all veterans, including those who may have other health care coverage.

If they are insured, we will seek reimbursement of that deductible from their insurance companies, and we hope that deductible will provide an incentive for Category 7 veterans to let us know when they do have insurance so that we can bill their insurance companies.

If they do not have insurance, and they cannot afford to pay, then we will work out a repayment plan with them to ensure that

they still come to us for care, but that they can pay that portion of the deductible in a way that meets their incomes and whatever.

In addition to a record increase in medical care, VA's clinical research program is funded at the highest level in history with a partnership of government, universities, and the private sector.

Over $1.46 billion will be invested in 2003, $409 million in direct appropriations, $401 million in support from the VA medical care appropriation, and support in the form of salaries, support for our clinical researchers, $460 million from federal organizations such as DOD and NIH, and $196 million from universities and other private institutions. This investment is relevant to the medical needs of the entire nation, and will enhance future quality of life.

In veteran benefits, we're requesting $1.2 billion for 2003. We have hired over 1,000 new workers and we expect to hire an additional 125 with the funds allocated to us, and we hope that these new employees, once they're trained, will allow us to continue progress towards dramatic improvements in claim processing timeliness and continued improvements in accuracy, which I know is an issue of importance and concern to all members of this committee, as well as to myself.

We have studied claims processing long enough. We had a Task Force headed by Admiral Cooper, who will soon be the new under secretary of veterans' benefits, assuming the Senate consents to his nomination, and now it's time to end the Powerpoint presentations and get on with the implementation of those recommendations.

Under Judge McMichael's leadership, we have, in fact, done that. We've had focused, disciplined implementation of those Task Force recommendations, and I'm confident that in a short period of time, the backlog is going to come down.

To give you an example, in January of 2001, we decided 29,036 claims for that month of January. This past January 2002, we decided 62,536 claims.

That's a dramatic improvement in getting veterans the decisions they need, the disability compensation they need to get on with their lives. I'm very, very proud of that, and I hope we can continue to make an inroad into that backlog.

But then again, with the diabetes claims and the duty to assist and other initiatives, that backlog continues to remain high.

I will conclude in just one moment, Mr. Chairman, if I may. I know I'm running longer than the 5 minutes.

Our capital funding program and grant program is at $536 million, and this is the largest request since 1996. You pointed out, Mr. Chairman, our capital infrastructure needs, and I believe this will help make some inroads there.

Our budget includes funding for two new national cemeteries in the vicinity of Pittsburgh and Miami, improvements at Willamette, Oregon, and $138 million to operate our national cemetery system.

We are working very, very diligently to implement the one VA information technology enterprise architecture developed in 2001, and are working toward development of a strong program for cyber security.

Finally, I would like to mention that shortly we will begin to review the procurement reform Task Force recommendations that I believe will allow us to be a better purchaser of medical supplies

and services, pharmaceuticals, and equipment. I look forward to receiving that procurement reform Task Force report and getting on with the implementation so that we can save dollars that can be used to expand the reach of health care.

Again, I appreciate the opportunity to testify, Mr. Chairman, Mr. Evans, members of the committee, and I look forward to your questions.

[The prepared statement of Secretary Principi appears on p. 72.]

The CHAIRMAN. Thank you very much, Mr. Secretary. Your full statement—I read it last night, it was very comprehensive and I appreciate the details you included in it—will be made a part of the record without objection.

Just a couple of opening questions. I've read the Independent Budget and I've read the testimonies that have been submitted by our witnesses who will appear later, and there's a concern, a gap, if you will, in terms of what is needed to continue or just retain current services.

John Baldwin with the PVA, speaking for the Independent Budget, talks about $25 billion, and that's not including monies that would come in from the medical care collections, and I know you're working very hard to increase that.

The Legion's number is $23.1 billion, and they emphasize that medical care collections are to be seen as a supplement and not an offset, again, to just continue current services.

And again, as I indicated at the outset, I don't think there's support in Congress for the $1,500 deductible. I certainly don't support it.

I know you have to go through the very difficult process of being cut by OMB.

What we'll try to do on this committee is to, as faithfully as possible, get to the number to meet a needs-based budget rather than something that is just moving the deck chairs around, and that's a big objective.

Sir, I would ask you to comment, if you would, on this significant gulf between your request and what the Independent Budget suggests, $24.5 billion for medical health care.

The second question would be on the whole Millennium Health Care Act, which we all supported. It was bipartisan. It went through a very rigorous House-Senate Conference Committee. We did write you last April, Mr. Evans and I. We did get a response back. We appreciate that.

But your response basically suggests that it is not implementable, that the goals set out and the capacity capabilities could not be met.

Again, if it means more money, that's what we need to be all about, and we fight for appropriations and for the budget.

But, you know, this is the law. Can you provide us within, say, a month, 30 days, a plan to implement that law faithfully? And if you could, speak to that issue, I'd appreciate it.

Secretary PRINCIPI. Certainly, Mr. Chairman.

Again, I'm pleased that we have a record budget. You asked what it would take to maintain current services, without the deductible, I'm assuming, to continue to have open enrollment for any veteran who comes to the system, and to maintain high quality and reason-

able waiting times for an appointment, which we're already finding that some of our clinics are extending beyond acceptable levels.

Based upon that question, and not to appear to be asking for more money, it would probably take about $2.7 billion to maintain current services, $1.1 billion of which will be realized through the deductible.

So indeed, the deductible is an important component of it, from a revenue perspective, so I will say about $2.5 billion to maintain current services.

With regard to the Millennium Bill issue on long-term care, we are in compliance, I might add, with two of the three parts of that provision dealing with non-institutional care for the basic benefit package and also for the 70 percent service-connected disabled.

Where we've had difficulty in recent years is with the institutional component that only counts VA nursing home beds. This component does not count State nursing home beds, which we have made a big investment in, Congress has made a big investment in, and we pay per diem for each veteran in the home, as well as community nursing homes, because we have found that veterans like to be closer to their residences, rather than at a VA nursing home further away.

I would request the committee's consideration of including in the census not just VA nursing home beds but also State nursing home beds (which VA has increased), and community nursing home beds, as well as the non-institutional portion, to try to keep veterans in their homes as long as possible, because they prefer to be cared for in their homes rather than in nursing homes; that would: include hospital-based home care, adult day care, respite care, all of which are so important in improving their quality of life.

I think if there's some way we could work out a floor that takes into consideration the other institutional components and the non-institutional components, we would have a better package of benefits.

Of course, if you increase the budget in one area, you've got to take money away from another area. The question is: where do we take away?

Do we take away from the community-based outpatient clinics or from acute care in general? That's been the struggle that we have had to deal with over the past couple years.

The CHAIRMAN. Thank you. I do hope that, if you could, provide us with a plan to implement this, because, you know, my sense is that, the capacity has shrunk.

I understand the argument of what's happening on the State level, but obviously there's almost a balloon of need, particularly with our World War II veterans, who, if they were available, would require the services; so I look forward to working with you on that.

I want to say very clearly that I know we fought the inside fight very, very hard to try to get as much funding as humanly possible. Many of us on this committee will look at your number, I certainly will, as a floor. We will try to increase it, because we think you need the resources to care for the veterans which you and your staff care about so very much.

I do want to commend you for fighting so hard.

Secretary PRINCIPI. Thank you very much, Mr. Chairman.

The CHAIRMAN. My time is up, but we 're concerned about the national emergency mission, and I'm sure some of the other members will get into some questions along those lines, but I want to thank you again for your leadership.

Chairman Moran.

Mr. MORAN. Mr. Chairman, thank you. Mr. Secretary, thank you and your staff, fellow secretaries, for being here.

I also will joint our chairman in commending you for your efforts on behalf of veterans and in this budget process, where we are today. I know it was in large part due to your leadership.

There are troubling aspects of this budget, and as Chairman Smith has indicated, the $1,500 deductible is one that stands out in all of our minds, I assume yours as well.

I am interested in a couple of things about that. You indicated that, in your testimony, that we would expect veterans, and I think more significantly, their insurance companies, to pay that deductible.

Do we have numbers that suggest how many of those veterans are insured and such that the $1,500 is not coming from the veteran but from their insurance carrier?

Secretary PRINCIPI. A small percentage identify insurance coverage. We don't know if those are the only ones who have insurance. There's never really been much of an incentive to identify insurance.

I believe that a deductible would, in fact, increase the number who would advise us that they have insurance, and we could increase our third-party collections.

But it's a relatively small percentage.

Dr. Murphy?

Dr. MURPHY. Probably about 15 percent of the veterans who receive health care from VHA identify insurance. The majority of them, however, have Medigap coverage, and the average reimbursement for the Medigap payment is about 13 percent of our billable amount.

Mr. MORAN. How does that apply to Category 7 and whether or not they have insurance?

Dr. MURPHY. Based on a priority.

Mr. MORAN. It's got to be a higher percentage, I assume, perhaps than other veterans would have insurance?

Dr. MURPHY. Yes, but overall it's about 15 percent.

Mr. MORAN. Okay. Was the $1,500 chosen for any reason, other than the number of dollars necessary to make the budget work?

Secretary PRINCIPI. The average cost for VA health care is approximately $1,800 for Category 7's, and the $1,500 was chosen based upon that $1,800 figure.

Mr. MORAN. What's the relationship between the $1,800 and the $1,500? That's the amount we believe veterans are able to afford or that's the amount necessary to cover the cost of providing the service?

Secretary PRINCIPI. We believe that would allow us to cover the majority of the cost of providing the service, and that's why that $1,500 was chosen.

Mr. MORAN. In December, when you proposed, when the department proposed a cutoff in enrollment of Priority 7 veterans because

of funding shortages, you indicated that certain management changes and procedures could result in savings sufficient to help us meet that so-called shortfall.

We've asked for what those management changes might be. We've requested kind of a briefing on those management changes.

Is something in the works that you believe results in sufficient savings to meet the enrollment of Category 7 veterans?

Secretary PRINCIPI. I certainly do. In 2002, we estimate just about $300 million in management savings and another $316 million in 2003.

The kinds of efficiencies that I envision, and that the Veterans Health Administration has embraced, are consolidations of many of our administrative functions, IT, finance, and supply.

We have a procurement reform Task Force that will shortly submit recommendations on the standardization of medical/surgical supplies, equipment, utilizing our shared purchasing power, clinical operations, and other consolidations throughout our system.

We believe there are efficiencies that can be achieved in our health care delivery system and those figures are realistic.

Mr. MORAN. Is there a plan of what those management changes might be and the anticipated changes that would come from each one? Is there something we can review?

Dr. MURPHY. We do have a list of mandated efficiencies that each network was asked to accomplish. Some of them had already begun, some of these consolidations of administrative functions in the past.

In addition, we've asked our centralized programs to take a 2 percent efficiency in their allocated budget, and that money will be returned to the field.

Mr. MORAN. Are there efficiencies to be found in additional cooperation with the Department of Defense or do you see that as an increase in cost?

Dr. MURPHY. There will be some additional efficiencies there. It will take us some time to come to agreement with the Department of Defense, so I don't believe many of those increased receipts will occur this year.

Mr. MORAN. You indicated back in, Mr. Secretary, back in February that we couldn't afford to maintain nursing home beds, despite a congressional requirement that you do so.

In our Health Care Improvement Act that was just signed by the President earlier this year, we have requirements for maintaining capacity related to substance abuse, traumatic brain injury, and other programs.

Are we anticipating an inability to comply with that law?

Secretary PRINCIPI. No.

Mr. MORAN. Can we maintain those facilities in each VISN?

Secretary PRINCIPI. By and large, all of our capacity for spinal cord injury disorders, spinal rehabilitation, seriously mentally ill, homeless, PTSD, are at or about the capacity requirement.

The program that is below the capacity requirement is substance abuse, but everything else is up, and I believe we are in compliance.

Mr. MORAN. Mr. Secretary, thank you for your testimony. I respect you and your work and look forward to working with you and

the department as we attempt to take care of the veterans of our country.

Secretary PRINCIPI. Thank you, sir.

The CHAIRMAN. The chair recognizes Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman.

Mr. Secretary, first and foremost, let me thank you for coming to my veterans town hall meeting last August. I'm hopeful that you'll be able to return back to El Paso again.

Believe me, I think all of us know that you're riding a horse you didn't pick. Somebody else picked the horse. You got to ride him. That's part of the process.

But there's a couple of areas that I'd like to ask you about. The first one deals with the backlogs. Since the beginning of this fiscal year, benefits backlogs have gone up some 50,000 cases.

However, when reading your testimony and when looking at the issue of instructions to the VA offices across the country, I'm concerned that there are a number of new hires, brand new employees in a lot of these offices.

For instance, I'll give you an example. In Waco, I think 32 percent are new hires, so they are, in essence, trying to learn the job, while at the same time they've gotten these marching orders from you in terms of reducing the backlog.

I, like every member of this committee, and people that don't understand veterans' issues, would like nothing more than to reduce those backlogs.

However, I'm concerned, given the statistics that we're starting to see, that it's leading to decisions that are made without everything from good judgment to perhaps all the evidence being gathered, medical opinions, those kinds of things, and it's just creating additional frustration.

We get a lot of complaints in my office, and even here, in our office here, from veterans around the country that are complaining about that issue.

They are even saying this is a stall tactic by the Department of Veterans Affairs where they send a case to the Board of Veterans' Appeals that they haven't fully worked. They send it forward knowing that it's going to be remanded, and so they have all this additional time to decide or to delay benefits to veterans.

So those are very real concerns.

Can you address that?

Secretary PRINCIPI. Certainly.

Mr. REYES. I again want you to know that I support reducing the backlog, but it just seems to me that the combination of new employees with the edict to get a reduction by 50 percent just is not getting us anywhere.

Secretary PRINCIPI. I understand, Mr. Reyes, and Judge McMichael our acting under secretary of benefits may want to add his own comments.

Let me say that, indeed, reducing the backlog has been a very, very high priority of mine. It's terribly high. Justice delayed is justice denied. Too many veterans are dying before their claims are decided.

First, we need to put in place performance standards and procedures that will allow us to evaluate these claims fairly and accurately in a timely manner. I think we're doing that.

I also share your concern about the stress on our employees and burning them out. They're trainees. They've just come on board, and we need to ensure that the performance standards that they have are less stringent than those who are experienced and have been there 5 and 10 years.

Unfortunately, for whatever reason, our productivity has dropped rather precipitously.

About 10 years ago, a rating specialist was doing eight to 10 claims a day. In the intervening 10 years, we have spent hundreds of millions of dollars of taxpayers' money on information technology, and today many of our rating specialists are doing two or three claims a day, maybe one a day.

Now, I understand that the complexity of the claims, specifically, the number of issues to rate have increased, but still, veterans will not be well served unless we can improve our performance.

We're putting in steps like triaging and specialization to allow our people to work smarter rather than just working harder.

I am concerned, especially if there are indications that our people are becoming frustrated and wanting to leave the VA, that we need to make some adjustments. I will, in fact, look at those issues and work with the Under Secretary if necessary to make changes.

Do you want to add anything, Guy?

Judge MCMICHAEL. Well, just two things. We do have inexperienced employees. One of the problems we had in the past was that we brought on new employees and really asked them to be experts in everything.

Part of what the Task Force has recommended is that we specialize, so that you can take new employees put them on less difficult claims, put your more experienced employees on the more difficult claims, and hence improve productivity. We believe that implementation of the Task Force recommendations will help that.

Secondly, they are gaining experience. Each month they have more experience and they're gaining more expertise.

We are concerned about decisions that are not correct. We have increased the amount of quality review we do. The evidence that we have so far is that quality is not suffering. We are looking very closely at that.

Rendering a decision quickly that is not correct doesn't benefit the RO. They're penalized against it in terms of their production standards if they render decisions that are incorrect.

We think we've set in place a number of procedures and review mechanisms that will ensure that we get good decisions in a timely manner.

Mr. REYES. Thank you. Mr. Chairman, I know that my time is about to run out, and just one comment, Mr. Secretary. That $1,500 deductible is a non-starter. These are veterans that are in the category, they're not rich. They're making, in most cases, $24,000 or a little bit above that, and they have been very vocal.

In fact, a lot of those veterans that you met in El Paso would come under that category, and they're very upset about it, and it's a non-starter.

Mr. Chairman, as you know, Armed Services has another hearing, so I'm going to have to go there, but I appreciate it, and I'll have some written questions to submit for the record.

The CHAIRMAN. We'll submit them.

(See p. 166.)

Mr. REYES. Thank you.

The CHAIRMAN. Thank you very much, Mr. Reyes. Chairman Buyer?

Mr. BUYER. Thank you. I'm not going to jump into the arena of non-starters, because I think what you've done is you've stepped forward.

One thing about leadership is sometimes you have to be bold, and when you're bold in your leadership and you're at the point that people want to take shots at you, there's a realistic problem.

The realistic problem is this committee, working with the Senate, on the Millennium Health Care Act, it opened up Category 7's and then we didn't fund it because we didn't anticipate the level of veterans that would be accessing the system.

So it's wonderful, you know, for the committee. We can sit here and we can beat you up, but if we're not funding for the level of access, then shame on us. I think it's that simple. So we have created a real a problem for you.

So you're trying to meet the law under these unrealistic guidelines, and we're almost changing what the VA system created for, and so now need to make some very serious decisions of what type of VA we want.

So I'm not going to jump into that category of a complete non-starter here, because you're trying to tackle a difficult issue, and I don't know how we come to terms with this.

If, in fact, with Category 7's, VA wants to provide access to care for these veterans, VA needs to ID them better, Dr. Murphy, and you know that, and not only do VA needs to ID them better and provide access to that health care out there VA need to better identify veterans who have other health insurance and to bill them for that care.

I'll continue to work with you, Mr. Secretary, and those in your departments. It's almost shameful.

I know that if you can enlighten us any, provide us with an update on any of the 24 recommendations made by Price Waterhouse in its 2001 report, how many of those have been implemented I think will be very important to this committee.

I also note that we've had a continuing discussion since we conducted a field hearing in Indiana about the IGs, and you made a request to OMB to beef up your IG staff by over 55 FTEE, yet OMB must have said no to you.

So I'd like to work with you, since it wasn't in your budget. I think this committee would like to, willingly, on a bipartisan basis, work with you. It's an issue that Ms. Carson also brought up at the field hearing that we had, and somehow we have got to work this out.

Your IG office does great work, good service, and the return on investment is pretty strong.

I'd like you to address my comments on the Category 7, the medical costs recovery, and your request to OMB for additional funding for your IG staff.

And last, letting you know that we're going to be holding a hearing here real soon on that so we can get your input.

You asked us to pause. You wanted to look at your information management systems, and to eliminate the three stovepipes. We've given you the opportunity to work with industry on the outside, and we need for you to come tell your story.

With that, I will anticipate your response.

Secretary PRINCIPI. First, with regard to the IG, I could not agree with you more about having an adequately staffed IG, an IG that has the ability to do complete audits, accounting of every VA organization, medical center, VISN, regional office, on a 3-year cycle, apart from the investigative arm, the criminal side of the house that has helped us not only to deter fraud, but to recover when fraud is found.

But I'm concerned that we do not have adequate staffing in the IG's office to, in fact, do the kinds of audits every 3 years that should be done, and to gain a lot of that information so that we can look at it systemwide and make the changes necessary to improve the management and the efficiency of our system. I think it's terribly important.

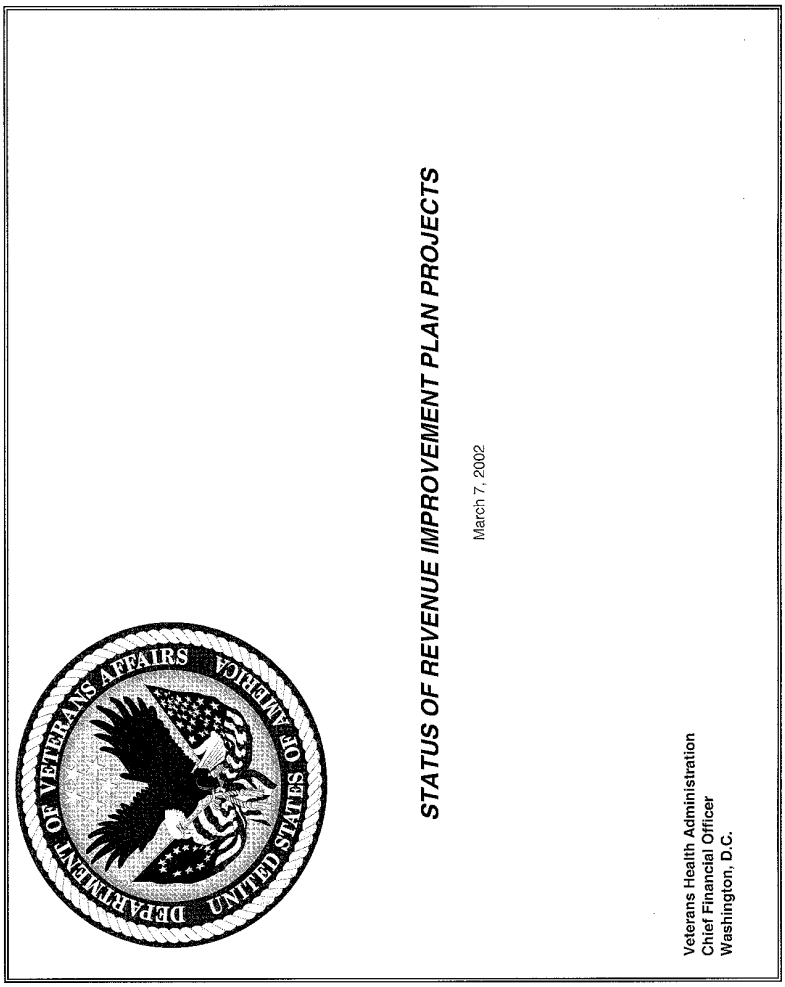
With regard to MCCF, I'd like to give you a detailed readout of all of the recommendations that have been made. Some of them were completed. Many of them are in progress.

It is something that I'm very serious about and will continue to work with you.

Mr. BUYER. Could you submit those for the record?

Secretary PRINCIPI. I will submit those for the record.

(Subsequently, the Department of Veterans Affairs provided the following information:)



Revenue Improvement Plan Status

Rpt Itm	Item Description	Action/Status	Date Due	Date Complt	Chg Due	Comments Actual
1	Mandate pre-registration of veterans	VHA Directive 98-042 issued 9/23/98. ADUSH memo dtd 12/10/01 to network and facility directors re-emphasizing requirement. Project Team will serve as Focus Group for the EDI Insurance Team. ADUSH issued memo dtd 12/26/01 summarizing Revenue Office action(s). Re-issue Directive scheduled for 2nd Qtr, presently in concurrence. Article for Fast Track Newsletter drafted, pending publication.	12/01/01	12/10/01		Completed. Addtl followup required to monitor compliance.
2	Define standards for complete/accurate (insurance) data capture	Project team established 12/01;Team meeting (conf call) conducted Feb 2002. Project Team will serve as Focus Group for EDI Insurance Team. Team Report on intake requirements for insurance data issued 02/02, and presently in clearance process. Guidelines to address procedural requirements during interim period prior to EDI implementation being drafted. Completion date is revised HIPAA deadline coiniciding w/EDI implementation.	12/31/01		10/30/03*	In-Progress. EDI Team addressing long-range conversion. * Indicates revised HIPAA deadline
3	Implement veteran education program	Pamphlets and posters on new copay amounts developed. Statement inserts distributed in January 2002 mailing. Inter/Intranet websites updated 01/02. An Education workgroup was formed 02/02 to collaborate w/EES on education/awareness campaign.	12/31/01	1/31/02		Initial distribution completed 1/02. Additional education/training program development in-progress.
4	Implement employee education program	Project team established 12/01; Team meeting (conf call) conducted Jan and Feb 2002. Additionally, the Education workgroup is coordinating with the (HEC) pre-registration workgroup in collaborating w/EES on education/awareness campaign.	12/31/01			In-Progress. EDI Team addressing long-range conversion requirements for HIPAA implementaion.
5	Implement electronic insurance identification and verification	Project team established 12/01; Team meeting (conf call) conducted Feb 2002. Pilot in-progress in VISN 2. Project Team will serve as Focus Group for EDI Insurance Team. Completion date is the revised HIPAA deadline which coincides w/EDI implementation. Conference call with the EDI Team was held 02/02 to coordinate integration of both team's efforts in identifying system requirements and establishing business rules and models.	3/1/02		10/30/03*	In-Progress. EDI Team addressing long-range conversion. * Indicates revised HIPAA deadline
6	Consolidate insurance information at the enterprise level	Project team established December 2001. Results from VISN 2 Pilot (in-progress) may provide support to this item. Discussions w/St Anthony's Publishing and Ingenix ref: electronic insurance directory file in progress.	7/1/02			In-Progress
7	Develop an employer master file	Project team established December 2001. Project team meeting (conf call) conducted Feb 2002. Identification of systems requirements in progress.	12/1/02			In-Progress

Revenue Improvement Plan Status

Rpt Itm	Item Description	Action/Status	Date Due	Date Complt	Chg Due	Comments Actual
8	Enforce national documentation policy	ADUSH memo dtd 12/10/01 issued to network and facility directors. Contract awarded to PwC on national documentation policy. Draft VHA Directive in progress.	11/30/01	12/10/01		Completed. Addtl followup and monitoring required
9	Mandate use of electronic medical records (CPRS)	ADUSH memo dtd 12/10/01 issued reminding network and facility directors of this requirement. Additional guidance published 1/30/02 mandating full implementation via EDMS(166245).	6/30/02		8/30/02	Performance indicators to monitor CPRS compliance in approval process.
10	Develop national clinical education program	Mtg scheduled 02/11-12/02 in Minneapolis for development of (education/training) tool kit which is in progress.	12/31/02		2/2/02	In-Progress
11	Develop and mandate use of electronic encounter form and documentation template	One encounter form developed and is in testing. Other encounter forms anticipated due by 2/28/02.	1/1/03			In-Progress
12	Develop and implement documentation tracking system	Requirements identification in progress by Project team. Draft of VHA Directive in progress.	12/31/03			In-Progress
13	Develop staffing plan for coding resources	Requirements identification in progress by Project team. Questionnaire in-progress. Recruitment and Retention Handbook in draft. Extension requested thru 3/30/02.	12/1/01		3/30/02	Questionnaire in-progress. Recruit/Retention Handbook in draft.
14	Mandate use of encoder software	ADUSH memo dtd 12/10/01 issued to network and facility directors. Followup required to monitor implementation of encoder software.	12/31/01	12/10/01		Memo drafted on use of standard software in review by CIO
15	Develop national standard for laboratory, radiology and other ancillary test names and corresponding CPR codes	Project Lab and Radiology subteams reviewing (VistA) clinical packages to determine feasibility of subroutines tied to national annual CPT roll out to update all xray/lab and ancillary codes.	3/29/02			In-Progress
16	Mandate minimum access policy to VistA ancillary packages	ADUSH memo dtd 12/10/01 issued to network and facility directors. Additional guidance in draft to network and facility directors to provide minimum access to field Revenue Staff is in progress.	12/1/01	12/10/01		Completed. Addtl followup via joint CIO/ADUSH memo scheduled for 02/02
17	Complete implementation of:					
	EDI Billing Project	National training completed in Chicago and Atlanta. Site testing in progress.	12/31/01	12/31/01		In-Progress. Systems capacity testing successfully completed 02/02.
	MRA Project	Alpha testing in progress. Identification of Systems Requirements Specifications anticipated 05/02. Completion date is revised HIPAA deadline.	4/30/02		10/01/03*	In-Progress. * Indicates revised HIPAA deadline.
18	Implement claims analyzer tools		3/29/02			In-Progress. See Item #14
19	Improve the charge capture process	Project Subteams reviewing high dollar volume clinical packages for billable events. CIO billing package plan development in progress. Project Team meeting scheduled for 03/02 to conduct requirements analysis and develop systems specifications.	10/1/03			In-Progress

Revenue Improvement Plan Status

Rpt Itm	Item Description	Action/Status	Date Due	Date Complt	Chg Due	Comments Actual
20	Consolidate/outsource VHA 3rd party accounts receivable follow-up	ADUSH memo dtd 12/10/01 issued to network and facility directors. RFI closes 2/6, RFP follows. Extension due to contracting and budget constraints. PwC contract for development of CIP for nationwide contract solution. Requirements analysis and draft of proposal in progress. 90 day pilot in VISN 12 in progress to collect on aged receivables thru private vendor.	12/31/01		8/30/02	See Note a.
21	Develop utilization review program	Project Team drafting SOPs, policy, position description & identifying software enhancements. Project Scope change to include Web-based training module, national UR training initiative & proposing more software enhancements for UR activities extends due date to 9/30/02. Questionaire administered 12/01.	3/29/02		9/30/02	In-Progress. Questionaire results under review.
22	Request VA GC more aggressively pursue referred 3rd party AR	Discussions w/OGC held Dec 2001, Jan and Feb 2002. Meeting planned for Jan/Feb w/Project Subteam Leaders.	4/1/02			
23	Implement 3rd party payment and remittance program (EDI Lockbox)	Project team (Mellon Bank, AAC and Technical Development Staff of Revenue Office) established. Systems requirements identified, currently in design. Systems stress testing completed 2/19/02. Software deployment anticipated Apr/May-02.	1/1/03		10/01/03*	In-Progress
24	Implement accounts receivable management software	UNISYS providing DEMO of product currently in use in Pitts VAMC. Visit to Asheville CRU scheduled January 2002. RFI in progress for assessment of additional vendor/products. Other CRUs to view demo @ Pitts, VAMC 03/02.	6/2/03			In-Progress

Additional Notes:

a. Legislation to establish a demo project for a Patient Financial Services System may impact upon this item. Another initiative to establish a National Business Center (billing and collections) may also impact upon this item.

Secretary PRINCIPI. I will be pleased to meet with you and staff to talk about, along with Dr. Gauss, our new CIO, some of the changes that we have put in place to build our enterprise architecture, to end stovepipe design, stovepipe development, and to just improve our entire strategy of IT procurement and management.

We now are building a system that allows us to track every dollar from the time we budget it all the way through to program execution so that we know, every step of the way, how those dollars are being spent.

Did I miss one?

Indeed, I appreciate your statement, Congressman Buyer. It is a real challenge.

As I indicated earlier on, when we started open enrollment, 3 percent were Category 7. Now up to 33 percent of our enrollment base are Category 7 veterans, so we've had tremendous growth.

Again, we're a finitely budgeted health care system. Unlike Medicare, we get an appropriation every year and with the various mandates that the Congress requires of us, whether it be for long-term care or CBOCs or homeless emergency care, we have to spread those dollars evenly across, and it is challenging.

I don't want to see quality diminished, because we've worked too hard to get quality to a level that is recognized in the private sector, and by continuing to allow people to come in with no way to control that growth, it is causing the service-connected and the poorer veterans to suffer somewhat because waiting times are getting longer and I think the whole system will suffer.

So the $1,500 deductible was my best way of saying we don't have sufficient dollars to allow everyone to come in. There has to be some cost sharing, and we thought that the ones that would cost share were the higher-income non-service-connected.

But, I will be pleased to work with the committee on any option that would allow us to achieve our goals, whatever the committee determines should be the policy.

The CHAIRMAN. Thank you. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman, and thank you, as well, for being here, Mr. Secretary. It's good to see you again.

Secretary PRINCIPI. Good to see you, sir.

Dr. SNYDER. Just a couple of questions. I'm trying to understand some of the numbers here, and I think it will take a little time beyond today's hearing for me to do that, but a couple of statements from your opening statement here.

Mr. Secretary, you say that the budget ensures more veterans will receive high quality health care.

I thought that one of the effects—I assume that you're talking about your whole program, which includes the $1,500 deductible.

I thought that one of the effects of the $1,500 deductible is that clearly some veterans will choose to go probably to a private physician, so I mean, where are these more veterans coming from?

I would assume that there will be less veterans served under this plan than more veterans, or are we implying that there's now veterans are getting not high quality health care?

Secretary PRINCIPI. Well, clearly, we expect, even with the $1,500 deductible, that workload will continue to grow above the 2002 level, so we see an increased number of new veterans coming to us in 2003. I don't in any way see any decrease below the 2002 level.

We think we will see a slower growth in new workload, new enrollees.

For example, a significant——

Dr. SNYDER. I'm sorry to interrupt you. My time is limited.

Secretary PRINCIPI. I'm sorry.

Dr. SNYDER. One of the effects is that you do expect that some of the Category 7's will choose to go elsewhere, is that not correct?

Secretary PRINCIPI. Yes. Yes, clearly. And I was going to say that Tricare For Life might be a good example, where a military retiree who is enrolled in Tricare For Life might choose to utilize his or her benefits under the Tricare For Life program rather than coming to the VA, so they're fully covered by Tricare and then they choose to have an option.

Others may choose to use their insurance, or Medicare, to seek those benefits.

Clearly, a segment of the Category 7 population would look to other options for care.

Dr. SNYDER. You made a comment in your oral statement that—in your written statement—about the—I think you were referring to the health care budget as having a real and very large increase of $1.57 billion. Am I quoting you correctly?

Secretary PRINCIPI. Yes.

Dr. SNYDER. Help me with figuring that out. They give us these little blackberries, you know. It actually has a calculator on it that I finally figured out how to operate on the plane the other day.

If I take the 2002 total medical program's number of $22.8 billion and then do my little long division there, $1.57 is just short of a 7 percent increase over the budget.

Secretary PRINCIPI. Correct.

Dr. SNYDER. Well, maybe I'll ask Dr. Murphy. What's the medical inflation rate now? It's substantially higher than 7 percent. So when we talk about something being real and very large, I don't see that you're holding your own.

Secretary PRINCIPI. Yes, I think medical inflation is probably higher than 7 percent in the private sector, though I'm not sure it's comparable in the federal sector.

The vast majority of our employees are federal employees, so we don't have the wide variations and fluctuations in salary costs that you see in the private sector.

While medical inflation is high, but our pharmaceutical procurements, for example, command the best discounts in the country, our starting point is 24 percent below the average wholesale manufacturer's price. We're a large procurer, so we can control our costs, perhaps better than some in the private sector can.

Dr. SNYDER. I understand all that, but when we're talking about real and very large increases, I don't see that you're doing much more than barely holding your own, if that. I mean, is that fair?

Secretary PRINCIPI. I think that's somewhat fair, but again, our pay increase is 2.6 percent in the federal sector. The vast majority

of our expenses in medical care are payroll expenses, and we hold those at 2.6 percent. That's far less than the private sector.

I think we are gaining a little bit, but you're right—inflation does take its toll.

Dr. SNYDER. One of the other statements, you say that the budget reflects the largest increase ever proposed for veterans' discretionary programs.

If you took out the $800 million——

Secretary PRINCIPI. Yes.

Dr. SNYDER (continuing). Well, $800,794,000 for the transfer, the OMB transfer, I assume that was imposed on you all, and if you took out the $1,500 deductible, is it still accurate to say this reflects the largest increase ever proposed for veterans' discretionary programs?

Secretary PRINCIPI. Yes. At $1.57 billion, I don't believe that there's ever been an increase equal to that amount.

So if you take out the $800 million, you take out the $260 million for the deductible, with the $1.57 billion increase, that is the largest increase ever requested.

Dr. SNYDER. What was the largest increase ever asked?

Secretary PRINCIPI. I think it was about $1.4 billion.

Dr. SNYDER. And then my last question is perhaps more just a comment.

We had a fairly vigorous discussion here last year about education benefits and the Principi Commission, and as you may recall, there were some fairly lofty statements here that we're all going to sit down this next year and work out a way to fund the very lofty goals of the Principi Commission that basically would mean a veteran would be able to go to the college of their choosing that they qualified for, which may be a Harvard and it may be a 2-year technical college somewhere.

We're going to be fighting, as the chairman said, just to fund the improvements we made last year. I don't see us making any more steps on that road. Do you?

Secretary PRINCIPI. I think you've taken a gigantic step with the passage and the enactment of the legislation this committee initiated.

It doesn't buy you an education at some of the best schools in America, limited only by your aspirations and ability, but I think you've done a great deal more than I ever expected.

I think more needs to be done, because a large number of men and women leaving the active service who paid for the education benefit still are not using it.

Dr. SNYDER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Snyder. I would just note for the record that it was a 46 percent increase. Obviously, we had more in our original bill. The Senate would not agree to our higher number, which we pushed very hard for, as part of H.R. 1291, but I thank you for your comment.

Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Secretary, why does VA buy almost 60 percent of its medical and surgical supplies and equipment using open market purchases, and is this consistent with the VA's policy?

Secretary PRINCIPI. You are correct, and I intend to make procurement off the FSS mandatory. I applaud your bill, your legislation. We agree on the need for procurement reform, and we are taking administrative steps to implement those kinds of recommendations; but I agree with you that the FSS should be mandatory.

Mr. EVANS. Mr. Secretary, is every veteran enrolled in VA medical care obtaining a clinical appointment within 30 days?

Secretary PRINCIPI. I'm sorry, I didn't hear that?

Mr. EVANS. Mr. Secretary, is every veteran enrolled in VA medical care obtaining a clinical appointment within 30 days?

Dr. MURPHY. Overall, the enrollees are obtaining primary care appointments in 30 days, in 87 percent of the cases.

Mr. EVANS. What is your advice to the veteran who is waiting up to a year for treatment who has a service-connected condition?

Secretary PRINCIPI. My advice is to e-mail me or get in touch with my office, and we'll get that situation corrected immediately.

No service-connected veteran who is seeking care in the VA should wait more than 30 days for an appointment. Emergent situations should be seen immediately. In any event, a year is totally unacceptable. That should not exist, and I apologize for it.

Mr. EVANS. Would you mind if we put your e-mail address in the Congressional Record?

(Laughter.)

Secretary PRINCIPI. I'll give it to you privately.

Dr. MURPHY. You may want to put my e-mail address in, not the Secretary's.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Chairman Simpson.

OPENING STATEMENT OF HON. MICHAEL K. SIMPSON

Mr. SIMPSON. Thank you, Mr. Secretary. I appreciate your testimony and your being here today, and I appreciate all that you do for the veterans.

I do have a couple of observations, and then a few brief questions.

As some of the members here have suggested today, it is a two-way street with respect to disability claims, because the Department, indeed, is administering a system that is designed by Congress.

In my view, your claims task force did an exemplary job of finding ways with current law to wring every ounce of productivity and quality out of the claims system Congress has put the VA in charge of.

The Congressional Veterans' Claims Adjudication Commission, the General Accounting Office, the National Academy of Public Administration, and the Transition Commission, which you're probably a little familiar with, all have made efforts to unravel the consequences of 50 years of incremental policymaking in the adjudication area.

Despite VA's implementing recommendations of all the previous studies and commissions, the problem remains the same.

For example, in December of 1993 when Congress was contemplating legislation that created the Veterans' Claims Adjudication Commission, the pending claims workload was 570,000 claims.

This past November, when the VA Claims Task Force issued its report, the pending workload was 533,000 claims, I suspect in large part due to the VA having to apply the new duty to assist standards to 244,000 pending claims and to readjudicate 98,000 claims that had been previously denied under old standards established by the Court of Appeals for Veterans Claims.

So frankly, I'm hard pressed to believe that staffing, technology, and other good government initiatives alone are going to solve the pending workload issue.

I think the time has come when Congress can best serve veterans by taking the advice of the Transition Commission and dispassionately examining some of the policies driving the current system.

The Signal Group of General Electric Corporation reviewed the current system and concluded, and I quote, "It is perfectly designed to get the results that it gets."

With respect to veterans' employment, our most recent data shows that seven out of 10 veterans that go to a job services office seeking employment do not get jobs.

I'm working on a legislative proposal that will focus on incentives, accountability, and results that I hope to share with Ranking Member Reyes later this week or next week.

In any case, Mr. Secretary, I look forward to working with the Administration as we jointly endeavor to improve the $180 million per year Veterans' Employment and Training Service.

Now, one of the things I want to add, and it's been mentioned by Mr. McMichaels and by yourself, that as you set a goal to try by the year 2003 to process claims within 100 days, some people have suggested that that's going to sacrifice quality, and you've mentioned that it's not.

I want to make sure that you've got that on the record, that quality is your number one priority.

Secretary PRINCIPI. Clearly quality is very, very important, and I think we have mechanisms built in to ensure that people do not get credit for inaccurate decisions, and our accuracy has never been higher, at about 88 percent today. That compares to 59 percent in the year 2000.

We have our star reviewers who objectively look at decisions to ensure that they're correct.

We continue to focus on quality, at the same time looking at what steps we can take to improve our timelineness.

Mr. SIMPSON. What are you doing to work with, as the recommendation of the Cooper Commission suggested, to work with the VSOs so that they bring forth more fully developed claims, and will that help reduce the backlog if we can work with the VSOs and get that done?

Secretary PRINCIPI. I don't think there's anything more important than to ensuring that we get a well-grounded, ready to rate claim and that we don't have to spend inordinate amounts of time in developing that claim. To the degree that the service organiza-

tions can provide us with a complete claim that's ready to rate, that will certainly reduce the time it takes to adjudicate the claim.

Judge McMichael and I mention that frequently to the veterans' service organizations when we meet with them to try to get them to let us know what we can to assist them in providing us with complete claims. I think it's very, very important.

Mr. SIMPSON. I appreciate that, and anything that we can do to assist in that effort and work with both the VSOs and yourselves in assisting in that effort, let us know.

Finally, despite our warnings last year that prompted you to add 78 employees to the VA's educational service, the average time to process an original education claim soared from 36 days in 2000 to 50 days in 2001, a 38 percent increase in the time needed for a veteran to get his first education check.

Even worse, the blocked call rate soared to 45 percent in 2001, an unacceptable level compared with a 3 percent blocked call rate in other VBA activities.

Do you want to comment on that, and how can that happen when we have 78 more employees?

Judge MCMICHAEL. Well, part of the problem was that education calls used to go to all the regional offices. They were then shifted to go into four of our educational processing centers, and we were really unequipped at that time to handle it.

I think we've gotten a handle on that, and the blocked call rate and abandoned call rate is going down dramatically.

We did have some problems in transitioning to new IT equipment which caused some problems. We think we now are on track. The processing days are decreasing, and we think we'll be able to reach the targets we have.

Mr. SIMPSON. Thank you. I thank all of you for the work that you do in helping our veterans, and this committee is here to help you do your job better, and work with both the veterans and you, so I appreciate your testimony.

Mr. Chairman, thank you for the time, and I apologize. I have a video conference with my Senators, and as you well know, while the Democrats and Republicans are oppositions here, the enemy is the Senate. (Laughter.)

If I'm not there, they would take credit for everything good that happened and blame us for everything bad, so I need to be there for the last few minutes to defend the House.

The CHAIRMAN. Thank you. Mr. Boozman.

Mr. BOOZMAN. As a new member, I'd like to thank y'all for working so hard to get me up to speed, and I really do appreciate it.

I was looking at your testimony, and you talked about the Priority 7's increasing 30 percent the last 6 years, and it looks like that trend is going to continue.

Can you tell me why that is?

Secretary PRINCIPI. A combination of factors: better quality, better customer satisfaction, the opening of some 600 outpatient clinics close to the veterans' homes have made VA the provider of choice, not just the last resort when you don't have an insurance program.

Of course, the pharmacy benefit is one of the most generous in the country.

And then coupled with what's happened to the economy, and the HMOs having closed—leaving veterans out there without any health care coverage, as well as factories having closed around the country, veterans may have had no health insurance as they've gone to new jobs, even though their income was above the threshold. I think those all are factors.

So there are some positive reasons, but there're also economic factors that have led to some veterans not having health care.

Mr. BOOZMAN. In your report, it looks like that trend continues to 2007, 2010, whatever. Do you see any leveling off in the future?

I mean, it looks to me like it's kind of like you might have the situation where maybe people are talking, you know, for all the things that you mentioned. I mean, will there be a leveling off where eventually the word gets out and they're kind of there?

Secretary PRINCIPI. I think at some point it will slow down, but not for the foreseeable future. I think a lot depends upon what happens in the private sector or with Medicare with regard to a pharmacy benefit.

A very, very significant number of the veterans' Category 7 come to us solely for medication—the pharmacy benefit.

Of course, we enroll them in the system for the continuum of care purposes and provide them with a physical evaluation, but their sole purpose is to get the benefit of the pharmacy.

So I think it depends on what happens in those other areas that will influence the use of our pharmacy benefit.

I think because the VA has so improved and because we have those outpatient clinics close to home, we do not expect to see any leveling off anytime soon.

Mr. BOOZMAN. Okay. Thank you, sir.

The CHAIRMAN. Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Thank you, Mr. Secretary. Good morning. I know it's one of your favorite days of the year.

We're starting a long budget process.

Secretary PRINCIPI. Yes, sir.

Mr. FILNER. And clearly, the budget is a reflection of our priorities, and it's from the budget that all these terms we talk about, whether they're backlogs or waiting times, come from. So we have to have a clear and honest understanding of the budget so we can determine how we want to deal with it. An honest accounting of the numbers is very important.

I read your press release when this budget first came out. "It's the biggest thing in the history of mankind." I was very thrilled with that. I said at last we have the kind of increases that we need.

I know you to be a straightforward, honest individual who is really caring about veterans.

So, if I would characterize the budget statement in your press release as smoke and mirrors, it couldn't have possibly come from you. It must have come from other people around you. I don't want to characterize the Secretary here, who I love so much.

What I want for all of us is to have a clear understanding of the budget and what we have to do for our veterans and work with you to do that.

Now, as I understand the budget, and Mr. Snyder brought it up first, almost $800 million is a transfer from OPM. There's no new money here. It raises your budget, but your budget also assumes a $1,500 deductible will go into effect.

When answering Mr. Snyder's question, I think you answered, if that doesn't go through, I deduct $264 million and we still have the greatest budget in the history of mankind.

Secretary PRINCIPI. Right.

Mr. FILNER. Now, as I read your budget, and correct me if I'm wrong here, you also attribute to that $1,500 deductible a savings of about $885 million; is that correct?

Secretary PRINCIPI. Correct.

Mr. FILNER. So a real answer to Dr. Snyder's question would be if you deducted the $700 million or $800 million from the OPM and you deducted now $1.1 billion from the assumption of the savings, you have lost now almost $2 billion, so it wouldn't be the greatest increase in history.

Secretary PRINCIPI. Oh, no. No.

Mr. FILNER. What am I doing wrong here?

Secretary PRINCIPI. No. The real increase is $1.5 billion. I mean, the fact that if you have a deductible the growth may not be as large——

Mr. FILNER. You wouldn't have $885 million that you think you have, right?

Secretary PRINCIPI. I don't have it. I don't have it. If I had that $800-some-odd million, my real increase would be $2.7 billion, not $1.57 billion. Am I right? I mean, I have $1.57 billion without including the deductible.

Mr. FILNER. You have expenditure reduction, according to your budget, expenditure reduction of $885 million. That wouldn't occur if that didn't go into effect, so you have 885 more expenses, right?

Secretary PRINCIPI. Well, it's not an expenditure reduction.

Mr. FILNER. That's what it says here.

Secretary PRINCIPI. Cost avoidance perhaps, but it's not an expense reduction.

Mr. FILNER. I get that from your budget. This proposal will generate an overall net workload expenditure reduction of $885 million, and a revenue increase of $260 million for an overall savings in the appropriation of $1.1 billion.

Secretary PRINCIPI. That's the difference between the $2.7 billion identified earlier. You take out the $1.1 billion, and you come out with $1.57 billion increased funding for medical care separate and above the $800 million from the OPM transfer.

The increased resources for medical care are on top of the retirement fund transfer from OPM. That's on top of that, seriously. I mean, it's $1.57 billion that's new money that's coming to the VA.

Now, I think either it's new money or it's not new money. I believe from the Treasury of the United States, we are——

Mr. FILNER. I think we have to have an understanding, and we will come to that.

You have inflation cost built into your budget for pharmaceuticals and other inflation.

Secretary PRINCIPI. Right.

Mr. FILNER. And it looks pretty low to me. What figures did you use for that?

Secretary PRINCIPI. For pharmaceuticals?

Mr. FILNER. No, for anything. You have inflation in there, also.

Secretary PRINCIPI. Well, 2.6 percent is for our personnel costs.

Mr. FILNER. Well, that's something different. You have personnel costs, $370 million, inflation of $396 million.

Secretary PRINCIPI. 3.9 percent for pharmaceuticals.

Mr. FILNER. That's a pretty low figure. But if you deduct from your total increase—forget the $1,500 deductible for a second——

Secretary PRINCIPI. Right.

Mr. FILNER (continuing). The OPM and the mandatory sort of increases that have to be there for pay raises, inflation, et cetera, you come out with almost exactly the figure that you've increased the budget, which means, if I have this correct, there's not a dime of new money for better health care. That's the way I see it.

That's the way we have to see it, because all you're doing in your budget is barely keeping up, and I don't even think we are, as Dr. Snyder said, because your figures on inflation are pretty unrealistic, and that's on top of a shortfall from last year.

The baseline is not even sufficient to meet the needs of our veterans now, so if we have a shortfall of $400 million, or $1.5 billion by the Independent Budget, and we're not even keeping up, we are really shortchanging our system, and this committee had better do something about it.

I mean, you're dealing with the President's request. I think the President's request is several billion dollars short, based on these figures, and the Independent Budget will try to show where that is.

By the way, it doesn't even assume that, when you put the retirement money in, in the discretionary accounts, now they're going to be competing with the medical health of, you know, of veterans, and somehow that's going to, in the future, give us some problems, I believe.

In any case, I would like to point out—I appreciate the forbearance, Mr. Chairman—that if I'm right, and I'll take out the $1,500, because that's a whole other story that's going to cause problems for you in the end, I think, because we may not pass that co-payment requirement.

This committee had better understand that we haven't added a dime, and we may be losing better health care for our veterans, and we better add to this budget, and we better look at this very carefully.

The CHAIRMAN. Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman, and welcome, Mr. Secretary.

I think that the $1,500, just to reiterate it, I didn't come with my Captain America hat here today, so I'm going to reiterate what my colleague, Mr. Reyes, says.

I think the $1,500 is a non-starter and I think you're going to hear that. Maybe some other people want to go on the record here, and I hope the chairman will leave the record open so that members of the Veterans Committee can say today whether they think that we should charge the veterans an extra $1,500.

I think that's the Captain America thing to do today at this hearing, because I'm going to go on record and say it's a non-starter and I hope other colleagues will say the same thing.

I say that specifically because really it's not that huge of an increase. What we're talking about is $1.4 billion, which you stated is the largest increase ever, and $1.57. So, you know, so a 10 percent, 11 percent, maybe a 12 percent increase—I don't have my calculator here—over the largest.

Given inflation and everything else, it's really—and given the needs of the veterans' community—it's not really there, and given the Independent Budget that we're about to hear from, from a veterans' organization, it leaves a lot to be desired.

Secondly, I hope we don't get into this today here in this committee, to throw around the category, the Priority 7 veterans, and kind of throw them around, because I think we're being a bit dismissive about them here.

I think everybody that's in Afghanistan, including just men and women who come back, and I hope they all come back without wounds. But if subsequently, they need the Veterans Affairs Administration, we shouldn't say, "Oh, that's a Category 7."

You know, they're not Category 7, they're all Category 1 when they're out in Afghanistan and the Gulf War or wherever, defending this Nation, and we should treat them all the same and there shouldn't be a difference of how we approach them. It's almost gotten again to be as though a bad word, Category 7. "Oh, it's not related to an injury they suffered in time of war and combat." I think they all should be treated equally.

I think especially at a time when we have our President, Commander-in-Chief of our armed forces, saying "We need more money to train them better, we need more money to equip them better, we need to pay them better," we also need to make sure we're going to spend more money so we can take care of them better when they come back after the service.

I think there's kind of a, I don't know, just a disconnect between preparing our men and women for service and for combat, and then what we say when they come back.

We're talking about increasing their salary, but then we want to take it back on the other end by charging them $1,500 when they come back if they want to use the VA, by charging them additional co-payments, which we have increased in my 9 years in Congress, we continue to increase payments and co-payments on veterans; and the services, I'm sorry, according to my veterans, are getting worse.

The one thing I do want you to address is this whole issue in Chicago with the CARES.

Now, I don't think, Mr. Secretary, it's fair to our men and women to announce Friday, at 2 o'clock, without informing anybody—I got the press release in the morning. That's when I found out about it, in the morning.

Now, you gave a little more forbearance to the Senators, which you sent, for my state, on Thursday.

Now, I'm a member of this committee. I don't expect any special prerogatives, but I think in Chicago somebody would have called and said, "This is what we're going to do." But that's really not the case, Mr. Secretary.

You know what was worse? You didn't call any of the stakeholders, which I really don't like, because I find there's a new euphemism for veterans. People don't want to say veterans, so people now say stakeholders, because it's easier to talk about stakeholders than veterans.

You didn't call the veterans groups, which work in every one of your hospitals—Paralyzed Veterans, the American Legion, they're there, working, and I mean so many different organizations.

So I'm a bit concerned, because Mr. Principi, I've been to Hines. I've seen men, I've seen women without arms, with a plate of food in front of them, and nobody to serve them that food.

And when I say, "What happens to that food?" The patients said, "There's nobody." The hospital staff said, "Well, we don't have enough personnel. We'll warm it up."

You know, that's almost a crime, to give a person that doesn't have arms a plate of food and say, "We're going to warm it up." When they serve me my food, I expect it to be hot, so that I can eat it, and I expect the veterans to get it not warmed up.

I don't know if you've visited Lakeside, Mr. Secretary. I visited Lakeside. That place is jam-packed. People are there waiting for appointments. It's not like, you know, Lakeside is empty and Hines is empty. The fact is, people are waiting for services.

And now we're going to close a hospital, and Northwestern Memorial Hospital has said, Mr. Secretary, "We're not sure we're going to cooperate. We're not sure we're part of this deal." So what if we lose it for our veterans? That's what Northwestern Memorial Hospital has said.

And you know that they issued a press release on Tuesday, because they weren't happy with it, because they knew you guys were going to go in on Friday at 2 o'clock and everybody in politics knows that when you want a very bad news cycle, the day you put it out is Friday afternoon, so that hopefully, no one will know about it. That's a bad time to put it out.

If you've got good news and it's going to improve the veterans' services, then I suggest you—when I got good news for people in my community and I'm proud of it, I'll tell you what I do. I go out there and call a public hearing and tell everybody, call a public press conference and tell them, "Look what I've done." That didn't happen in this case.

Lastly, I'm really worried, because I know you have good motives, and honest motives in doing this stuff, but if you look at the educational benefits, I mean, we all know what happened. We had good intentions, right? But you weren't equipped when you made the changes.

How do we know that, given the good intentions, that when we close down, as you wish to do with Lakeside Hospital, we're not going to have the same detrimental effect that we had with educational services when you switched them.

I mean, I think we should be very, very careful here in how it is we treat our veterans.

And lastly, we hope that someone will show up. The Illinois congressional delegation is going meet this Saturday at 1 o'clock, and we've called on the VA Administration to send a representative and we hope the representative will come, because our VA organizations are all coming down to testify, to talk about how they feel about Lakeside.

Secretary PRINCIPI. Can I respond?

Mr. Guttierez, I apologize if you didn't get the word on Thursday. There's no excuse for that. The word was that all the members of the delegation were to receive the information the afternoon of the day before.

Now, I agree with you about Category 7's, and, Category 7 versus Category 1 through 6. There are no easy decisions.

I believe the Congress established seven different categories. They've asked me to make an enrollment decision every year based upon the resources available for Category 7's, and I think that's why the focus is on Category 7's.

But you're right. Many of the Category 7's scaled the walls of Normandy and, to the degree we can provide them with health care, I think we should; but we know what the growth has been, and how do we grapple with that growth?

With regard to Lakeside, I know that's a difficult decision, and I believe it was the right decision. I know it's difficult.

I want to stress that there is going to be an outpatient clinic on that site. It's only the inpatient tower, the inpatient beds that are going to be consolidated.

I think we need to do that because that's where health care has gone, in consolidated inpatient services and moving more into outpatient care, primary care with outpatient clinics around the country. We've tried to accomplish that.

I'm disappointed by Northwestern's attitude. We have a great affiliation with the University of Illinois at Westside, and Northwestern has been invited to participate, just like Harvard and Boston College do up in the Boston area if they choose to do so.

If they choose not to affiliate with us, then we will have a top-notch affiliation with the University of Illinois.

But we've made an outreach to them. We've invited them. We've implored them to join us in that affiliation, but they've taken this as it's a reduction in revenues to the university.

We're in the business of health care treatment. Education helps us to get there. They're an important partner.

But our primary mission is treatment, not medical education, and to the degree that they work with us and we both benefit from it, I think that's the ideal world.

But I cannot be held captive because a medical school doesn't want us to change, because it somehow impacts on revenue to the university.

We're in the business of treating patients, and we can treat more patients with outpatient clinics and by consolidating beds. Remember, we have three other hospitals in Chicago. Many of the private sector hospitals have closed down, but we somehow are being held back to the mid-20th century.

And I believe that the stakeholders were involved in this, Mr. Gutierrez. We involved the stakeholders.

Mr. GUTIERREZ. Let me just suggest, Mr. Secretary, that someone should come and explain to the stakeholders, because there are, in all fairness, there are 435 of us, and only one of you; so probably we'll talk to the stakeholders more than you, just by our sheer numbers.

So someone should come and explain to them and call them together, and say, "We're making this decision," get everybody together and say, "Here's how we're doing it."

Secretary PRINCIPI. Sure. We'll have someone there to represent the VA.

The CHAIRMAN. The gentleman from Texas, Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Secretary. I also want to thank you for coming to San Antonio. I know you have a great deal of respect from both sides of the aisle, and we all recognize that you're sincere, and we understand the dilemma that you find yourself in.

I do want to just indicate—and I know you made a distinction between the largest budget requested and the largest budget you've obtained.

My understanding is that both sides—Democrats and Republicans—have not been providing adequate resources for the VA. I've been up here 6 years, and it's been like pulling teeth.

Basically, what you've just laid out, the additional $3 billion in discretionary spending is what is needed in real money, because what I figured—and I don't know if you guys get sent to the fuzzy math school—is that the increase is less than a billion. And follow me if you can.

My understanding is that the proposed $1,500 Priority 7 deductible amounts to is actually $1.1 billion. Another $400 million is attributed to higher co-payments for prescriptions. Then, $600 million is based on "cost savings" or cuts. To me, that adds up to $2.1 billion with a billion leftover.

Is that correct?

We have to go back and check it out.

Secretary PRINCIPI. We'll be happy to look at what goes into the base and what——

Mr. RODRIGUEZ. If that's the case.

Secretary PRINCIPI. Okay. I'm sorry.

Mr. RODRIGUEZ. If that's the case, it's actually the same amount that this administration proposed last year.

Last year we had an extra $1.4 billion, which was less than the previous 2 years, which was, I think, $1.5 billion or $1.7 billion. So if this year $1.7 billion more is provided, it brings it up to par—if it's real money.

What I see is a need for us to work on is appropriating about $3 billion more in real dollars to make some things happen at the VA.

Because our veterans are getting older, and they're going to need us more. I'm not going to play around with the numbers, because I think we really need to come back to that.

I do want to get to one other issue that is real critical in my back yard. As far as I know, and you can tell me otherwise, I, Congressman Ortiz, Congressman Hinojosa, Bonilla, Congressman Lamar Smith, represent one of the largest number of veterans in the country, in one of the largest regions in the country, and there's a real need for a national VA cemetery.

I was wondering what the justification was for two additional veterans cemeteries, with one in Pittsburgh, what is the criteria?

Secretary PRINCIPI. It's based on the number of veterans and the fact that there's no national cemetery within 75 miles. We have a 75-mile radius that we use for planning purposes.

Mr. RODRIGUEZ. I have 240 miles. Can we talk? I mean, I have veterans, I got a county with 600,000 people, that's 200 miles away from San Antonio. There is another county, Nueces, with 300,000 or 400,000 residents, 150 miles from San Antonio.

There is also Cameron County with 300,000 people. That's a little farther from San Antonio, farther south.

I don't represent all those areas. Ortiz has both Cameron and Nueces. Hinojosa has a lot of the area, I have the rest.

So I wanted to ask you the rationale for that, and you're already moving on that, is that correct?

Secretary PRINCIPI. I'll look at that, yes, sir.

Mr. RODRIGUEZ. Can I talk to you seriously about it? Because we really need to talk.

I just assume Miami has a lot of veterans down there, because veterans are retiring down there, and therefore, I didn't ask you about that. However, I am concerned about an area that's losing population, like Pittsburgh, in terms of the number of veterans will put my number against anyone else's.

Secretary PRINCIPI. I would be pleased to talk with you about it.

Mr. RODRIGUEZ. Yes, and then we can sit down and see what we can do for those people.

And once again, I'm addressing the needs of not just my constituents. There are a lot of veterans down there in those other congressional seats that adjoin my district and are part of the same VA region.

Secretary PRINCIPI. Yes, sir.

Mr. RODRIGUEZ. Once again, we thank you for your sincerity. I know you're sincere about wanting to do the right thing.

Mr. Chairman, I hope that we can really come to terms with this, because I really feel that that $3 billion needs to be in real dollars, because that $1,500 deductible is not realistic for some of those people. I already had a meeting on Sunday with a VFW chapter in my district. I can assure you that they're going to start raising all kinds of hell. They already know about it.

The CHAIRMAN. My understanding is Mrs. Carson has to leave. Mr. Lynch, if you wouldn't mind, I'll yield.

Mr. RODRIGUEZ. And one other thing, Mr. Chairman. I apologize one more time.

The CHAIRMAN. Sure.

Mr. RODRIGUEZ. This hearing was scheduled at the same time as the Armed Services Committee hearing. I don't know how we can work that out.

The CHAIRMAN. Ours is scheduled first, I'll say for the record. Mrs. Carson.

OPENING STATEMENT OF HON. JULIA CARSON

Ms. CARSON. Thank you very much to my colleague for yielding, and thank you very much, Mr. Chairman, and thank you very, very much, Mr. Secretary for being here.

I'm certainly a very ardent fan and appreciate and respect so much your great job, and for you being in my district, I have to add that, since everybody else is bragging about you being in their district, as well.

A very quick question. Mr. Chairman, I'd like to submit a statement for the record.

Mr. Secretary, Mr. Reyes raised the issue of funding for the VA inspector general. From my first day on the oversight subcommittee, I recognized the cost effectiveness of the VAIG. They save VA $86 for every dollar that IG spends, so I'm glad Mr. Reyes joined me.

By adding an additional 39 people to the IG office beyond the increase proposed by VA, the IG will be able to review issues like credit card fraud and other problems.

It still takes 110 FTEs to get a 3-year cycle for management assessment. The VAIG is small and the VA is large.

And I guess that's all I have to say about that. Thank you very much.

The CHAIRMAN. Thank you, Mr. Lynch, for your courtesy, and I yield to Mr. Lynch.

Secretary PRINCIPI. I agree with you, Congresswoman, and we've increased the IG 15 percent or 56 FTE since I arrived. I'm concerned that we don't have the staffing for a 3-year audit cycle. We need to work through that.

But they certainly have helped us improve our management and our efficiency, clearly.

OPENING STATEMENT OF HON. STEPHEN F. LYNCH

Mr. LYNCH. Thank you, Mr. Chairman. Mr. Secretary, I'll just say that I just finished my third tour of my VA facilities in my district since being appointed to this committee, and actually being elected to Congress, and I'm encouraged to say that I have yet to hear a complaint about the quality of care.

Whether it's the VA hospital or West Roxbury facility or Jamaica Plain or the shelter for homeless veterans on Court Street in Boston, not far from where I live the quality of care is applauded by the veterans, and they have nothing but the most wonderful remarks about the nurses and doctors and staff in our VA hospitals.

The complaint that I hear is about access. Access can mean—and I won't go into it in detail, because it's much too parochial and I want to avoid that.

But access can mean the 18-bed psychiatric facility in Jamaica Plains that is being moved some 30 miles south, and then it's going to be moved back after 4 years or 5 years, back into Boston, the upset that causes, that break in access for a lot of my veterans, and we have to figure out a way to do that. I won't take up the time of the committee on that.

There's also another kind of access, and that is the matter of claims.

Now, I know we have about a half a million outstanding claims. I notice that in Boston, we have about 5,000 claims outstanding, and the number is rising.

I noticed down in Florida, where a lot of my constituents are retiring to, the number is about 30,000.

Do we at all prioritize between the type of claims? Just in my visit yesterday, I had complaints from veterans who were just recently leaving the service or just about to leave the service, active duty.

I also had some heartbreaking reports from the veterans' homeless shelter in Boston. We have people who are just basically waiting to die and they've got outstanding claims.

Do we prioritize? Do we look at the situation of a veteran, and say, "Okay, well, we'll move them to the top of the list?" Is there any of that going on?

Secretary PRINCIPI. We do have triage, but let me ask Judge McMichael, who runs the Benefits Administration, to perhaps give you some detail on that.

Mr. LYNCH. Thank you, Mr. Secretary.

Judge MCMICHAEL. Of course, one of the items, particularly for older veterans, has been the establishment of the Tiger Team, which is particularly looking at claims of older veterans, and that was an initiative of the Secretary, and we're handling large numbers of those through the Tiger Team.

The Tiger Team was established in Cleveland. We also have a number of Resource Centers. Some of our best people have been assigned to that, and they are looking at claims of veterans 70 and older throughout the country. Those claims have yet to be decided, and they're establishing priority on that.

We have entered into a Memorandum of Understanding with the National Archives and Records Administration (NARA) to aid in improving the timeliness of obtaining military records. Eliminating the delay will provide us the opportunity to address pending claims more rapidly. This is one avenue that we are pursuing.

Another thing is triaging. That is, looking at the claims as they come in and assigning some kind of importance to them.

You have a widow's claim come in, you have claims that somebody has serious medical problems, those are being examined and being assigned so that they could be dealt with quickly. Those claims needing the attention the most get it the quickest. This is the approach recommended by the Task Force, and one that we are implementing in all of our regional offices now.

Mr. LYNCH. Okay. I'm just fearful. I see us getting to that point, where going to get a huge wave of these type of claims, and it's not going to be something that we're going to be able to address in an orderly fashion, unless we set up a system to receive those claims now.

Secretary PRINCIPI. That's what we're trying to do.

Judge MCMICHAEL. That's the whole idea behind triaging of the claims, yes.

Mr. LYNCH. All right. Thank you, Mr. Secretary. Thank you.

Mr. FILNER. Mr. Lynch, would you yield to me?

Mr. LYNCH. Yes.

Mr. FILNER. I didn't know if you were finished. I don't want to interrupt.

Mr. LYNCH. No, go right ahead.

Mr. FILNER. As I listened to the testimony and the answers to my colleagues, I've come to the following conclusion.

I think, Mr. Secretary, the trumpeting of this big increase when, if you look at the figures that have been brought out here, is not really an increase in real terms, and if the $1,500 doesn't go through, forget what the baseline is now, you're going to need $1.1 billion more to make up for that, you've made it more difficult for us to convince our colleagues that we need more money here.

That is, if they think you've got the biggest raise in history, and we want—and I know you do, too, sir, we're not questioning that—we want to treat our veterans better, we're going to have problems, because of that publicity.

They'll say, "Hey, you already got the biggest increase in history, you don't need more."

So I think we have to be, you know, restrained here and honest, and work together, to get some more money for you, because we're going to have to convince our colleagues.

Our chairman fights very hard in the Appropriations Committee and, the leadership, and we've got to give him all the ammunition that we can.

Thank you.

The CHAIRMAN. Thank you, Mr. Lynch. The chair recognizes Mr. Hill, the gentleman from Indiana.

OPENING STATEMENT OF HON. BARON P. HILL

Mr. HILL. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for coming and agonizing over us once again.

I'm going to pick up on the claims, the rating claims. The chart here that I'm looking at, in February of last year, in the Indianapolis area, there were 752 rating claims pending over 180 days. February 1, 2002, there's 2,360.

In Louisville, February 2001, there were 2,190 rating claims pending over 100 days. Today there's 5,962.

Now, in your testimony you talked a great deal about the Tiger Team and you have an ambitious goal of reaching 100 days to process compensation and pension claims by the summer of 2003.

That seems to be, to me, unrealistic, but I'll let you defend it and explain to me specifically, and this committee, why you feel like you can attain that goal.

Secretary PRINCIPI. Well, first, we've hired 1,100 new people this past year. We will hire another 125 this coming year.

It is my hope that very shortly they will all be adequately trained and capable of meeting the performance standards we expect of them.

We have put in place new mechanisms, new procedures upon which to expedite the processing of claims. As Judge McMichael indicated, we've begun triaging, so as these claims come in, they're placed under control almost immediately and claims that are ready to rate can be rated.

We now have specialists who can work on specific types of claims, whether it be diabetes or whatever, pension claims.

I think veterans will see increased productivity from the totality of the steps we've taken, including the important one of hiring new people and getting them trained quickly, along with our performance standards and our production goals. All our workers are now focused. They now know what needs to be done.

I'm optimistic. I know it's a sobering fact in the sense that we have a long way to go, but I believe we need to stay the course and we can work toward that goal.

If we have to make adjustments along the line, I'll be the first to make the adjustments. If we need more people, I'll be the first to go to the President and say, "I need more people to get the claims backlog down."

But at the same time, you're correct. We've had 60,000 diabetes claims when we expected 30,000 the first year. We've had other areas where we received more claims than we expected, Gulf War for instance. We've had an increase in claims in that area.

So I'm not ready to say we need to change the goals from 100 days. We'll watch it carefully, and we will make adjustments as we go along.

Mr. HILL. I wish you well. I hope that you can get the job done here. It is a serious problem that needs to be taken care of, and people are suffering because of these pending claims, so I wish you well.

But I hope this committee will monitor this very closely in the next 18 months, and if there does need to be adjustments between now and that stated goal, then we ought to come back and make those adjustments and see what the committee can do to help you.

Another question. Under the new Employment Grants Program, you have proposed to transfer three grant programs to VA—the Disabled Veterans Outreach Program, the Local Veterans Employment Representative, and the Homeless Veterans Reintegration Program.

What will happen to the federal personnel associated with these programs and what will happen to the State and local personnel associated with those programs?

Secretary PRINCIPI. The federal personnel will come over to VA. They will be transitioned to VA.

We're in the process of preparing legislation to move the entire program over to the VA. We would like to see some changes made in how the program is administered. We believe that it's important that there be performance goals, that it be outcomes based.

I think notwithstanding the fact that we've got good people, we're working under a model that is no longer workable in the information age. As a result, we see an unemployment rate of 9.6 percent for recently separated veterans between the ages of 20 and 24.

We have 17 States wherein fewer than 10 percent of the veterans who go to the employment offices were placed in permanent, suitable employment. We have over half a million veterans who have been unemployed for more than 15 weeks.

I think we could do better than that, and I believe that with increased emphasis and looking at some new ways to do that work, we can get it done. But I plan to bring everyone over to the VA.

Mr. HILL. Including State and local?

Secretary PRINCIPI. I don't think the State and local would come over.

Judge MCMICHAEL. They're the ones that receive the grant money, and assuming that the State complies with the requirements we lay out, they presumably would be eligible to continue receiving that funding.

Mr. HILL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Miller.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Mr. Chairman.

Mr. Secretary, thank you for your testimony, it's good to see you again, and your work on behalf of our Nation's veterans, and Colonel Higgins it's going to be a pleasure to be working with you again.

I would say that again, it sounds like the Secretary has been in everybody's district but mine, so I look forward to the possibility of your visit to the First Congressional District of Florida.

This committee, under the leadership of the chairman and the chairman of the Armed Services Committee, Chairman Stump, has grown increasingly interested in the prospect of joint health care ventures and facilities sharing between DOD and VA, and I guess these two committees are planning to hold hearings on this topic in the coming months.

Additionally, I know that many of the health system planners and health care networks have identified these partnerships as possibly the best way to achieve long-term solutions to our growing health care service problems.

I just would like to ask if you could speak to the issue a bit more, and give us some concrete ideas on how and when you plan to seriously evaluate expanding this opportunity.

Secretary PRINCIPI. Well, sir, we have been working extremely hard with DOD to break down the barriers between DOD and VA on the delivery of health care.

I really do believe that we are making progress. Our executive council, made up of high-ranking officials from VA and DOD, have met. We have identified areas of cooperation in procurement, pharmaceuticals. We've made good progress in that regard.

I think over $1 billion worth of pharmaceuticals that DOD uses are now purchased by the VA. We're looking at equipment and medical/surgical supplies. There's some real progress there.

We have identified areas where we can work together in information technology, the computerized patient record, and more and more sharing at the local level with DOD and VA facilities, at hospitals around the country.

So there is a renewed emphasis on this. There are still a lot of, you know, walls that separate us, if you will. You know, change comes about slowly, but I think there's a high level of leadership interest in making the changes, so I'm cautiously optimistic.

Mr. MILLER. Thank you.

The CHAIRMAN. Thank you very much. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you very much, Mr. Chairman, and it's a pleasure to see you again, Mr. Principi. I'm very delighted that you also came into my congressional district and visited. (Laughter.)

As you know, I enjoy a very close relationship with my veterans, and they are extremely active on issues that impact the veterans community.

I've spoken many times, as a member of this committee, about the needs of the veterans in my district. As you know, I have approximately 260,000 veterans who are eligible for VA care and benefits.

Their needs are many, and unfortunately, it seems that our resources are still too few and to small to service the number of veterans in my district.

One of our major issues that I first spoke of 3 years ago when I was first elected is the waiting times at my VA clinic, which you visited. the waiting times have, in fact, decreased, but unfortunately, not by much.

As of July 2000, wait times for new patient appointments still ranged from 47 to 85 days. I'm still having trouble providing specialty services to veterans in a timely manner and many of my VA patients still have to travel to California for specialty surgeries.

You know what a hardship it is, not only on the veterans but the veterans' families, when their loved ones have to go several hundred miles away for care.

There's a serious staff shortage at the VA clinic in southern Nevada, with doctors being much in demand and the least available, and I'm not sure that this budget provides for the hiring of more staff, particularly the nurses.

32,000 veterans are treated by the VA in the southern Nevada health care system. For these 32,000 veterans in my health care system, in our health care system, there are approximately 600 full-time employees on staff. That's approximately one staff member for every 53 veterans that need treatment.

The number of staff is simply not adequate and I'm worried, with this budget, that it's not going to increase.

More facilities are needed for the veterans in southern Nevada. The greatest need, of course, is for long-term facilities and hospitals. Currently, we contract out for long-term care for 26 of our veterans.

Long-term care facilities in general are very rare in southern Nevada. Eighty-three percent of our long-term care facilities are bankrupt, anyway, so it's extremely difficult contracting out for this many veterans, and this number is only going to increase, because all those veterans that are leaving Pittsburgh are moving to Vegas, and that's the truth.

I'm a little perplexed by Mr. Miller's comments regarding the movement on the part of the Veterans' Administration to consolidate hospital services with the Department of Defense. Veterans in southern Nevada currently share hospital space, as you know, with the Mike O'Callaghan Federal Hospital.

Now, veterans account for 60 percent of the inpatient beds in the hospital and have a very large outpatient presence there.

I was under the impression that we were working very hard to get a VA hospital of our own so that we didn't have to share facilities with the Nellis Air Force Base personnel, and the preponderance of the most complicated acute care cases in the Mike O'Callaghan Hospital, which is right outside Nellis Air Force Base, the most complicated cases handled are cases of our veterans.

There's no doubt to me that we need a VA clinic, a VA hospital, in Las Vegas to service those 260,000 potential patients.

When it's your turn to comment, I'd really like to hear your thoughts on that, because I'm a little confused with what your answer was to Mr. Miller and what you and I have talked about.

And the last thing, the final thing that I would like to comment on is, as you know, there's a large homeless veterans population in my district. Twenty-seven percent of the people that are homeless in Las Vegas are veterans.

Last December I very proudly joined with members of this committee when President Bush signed into law the Homeless Veterans Comprehensive Assistance Act.

This legislation is a tremendous step forward for homeless vets, but the President's budget, as I see it, leaves little room for this program's expansions, and I would appreciate it if you shared with me how the proposed budget is going to accommodate the implementation of this new law so I could actually help and deliver to my homeless veterans, and also to my veterans that need a hospital so desperately.

Secretary PRINCIPI. Having visited the outpatient clinic in Las Vegas, I was not surprised, but I was awed, by the large number of veterans who were there. It was just incredible how crowded the clinic was and how many veterans were seeking their care at the outpatient clinic.

It's a beautiful outpatient clinic that I assume will probably need to be expanded to meet the growing workload in Las Vegas and Nevada.

As regards the hospital, we need to look seriously at the potential of expanding the hospital. I don't know if we're going to have the resources to build a new VA medical center in Las Vegas, if that's what you feel needs to be done.

Ms. BERKLEY. That's what Mr. Norby and I have been talking about. Unless he's been blowing smoke in my direction for the last 2 years, it was my understanding that that was our next project.

Secretary PRINCIPI. A new hospital in Las Vegas was the next project?

I'm not aware of any plan for a new VA hospital in Las Vegas. But if need be, we can look at expanding our presence at the joint VA-Air Force hospital in Las Vegas, to expand capacity, expand the number of beds, and to expand the outpatient capability.

There may be, in the future, a requirement for a new VA medical center, and I think that analysis will come about through the CARES process as we look at the entire infrastructure around the Nation and make determinations of what hospitals should be closed, what new hospitals should be opened, where they should be, and things of that nature.

I agree with you that there's a tremendous workload in Las Vegas. It's growing by the day. It needs to be addressed.

I would hope that the $142 million supplemental in 2002 that will be forthcoming shortly and the increase, depending upon how you calculate it—we've heard different ways to do that today—will allow for continued, some continued growth in Las Vegas to meet the burgeoning demand.

Ms. BERKLEY. The homeless?

Secretary PRINCIPI. The homeless. This year, we are proposing a 10 percent increase in our budget for homeless initiatives.

Again, I think we're doing a tremendous amount in the area of homelessness with our grant and per diem program. I believe last year I awarded $60 million in grants for transitional housing and other similar type programs.

Of course, addressing the underlying behavioral issues dealing with homelessness, PTSD, alcohol and drug abuse, chronic mental illness, are key areas.

But indeed, we have a 10 percent increase in the budget for homeless initiatives and will continue to expand upon the grant and per diem program.

So I think we're doing an awful lot. The programs are getting good resources. I think it's outcomes that we need to look at to ensure that the dollars we're spending and the programs are in fact yielding good results.

Ms. BERKLEY. And what about my nurses? Where are they coming from?

Secretary PRINCIPI. There's a tremendous nursing shortage in Nevada, Congresswoman Berkley.

We all know that there's a tremendous shortage, and we're doing everything we can to recruit nurses and to retain them in the VA health care system, to give them competitive salaries with the private sector.

But your city has a terrible crisis in nursing, and of course we feel that, just like all the private hospitals in Las Vegas feel it, as well.

Ms. BERKLEY. Thank you, Mr. Chairman. I've just been handed a breakdown of the budget, and it shows that money for the homeless veterans will decrease in fiscal year 2003, from $18,250,000 down to $17,500,000. Is that in contradiction to what——

Secretary PRINCIPI. I have in front of me an estimate that we will increase the number of patients treated from 39,000 to 43,000 in 2003. That's up from 35,000 in 2001, so we've grown about 7,000 new veterans that we're treating in the homeless program. Those are the figures I have.

Dr. MURPHY. And the budget goes to 39 million.

Secretary PRINCIPI. I'll provide you the budget figure, for the record.

Ms. BERKLEY. Okay, because the information I've received, with all due respect, is that the Homeless Veterans Reintegration Program is extremely popular with widespread support from the veterans community, but the Administration has proposed transferring this program to the VA and consolidating it with two other State employment grant programs that are constantly criticized as being ineffective. I'm not sure that's a really great idea.

And again, I'm dealing with a huge homeless population of veterans and requests on a daily basis for some request.

Dr. MURPHY. The homeless veterans program budget will increase by 10 percent this year. We're dedicated to making sure that we follow through on our commitment to improve our homeless veterans programs. In fact, this committee supported passage of Public Law 107–95.

We have challenges in our homeless programs, but we will work very hard to make sure that we have a plan in place that will address this issue and we will work towards implementation of Public Law 107–95.

Ms. BERKLEY. Would you share that, then, when you are able? Would you share that with me? Because I feel very strongly that I have a tremendous responsibility to help the veterans that not only live in my district, but live throughout this great nation, and I wan to be able to deliver on my promises to them, as well.

Mr. Chairman, before Mr. Udall left, he gave me a question and asked if I could give it. What is the proper procedure for that?

The CHAIRMAN. What we're going to do, several of us have additional questions that, for want of time, we're going to submit for the record, normally within 2 weeks or 3 weeks.

Ms. BERKLEY. May I submit this on his behalf?

The CHAIRMAN. Yes, without a doubt, and Mr. Secretary all members will submit some remaining questions that we all have, and we hope that you'll get back for responses expeditiously.

(See p. 166.)

Ms. BERKLEY. Thank you very much.

The CHAIRMAN. I'll just say for the record that I, too, was concerned with the Department of Labor's slight decrease of the Homeless Veterans Reintegration Program. We specifically increased that in our authorization, believing it to be another one of those programs that work well.

Money is policy, money means more people will be spared pain and hopefully will find gainful employment instead of homelessness.

So I share the gentlelady's concerns.

Let me just, in closing say to you, Mr. Secretary, you've been very gracious with your time, 2½ hours on the hot seat, and we thank you for that, not unexpectedly, though. You're always gracious with your time.

I just want to again ask that you provide us with that plan for the implementation of the Millennium Health Care Act.

Secretary PRINCIPI. Sure will.

The CHAIRMAN. Just a quick, cursory look at the numbers. If you went from 1999 to 2001, there's been a net decrease of nursing home beds, from 33,204 to 31,941. You're right, the States have seen an increase of about 1,200, but the VA itself and the community based beds are down 1,000 and 500 respectively.

So the trend line is discouraging, and, even if you feel the money isn't there, that's part of what our job is, based on a needs-based analysis, finding the money, and if we can't do it, if we fail, we fail, but certainly, if we had that data on a plan, that would be helpful for us to implement that bill.

Secretary PRINCIPI. You'll have the plan, Mr. Chairman.

The CHAIRMAN. Again, I want to thank you so much and your very distinguished staff.

I'd like to welcome our second witness, who is Mr. Fred Juarbe, Assistant Secretary for Veterans' Employment and Training, Department of Labor.

Mr. Juarbe has appeared before this committee on many occasions in the past, having served as Director of the VFW's National Veterans Service for more than 20 years.

This is your first appearance as the Assistant Secretary for VETS, and I want to thank you and congratulate you for being here today.

Most of your career has been dedicated to helping veterans in some manner. I understand that one of the highlights of your job was the important role you played when Congress created this position back in 1980.

Mr. Juarbe is an Army veteran who served as a medical corpsman with the 82nd Airborne Division. He worked for most of his career for the Veterans of Foreign Wars, beginning in 1971, in New Mexico, as a service officer and ending as director of the National Veterans Service.

Thank you for being here, and I look forward to your testimony.

STATEMENT OF HON. FREDERICO JUARBE, JR., ASSISTANT SECRETARY FOR VETERANS' TRAINING AND EMPLOYMENT, U.S. DEPARTMENT OF LABOR, ACCOMPANIED BY CHARLES S. CICCOLELLA, DEPUTY ASSISTANT SECRETARY, VETERANS' TRAINING AND EMPLOYMENT SERVICE, U.S. DEPARTMENT OF LABOR

Mr. JUARBE. Thank you very much, Mr. Chairman, good afternoon, and members of the committee.

I ask that my written statement be submitted for the record. Thank you.

Joining the panel today is Deputy Assistant Secretary Chick Ciccolella.

I have been asked to talk about this part of the proposed 2003 budget for the Department of Veterans Affairs containing grant programs currently administered by the Labor Department's Veterans' Employment and Training Service.

I have to admit, Mr. Chairman, that while I have long anticipated the opportunity of testifying before this committee in my present office, I never expected that it would be concerning the budget of another department, but given the purpose of my being here, I welcome the opportunity.

As we confront a world profoundly changed by the events of September 11, all Americans are looking at the men and women of our armed forces with a renewed sense of respect and pride.

Someday, many of these men and women will exchange their uniforms for civilian attire. Many of them will be looking to the government for training, job search, and employment assistance, to help them successfully transition into the civilian economy.

At the Department of Labor, veterans are among our most important constituencies. While my confirmation as assistant secretary was delayed by the tragic events of this past September, the entire VETS staff has been busy at work in administering those programs designed to put America's veterans to work.

They have also been carrying out a vigorous campaign of informing and Reserve members and employers of their rights and duties. To date, we have seen over 70,000 of these men and women answering the call to duty both on the home front and in far off places as we fight the war on terrorism.

Veterans seeking employment, especially those with service-connected disabilities, deserve the best and most up-to-date services that we can devise.

Secretary of Labor Elaine Chao and Secretary Principi are working together to carry out the President's commitment to improve employment opportunities for veterans. In fact, we're looking to improve the quality and delivery of employment and training programs in the President's fiscal year 2003 budget.

If approved by Congress, we will transfer the Disabled Veterans Outreach Program, the Local Veterans Employment Representatives, and the Homeless Veterans Reintegration Project Grants from the Department of Labor to the Department of Veterans Affairs.

This proposed transfer is part of the President's overall strategy to increase the effectiveness and accountability of government programs. It will also reduce duplication of effort and strengthen services to veterans by placing them in an agency solely devoted to the needs of veterans.

We have been working diligently with VA to draft legislation and to coordinate our transition strategy, which includes, as Secretary Principi indicated earlier, transferring 199 VETS employees to the VA.

I fully understand that we owe you, the Congress, as well as the States, veterans' service organizations, the Homeless Veterans Coalition, and most importantly, we owe America's veterans answers to the many complex questions.

There is, however, a general consensus on the need to provide services that better meet the employment and training needs of veterans in the 21st century.

I am confident, Mr. Chairman, that with the collective good will and genuine commitment to doing the right thing, that we together will produce the very best hospital system to meet that goal.

The trust placed upon us to administer the vital programs enacted by Congress to help veterans successfully transition from military service to civilian life is a stewardship responsibility we take very seriously.

We will keep faith with that trust, and ensure that this transition be a seamless one. No veteran will encounter a gap in service while these changes take place. We cannot afford to allow any veteran to be left behind.

I look forward to working with this committee and our other partners as we move forward to ensuring that all America's veterans get the best employment and training services, which they have so justly earned.

Thank you, Mr. Chairman. I will try to answer any questions you may have.

[The prepared statement of Mr. Juarbe appears on p. 79.]

The CHAIRMAN. Mr. Juarbe, thank you very much for your testimony.

I just would note, in reading the testimonies, the American Legion last night, or in their testimony they presented, Director Fischl points out that the American Legion adamantly opposes the President's new initiative to transfer VETS from the Department of Labor to the VA, and part of his rationale is that the American Legion believes that many of VETS problems stem from persistent inadequate federal funding, failure to be staffed at federally mandated levels, and inconsistent national leadership.

One, how do we respond to their opposition, and two, why wouldn't these same issues crop up once the transfer has been made, especially since, as we see even from today's hearing, we're talking about a budget that's a good faith effort on the part off the Secretary, but still, you know is a floor rather than a ceiling, and it's building, you know, something we're going to build up from, hopefully, going forward.

If you could respond to their criticism?

Mr. JUARBE. Mr. Chairman, if I may start with the last part of that criticism, this is new leadership. It's a new administration, and I am confident that, given the well-demonstrated record that Secretary Principi has of providing advocacy and services to veterans, that we will receive the support necessary.

When I signed on board with this administration to serve President Bush, it was in the firm belief that he was calling me not to manage a program, or to administer or to maintain it, but to lead.

We're there to lead, to provide the leadership that is needed to meet the needs of veterans today.

So far as the funding level, we firmly believe that the levels that we have maintained is the level of services that are required to deliver the services that are needed.

As we go through the transition period, we are hoping to be able to maximize the, or build the capacity to deliver better services.

That is precisely, Mr. Chairman, what is intended by placing the Veterans Employment and Training Service within the Department of Veterans Affairs, by being able to work with other programs that are there, and once seeing this continuum of services to veterans, we should be able to maximize that capacity and give it a more clear focus in delivering those services.

The CHAIRMAN. Mr. Juarbe, could you tell us who would qualify for these competitive grants? What does that situation look like? Who are the recipients of those grants going to be?

Mr. JUARBE. Mr. Chairman, that's a detail, since it is the initial proposal at this time, and those are details that have yet to be worked out, and we are working to introduce the legislation, and as we work together with your committee, and with the veterans community, and all of the others who have an interest in this, we will be able to define then how the grants will be competed and who will be the ones that receive it.

The CHAIRMAN. If you could tell us, what would happen, in your view, to the State employees who are now delivering these services, if we went to a competitive grant program?

Mr. JUARBE. Well, the intent is not to put veterans out of work, and especially disabled veterans, and I think it's important that we will, as we make the decision, as we determine the design of this competitive grant, that we take into account the pool of talent that

is out there that had been delivering effective services, and that that talent be utilized.

The CHAIRMAN. Mr. Juarbe, thank you very much. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

As I look deeper into the budget, as you've given us an opportunity to do, I used the term "smoke and mirrors" earlier, and I think we have another example here, Mr. Chairman, and I'm glad most of the VA people are still here.

They have made it more difficult for us. Let me explain what I mean, and correct me if I'm wrong, sir.

There is going to be a legislative proposal, of which we have no details, which will move almost 200 FTE from the Department of Labor to the VA with a funding level of $197 million. Is that correct?

Mr. JUARBE. That is correct.

Mr. FILNER. So that is part of the VA budget, right? I assume it was built into the VA budget. Right?

Mr. JUARBE. As it stands right now, it's part of the Labor budget. We've submitted it as a request for the Labor budget, because until Congress acts on it and authorizes it——

Mr. FILNER. It's not in the VA budget as an assumption, the 199 FTE?

Mr. JUARBE. It may be in there as an assumption, but——

Mr. FILNER. Exactly. Mr. Chairman, they put in the budget an assumption about the deductibles, and now they have an assumption, where we have no legislative details and which we haven't passed, of another .2 billion and another 200 FTE.

So without any new money and without any new positions in reality for veterans, they have built up their budget to make it look like it's higher. It's the same as the trading of the OPM for the retirees. Now they have the transfer from the Labor Department.

It isn't new money, it's no new positions, but the budget is higher, so it's the highest budget increase in history.

You are playing games—I'm talking not to you, sir, but to the folks in the first row—that are going to give us and the veterans very great difficulties. It looks like with the transfer of 199, you're going to have 51 FTE to do a lot of work. Do you think you can do your programs with 51 FTEs?

Mr. JUARBE. Mr. Filner, the intent is to transfer the staff that administers the grants, which is the 199 FTE, over to the Department of Veterans Affairs.

The 51 that will remain at the Department of Labor are those that have responsibilities for compliance programs such as USARA and Veterans Preference, and that staff that is there will be solely dedicated to carrying out that mission as opposed to now where they have numerous other missions, and so we expect that action to be an improvement within the Department of Labor in the compliance enforcement area.

Mr. FILNER. We'll have to determine that. When do you think we're going to get the legislative proposal?

Mr. JUARBE. I believe Secretary Principi indicated that that should be coming soon. We're attempting to put together the legislation, working very closely with the Department of Veterans Af-

fairs, and I'm expecting that it should be introduced by the end of this month if not shortly after this.

Mr. FILNER. I think again—I don't know how our colleagues feel, Mr. Chairman—that's another problematical issue which was included in assumptions by the VA, and I didn't even know about this until last week.

Looking at your budget. Again, we have added another 200 million, another 200 FTE, which is just a transfer and not an increase, and I'll probably find more assumptions built in as I read the budget.

But I'm really disturbed, frankly, at the way the VA budget is presented to us, with all these assumptions which were not made very clear, although I guess if you know how to read a budget, it would be clearer.

We're not adding one new dime, but the budget goes up. I think that's a misstatement of the facts that is going to cause trouble for our veterans, and I'm increasingly disturbed by it.

Thank you, Mr. Chairman.

Mr. JUARBE. Mr. Chairman, if I may respond to that?

Mr. Filner, I understand your concern, but the intent here is not to just transfer personnel from one department to another, but to place them where they can deliver the most effective services.

Mr. FILNER. I understand that, but the budget makes that assumption, and they use that money to claim that they got the biggest increase in history of mankind, and they have transferred a good part of that from other agencies.

I'm not questioning the intent and I'm not questioning the fact that the proposal may have some good points. I don't know that, although my prejudice is against what you recommended, just on the first reading.

But what I'm upset about is the way the budget was constructed, not the intent. The intent of all these folks is always good.

But to hide the fact, frankly, that our Nation's budget priorities are all screwed up because of what is going on, not at the VA or in your department, but what the President has to do, we're cutting veterans, we're cutting housing, we're cutting education, we're cutting health care, and we're cutting environmental protection, all in the name of homeland security, and VA is covering it up, basically.

You're trying to put the best light on the fact that the President's budget hurts millions of people in this Nation, and here we have a big example.

And your own position is going to be eliminated. Is that right?

Mr. JUARBE. No, as the Secretary said, I will transfer over to the Department of Veterans Affairs, still in charge of the——

Mr. FILNER. But your Labor position is eliminated, and you're transferred over?

Mr. JUARBE. Well, that's a decision that's yet to be made. I would be going over to the Department of Veterans Affairs as an assistant secretary. Secretary Chao would make the determination as to the role.

The CHAIRMAN. Just one final comment, if I could. It's my understanding that currently the placement rate is about 3 out of every 10 veterans get placed——

Mr. JUARBE. Yes.

The CHAIRMAN (continuing). So obviously there is a great need for boosting that performance, and if my understanding is correct, the sense is that if a new home were found in a competitive grant program, we're more likely to get a better outcome, a performance that is higher than 3 out of 10 for our veterans. Is that——

Mr. JUARBE. That is certainly our intent, Mr. Chairman.

The CHAIRMAN. We will follow this very closely.

Our subcommittee has already, as you know, worked at least 1 year on this, to try to find the best way to deliver service, taking into consideration all the objections and everything else out there.

The $197 million that is recommended, is that pretty much a straight line from last year?

Mr. JUARBE. That is level funding, yes.

The CHAIRMAN. Okay. Thank you, unless you have anything to add?

Mr. CICCOLELLA. No, no, no. That's all right.

The CHAIRMAN. Thank you very much.

Mr. JUARBE. Thank you, Mr. Chairman.

The CHAIRMAN. I'd like to invite our third panel to the witness table. It consists of four veterans' service organizations who have prepared the Independent Budget:

Richard Fuller from the Paralyzed Veterans of America; Rick Surratt from Disabled American Veterans; Dennis Cullinan from the VFW; and Rick Jones from AMVETS.

Thank you for your patience. We very much appreciate the job you have done consistently on the Independent Budget. It provides, I think, a very good blueprint for the committee and for members on both sides of the aisle, and it is taken very seriously, as you know, by all of us. So I do thank you for that.

If you would begin.

STATEMENT OF BOB JONES, EXECUTIVE DIRECTOR, AMVETS

Mr. JONES. Mr. Chairman, first and foremost, let me thank you and Mr. Evans for your assistance in distributing the Independent Budget and your recommendations to your colleagues that they read this valuable document.

Sir, I would request that my written statement be entered into the record.

The CHAIRMAN. Without objection.

Mr. JONES. Sir, this is the 16th annual budget presented by our coalition, and we're very proud that more than 40 veterans, military, and medical service organizations have endorsed these recommendations.

Our recommendations provide rational, rigorous, and sound review of the budget required to support the vital programs for our Nation's veterans.

Mr. Chairman, I would also like to thank you and the members of the committee for your comments to oppose the $1,500 deductible proposed by this administration. However, as pointed out by Mr. Buyer, I firmly believe that VA should not be strangled by unfunded mandates. Without adequate funding, health care services in the future could possibly be rationed.

Much has been said about the budget submitted by this administration, and we're very grateful that the President made comments

in the State of the Union to support an increase in veterans' health care.

However, after all our discussions related to the budget, we in the Independent Budget believe this administration's budget falls approximately $1.75 billion below than what we as a group believe is needed for veterans' health care.

Another point that I would like to make that I believe deserves comment is the transfer of the Veterans' Employment and Training Service to VA.

VA clearly has its own challenges in health care, waiting lists, backlogs and claims processing. VA is ill-prepared to accept a program which is so naturally suited to the Department of Labor.

DOL has the department knowledge regarding the job market, it knows where the jobs are and the skills required to fill them. Shifting VETS from one department to another is not a magic bullet and it will not, in my opinion, serve veterans better.

Now is not the time to transfer the veterans programs. Adequate resourcing, new vision, accountability, closer cooperation and coordination with VA, and improvement in management of VETS is essential.

The program is sick, but an ill-defined traumatic amputation of this program from Labor is not the answer. Improved service delivery is a must, as are adequate and enforced performance standards.

Mr. Chairman, I would like to yield the rest of my time to my colleagues here so that they can get into the grist of the Independent Budget, sir, without objection.

[The prepared statement of Bob Jones appears on p. 81.]

STATEMENT OF RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. FULLER. Good morning, Mr. Chairman, Mr. Filner.

I'm Richard Fuller. I'm PVA National Legislative Director. I'm sitting in today for our Deputy Executive Director, John Bollinger.

As we have for the past 16 years, PVA is pleased to once again be responsible for the health care recommendations and analysis of VA health care, and I shall address these in my testimony today.

For fiscal year 2003, the Independent Budget recommends a medical care appropriation of $24.468 billion, an increase of $3.1 billion over fiscal year 2002. This proposed increase does not assume any new initiatives or any new workload increases.

Over the past 5 years, the VA has served a constantly growing number of veterans with appropriations that have steadily declined in purchasing power.

The fiscal year 2001 health care appropriation was $564 million short of the amount recommended by the Independent Budget and the fiscal year 2002 budget falls $1.5 billion short. Already, a few months into fiscal year 2002, the Administration has reported a shortfall of close to $500 million and is seeking supplementary funding now as we speak, a step which we fully support.

Nationally, we are witnessing an explosion in health care costs, especially in pharmaceutical costs. The VA has not been immune to this national trend, even though, as the Secretary said, the VA does receive discounts.

According to a report from the Department of Health and Human Services national health care spending increased 6.9 percent in the year 2000. The fastest-growing segment of health care spending is prescription drugs, which increased 17.3 percent in 2000.

This represents the sixth consecutive year of double-digit increases for pharmaceuticals. Spending on drugs has doubled between 1995 and 2000, and has tripled between 1990 and 2000. VA health care budgets have not kept pace.

The real effect of inadequate health care appropriations is felt by sick and disabled veterans every day. Inadequate appropriations force the VA to ration care by lengthening waiting times and delaying services.

As has been discussed earlier, when you subtract all the window dressing from the Administration's budget, it amounts to approximately only a $1.4 billion increase in health care over fiscal year 2002. Although veterans appreciate any increase, we are also cognizant of the fact that this amount does not meet the needs of the VA in the coming fiscal year and does not provide the resources necessary to ameliorate the effects of recent inadequate appropriations.

Unless additional resources are provided, the current situation, as it is, will continue into the foreseeable future, and sick and disabled veterans again will be shortchanged.

Again, this year, we have not included collections as part of our recommendations for appropriated dollars. We have subtracted from all the Administration's requests amounts attributed to the legislative proposal put forth by the Administration, that would include accrual costs for pension and post-retirement benefits for federal retirees for medical care. This figure obviously inflates the Administration's budget by $793 million in fiscal year 2002.

As we state in the Independent Budget, we recognize that non-appropriated funding may be available to expand VHA operations and ultimately improve care for veterans, but we are strongly committed to the principle that the cost of VA health care is a federal responsibility that must be met in full by Congress and the Administration through adequate appropriations.

VA must not be forced to rely on subsidies from veterans or their insurers to cover the costs of caring for veterans. Veterans must not be held hostage through collection estimates that very well may be far-fetched or issued solely to cover budgetary holes left by inadequate appropriations.

The Independent Budget is also opposed to the Administration's proposal to begin charging a $1,500 deductible for health care for Category 7 veterans.

The only reason for the imposition of a deductible requirement is to discourage currently eligible veterans from seeking VA health care.

Last year the Administration announced that it would continue enrolling Category 7 veterans. It said that it would find the resources to cover the costs of these health care services.

Instead of providing the additional resources, it has proposed to have veterans pay for this care out of their own pockets, or to, in effect, disenroll themselves.

The VA estimates that a deductible will deter 121,000 veterans from seeking health care. Requiring a $1,500 deductible could adversely affect lower-income veterans, veterans whose insurance will not pay the deductible, and who want and need to go to the VA, particularly to obtain certain specialized services.

We are very concerned that the Administration has failed to provide funding for the VA to meet its critical fourth mission, that is, to serve as backup to the Department of Defense in time of war or national emergency. We fully support Secretary's request last year for an additional $250 million, which we did not see in the fiscal 2003 request, but we would like to have that looked at very carefully by the committee.

Mr. Chairman, although VA medical and prosthetics research has not suffered the same budget pressures that have beset VA health care, it is still suffering from an uncertain budget cycle.

Research, which is essential to the VA's continuing partnership with medical schools and universities, requires a long-term commitment and stable, reliable funding. The Independent Budget recommends an appropriation of $460 million, which is an increase of $89 million over fiscal year 2002.

In closing, Mr. Chairman, we recognize that this committee does not appropriate dollars, but you do authorize them, and you serve as a resource and as advocates to the budget committee and the appropriators as they fashion budgetary policy.

The authorization process must recognize the real resource requirements of the VA. We look to you and the committee and to your expertise in veterans' issues, as we always have in the past, for your help, to help us carry this message forward to your colleagues and to the public.

That completes my remarks, and I'll turn it over to my colleague from the DAV, Mr. Surratt.

[The prepared statement of Paralyzed Veterans of America appears on p. 90.]

STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. SURRATT. I am Rick Surratt from DAV. I will focus on the benefit programs, the DAV's primary area of responsibility in the Independent Budget.

Other than permanent authority for income matching between agencies for pension purposes, the President's budget includes only one legislative proposal for the benefit program, and that is for an annual compensation COLA.

In addition to recommending a COLA to keep compensation in line with the increase in the cost of living, the IB makes a number of recommendations to improve the benefit programs.

Last year, you enacted several of the things the IB recommended, and we appreciate that. In this year's IB, we have identified other areas where the benefits need changes to make them better or more adequately serve veterans. I won't cover those IB recommendations here, but we hope you will give them careful consideration.

Of course the President's budget includes no funding to cover the cost of these improvements, and this is an issue, of course, for the committee.

No matter how carefully the benefit programs are crafted, they lose effectiveness if they're not administered well.

If claims are not decided correctly and benefits are not delivered timely, veterans suffer, especially veterans seeking compensation to make up for the economic losses caused by service-connected disabilities and impoverished totally disabled veterans seeking pension.

VA has struggled unsuccessfully for years to overcome serious deficiencies in its processing of compensation and pension claims. There's no longer any question about the magnitude of the problem. The question is whether VA has the will and the resolve to take the necessary steps to correct the problem.

In the context of the budget, there's a question whether VA must have additional resources to enable it to gain control over its quality problems and its enormous volume of claims.

The IB has recommended to the VA that it concentrate its focus first on solving the root causes of the claims processing problems.

We have identified those root causes as inadequately trained adjudicators, a lack of accountability for proper actions and legally correct claims decisions, and management weaknesses.

The IB observes that VA's repeated failures to successfully overcome its claims processing problems stem from its failure to tackle the toughest problems—that is, the root causes—and to stay the course until those problems are resolved.

The VA must also resist its self-defeating tendency to rush decision making to reduce its claims backlog, only to rework a substantial portion of the cases because of errors, and add to the volume of work, and ultimately the backlog.

While the IB agrees with the argument that VA must get more serious about implementing meaningful reforms and follow through until those reforms are fully achieved, we do not agree with the convenient suggestion that VA needs no increase in staffing to accomplish this.

To take the necessary steps to properly train its workforce and increase quality without reducing the number of employees working on pending claims, VA still needs to increase staffing in its claims processing system.

The VA cannot succeed without properly training those who decide claims and without enforcing quality standards. With a large volume of pending claims, VA must at the same time maintain full claims processing capacity.

The IB therefore recommends 350 additional FTE be authorized for VA's compensation and pension service. The President's budget, as you know, seeks only 96 additional employees for C&P.

Even with the very best administrative process, mistakes are inevitable in a mass adjudication system like VA's. That is why an effective judicial review process is essential to ensure that veterans receive the benefits to which they're entitled.

The IB has made three recommendations to improve judicial review in veteran benefits matters, and we hope the committee will take action on these recommendations this year.

Mr. Chairman, that concludes my statement. Thank you for allowing us to come before you today to offer our views on the fiscal year 2003 budget.

[The prepared statement of Mr. Surratt appears on p. 97.]

STATEMENT OF DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Good afternoon, Mr. Chairman, distinguished members of the committee. I'm Dennis Cullinan. I'm the legislative director for the Veterans of Foreign Wars.

On behalf of the 2.7 million men and women of the VFW and our Ladies Auxiliary, I would like to thank you for the opportunity to participate in today's hearing.

The VFW's primary contribution as a member of the Independent Budget is analysis of the VA construction programs. Therefore, as in years past, I will confine my remarks to that particular area.

As this committee is well aware, VA must contend with an immense, aged infrastructure that is in need of urgent funding. In this regard, we applaud the introduction and passage in the House of your bill, Mr. Chairman, H.R. 811, the Veterans Hospital Emergency Repair Act. I assure you we will continue to work to achieve expeditious action in the Senate.

Unfortunately, the Administration is only requesting $194 million for major construction, up only $11 million over FY 2002, while funding for minor construction remains nearly flat-lined at $211 million.

An $11 million increase is hardly sufficient to sustain and improve roughly 1,300 care facilities, including 163 hospitals, 800 ambulatory care and community-based outpatient clinics, 206 counseling programs, 135 nursing homes, and 43 domiciliary facilities.

VA's capital asset value is in a constant state of deterioration. For nearly 5 years, we have cited an independent study conducted by Price Waterhouse that concluded VA should be investing an amount equal from 2 to 4 percent of the value of its facilities to maintain them and then another 2 to 4 percent to improve them. VA should be investing roughly $700 million annually just on upkeep.

VA's construction budgets since the 1998 study was published show, however, that VA has received only about $291 million a year for both major and minor construction. Including this year's funding proposal, the 5-year average is a mere $314 million.

These figures represent less than half the recommended investment and have forced VA to delay high-priority projects and other renovations to meet patient safety standards.

We note that CARES remains behind schedule while needed construction is being held hostage.

The Independent Budget recommends that VA immediately identify all facilities that will be definitely retained and move forward on already approved and/or urgently needed construction projects with an eye towards improving patient safety and environment.

As always, stakeholders need to be included and consulted in every step of the process.

One startling example of failing to take appropriate action with respect to safety is that 1 year after experiencing a 6.8 magnitude earthquake, the American Lake VA Medical Center in Washington has yet to receive a dime for structural repairs to its maim hospital and nursing home.

In order for VA to properly operate, maintain, and improve its facilities, the Independent Budget recommends a minimum of $800 million for major and minor construction projects for fiscal year 2003.

For major construction, we recommend that Congress appropriate $400 million, $217 million higher than FY 2002.

We also recommend $400 million for VA's minor construction account. This represents an increase of $190 million to support construction projects for inpatient and outpatient care, infrastructure and physical plant improvements, research infrastructure upgrades, and an historic preservation grant program to protect VA's most important historic buildings.

In order for VA to more effectively carry out these projects, we recommend raising the ceiling on minor construction projects from the current level of $4 million per project to $16 million per project.

Mr. Chairman, this concludes my statement. Thank you.

[The prepared statement of Mr. Cullinan appears on p. 102.]

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Mr. Chairman, Mr. Filner, on behalf of Commander Joseph Lipowski, AMVETS is honored to join these veterans' service organizations in providing you our estimate for a responsible VA budget for fiscal year 2003.

AMVETS' primary focus is on funding the National Cemetery Administration in the new year.

Before beginning on the budget, I would like to commend the chairman and the members of this full committee for your strong leadership on veterans issues, and legislative achievements in the first session of this Congress.

AMVETS and the members of the Independent Budget are truly grateful to you all.

Members of the Independent Budget would also like to acknowledge the commitment of the NCA staff. In particular, we applaud their extraordinary efforts on behalf of the veterans and their families of the World Trade Center, the Pentagon, and in Pennsylvania.

Since its establishment, the National Cemetery Administration has provided the highest standards of service to veterans and eligible family members. Their work oversees 120 national cemeteries located in 39 States, the District of Columbia, and Puerto Rico.

With recent openings of four new national cemeteries within the last 2 years, in Chicago, Albany, Cleveland, and Dallas and fast-track operations at Fort Sill and Atlanta, Georgia, the National Cemetery Administration maintains more than 2.5 million gravesites on nearly 14,000 acres of cemetery land. With adequate funding for design and construction, development of national cemeteries will continue for future facilities in Miami, Pittsburgh, Detroit, and Sacramento.

Currently, and NCA provides more than 83,000 burials annually, an 8 percent jump over last year. To ensure that the burial needs of veterans and eligible family members are met, the Independent Budget veterans' service organizations believe the budget must be increased to provide for new staff and equipment improvements.

To meet this commitment to maintain NCA facilities as national shrines, the Independent Budget veterans' service organizations recommend $138 million for the NCA fiscal year 2003. This would lead to an additional 65 full-time employee equivalents.

This level of funding will provide the additional full-time employees and supplies and equipment to maintain the grounds and continue program operations.

For funding the State Cemetery Grants Program, the members of the Independent Budget recommend $32 million for the new fiscal year.

As you know, the State Cemetery Grants Program works in complement with the NCA to establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans.

Enactment of the Veterans Programs Enhancement Act of 1998 increased the activity and attractiveness of this program. Through the State Grants Program, NCA can provide up to 100 percent of the planning, design, construction of approved new cemeteries.

At the start of the current year, there were 10 new cemeteries under design and 11 new cemeteries in planning. There were also scheduled fast-track openings in central Indiana, Northern Wisconsin, Arkansas, Massachusetts, Maine, and Montana.

The Independent Budget veterans' service organizations also request review of a series of burial benefits that have seriously eroded in value over the years. These benefits were never intended, of course, to cover the full cost of burial, but now they pay only a fraction of what they covered when they were initiated in 1973.

To properly support burial in State facilities, members of the Independent Budget support increasing the plot allowance to $670 from the current level of $300. Prior to last year, this benefit had not been adjusted for over a decade. Increasing the burial benefit to $670 would make the amount proportionately equal to the benefit that was paid in 1973.

In addition, we believe the plot allowance should be extended to all veterans eligible for burial in a national cemetery, not solely to those who served in wartime.

The Independent Budget veterans' service organizations recommend an increase in the service-connected benefits from $2,000 to $3,000. Prior to action in the last Congress increasing the amount by $500, the benefit had been untouched since 1988.

The Independent Budget veterans' service organizations also recommend increasing the non-service-connected benefit from $300 to $1,135 This would bring that benefit back to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers only 6 percent of burial expenses.

We also recommend changing current law to provide a headstone to mark the grave of all honorably discharged veterans upon request of the family.

The current code allows a headstone only for unmarked graves. This causes unnecessary confusion and unsettling aggravation to the families who see VA headstones at nearby marked sites and cannot understand why their loved one cannot likewise be distinguished.

Providing a headstone is a small price to pay for commemorating the service of a veteran to this Nation.

We also recommend that Congress enact legislation to index these burial benefits for inflation, to avoid future erosion.

Finally, we would note that the National Cemetery Administration's greatest challenge is yet ahead. We face a dramatic upward increase in the interment rate until 2010.

Members of the Independent Budget recommend that the National Cemetery Administration continue to provide you with information on plans for the future and establish a strategic plan for the next 5 years.

We must plan for a truly national system, and it must have congressional and administrative budgetary support, and in this regard, we call on Congress to make funds available for planning and fast-track construction of needed national cemeteries.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and would be pleased to answer any questions.

[The prepared statement of Richard Jones appears on p. 85.]

The CHAIRMAN. Mr. Jones, thank you very much, and thank you all for your very detailed testimony, and especially for producing an Independent Budget.

You know, Justice Scalia has often said justices should be read and not heard.

You're both read and heard, and I think the fact that you break out in such detail the needs, and do it in such a professional way, is of enormous help to this committee as we try to come up with a budget ourselves for this recommendation to the Budget Committee.

And you're right, Mr. Surratt, that many of those recommendations that were made last year were taken very seriously by this committee and we made sure they found a home in various bills, as we moved them through to the White House.

So it's extremely important now that you continue doing it, and every idea that you recommended we will take very seriously.

Regrettably, there's a vote on the floor, as you could surmise. I don't want to keep you any more. You've been here all morning and now into the afternoon.

We will have some questions to submit to you if that's okay with you, and obviously this is a dialogue and a two-way street that will continue.

[Recess.]

The CHAIRMAN. We'll resume this hearing, and I want to again apologize to our witnesses for these delays. They're unavoidable, but they still make it very difficult for you, so I do apologize.

Our final panel consists of Jim Fischl from the American Legion and Richard Weidman of the Vietnam Veterans of America.

Gentlemen, without objection, your entire statement will be made a part of the record, and we look forward to your testimony.

STATEMENT OF JAMES FISCHL, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. FISCHL. Mr. Chairman and distinguished members of the Veterans' Affairs Committee, thank you for the opportunity to appear before you today to express the views of the American Legion concerning the President's VA budget request for FY 2003.

Mr. Chairman, the American Legion is very appreciative of the work that you and your committee have done in support of the many bills that have recently been enacted during the 107th Congress—the Veterans Education and Benefits Expansion Act, the Homeless Veterans Comprehensive Assistance Act, and the Veterans' Survivors Benefits Improvements Act.

These bills have had a major impact on our Nation's veterans, but securing passage of a bill is sometimes only the beginning, and we also extend our thanks for the follow-up actions and oversight efforts that you have taken to ensure that the intent of these bills is fully implemented.

We all remember where we were on 9–11. Many of us were in this very room. The American Legion National Commander, Richard J. Santos, was preparing to present testimony before a joint session of the Veterans' Affairs Committees.

This presentation was not to be, however. America was being suddenly and brutally attacked, and before the testimony was to begin, a decision was made to evacuate the Capitol.

Although the national commander did not testify, he did submit his written testimony to both committees. In that testimony, the American Legion outlined its fiscal year 2003 budget recommendations for VA.

The American Legion greatly appreciates the actions of all Members of Congress regarding the $1.3 billion increase in VA medical care funding for fiscal year 2002.

However, even with that increase, veterans health care funding continues to be inadequate. This becomes a very important issue since the 2002 budget is the foundation on which the fiscal year 2003 budget is based.

Because of the dramatic rise in the Priority 7 veteran use of VA health care, and to keep enrollment open to Priority 7 veterans, Secretary Principi asked for a supplemental of $142 million in the fiscal year 2002 appropriations. We applaud this effort to allow Priority 7 veterans to continue to enroll.

The American Legion, however, believes that the additional request will not cover the anticipated shortfall. The American Legion recommends increasing the proposed supplemental to $300 million, reflecting our original fiscal year 2002 funding level for VA medical care.

Focusing ahead to fiscal year 2003, the American Legion takes exception to the proposed budget being portrayed as an 8.3 percent increase in health care, and I think that has been brought out very, very well today. There is no 8.3 percent increase.

The President's budget also relies heavily on the first and third party collections, and the newly proposed $1,500 deductible for Priority 7 veterans.

It's no secret the VA's track record concerning collections has been less than stellar, and the $1,500 deductible, of course, has not even been approved.

Mr. Chairman, we appreciate your voice added to the rising opposition to the proposed $1,500 deductible and your support of Medicare subvention.

While we understand that today's fiscal realities require VHA to seek other revenue streams to support the growing demand for service, the American Legion strongly recommends Medicare subvention as a more appropriate remedy.

Medicare subvention will result in more accessible, quality health care for all Medicare-eligible veterans. Medicare is an entitlement that veterans have earned. The advocate community is strongly united on this issue. Medicare subvention must and will work.

The American Legion recommends VHA medical care receive $23.1 billion in fiscal year 2003 and that al third-party reimbursement, to include Medicare, be considered as a supplement, rather than an offset.

As for medical construction and infrastructure support, the CARES program has limited construction projects throughout VHA. Many much-needed construction projects that would maintain and update VHA's infrastructure are being put on the back burner while CARES awaits full implementation.

The American Legion feels that the CARES process does not allow for local VA managers to impalement the facility improvement projects that they know are necessary to maintain a functional service delivery system.

The American Legion has testified that VA's major and minor construction appropriation must include all infrastructure priorities. Unfortunately, VA has not received appropriate funding.

The VA has identified over 70 buildings in need of seismic correction. Many other modifications also need to be done to ensure the safety of our veterans. Too many facilities in disrepair. No veteran should be placed in harm's way while being hospitalized.

The President's budget request for only $194 million in major construction severely inhibits VHA's ability to properly care for America's veterans.

Also among the many issues not considered by CARES is homeland security. VA facilities may well be suited for such things as warehousing emergency supplies or even housing troops.

Times have certainly changed since September 11, and we must factor these considerations into our decision process.

The American Legion recommends $310 million for major construction in fiscal year 2003.

The minor construction budget did not fare any better. With the added costs of the CARES program recommendations and the nearly $42 million request for minor upgrades in the research facilities, it is essential that minor construction funding be increased considerably from that of past fiscal years. It would be foolish to reduce this investment.

The President's budget request for $211 million falls short of VHA's minor construction needs. The American Legion recommends $219 million for minor construction in fiscal year 2003.

The Veterans' Employment and Training Programs. The President's budget request for fiscal year 2003, which, as stated, contains a proposal that add $197 million to the VA budget for a new competitive grant program that replaces that currently administered by DOL, this is something that the American Legion adamantly opposes, and we feel that it should remain with DOL.

We expressed opposition to a similar recommendation proposed by the Congressional Commission on Service Members and Veterans Transition Assistance in 1999.

The American Legion strongly suggests that this committee hold further oversight hearings before such an initiative would be allowed to prevail. DOL has the expertise and the resources in place for effective job placement and training. Moving this function to VA is simply not a good idea.

Benefit programs. The 2003 proposal outlines various internal changes VBA is making and intends to make to improve the level and quality of service it provides. We're closely watching the implementation of the VA Task Force.

Our major concerns here are that the Task Force has made many recommendations, and one of the big recommendations they made concerned accountability.

We agree with that; we feel that the VA should be accountable, but what we see is they are moving resources to offices that can better handle and better process the claims.

Our question simply would be, what about the offices that can't get the job done? Are they to be held accountable? And it doesn't appear like they are.

A lot of the specialization seems to be moving in that direction, and that concerns us a great deal.

Also, we're concerned that the number of employees that they have may not be adequate, the Secretary has indicated that if that turns out to be the case, that he would be the first one to recommend additional people.

We feel that it would be kind of late. It takes time to train these people, and that should be done before. Now is the time to decide if you need more people, not after the backlog goes up an additional 100,000.

We're also concerned about compliance with the intent of the VCAA.

This legislation was intended to bring veterans into the light, to tell them what was required to successfully prosecute their claims. Well, now we're concerned about claimants receiving only boilerplate notices rather than useful information on the progress of their claim.

The intent of VCAA, again, was to explain to claimants why actions were taken, and if a claim were disallowed, what it would take to grant the benefit.

And also the Board of Veterans' Appeals, it's similar there. They're reducing their number of employees, and we feel with all the changes that the VBA is going through, their requirement to develop cases that would have ordinarily been remanded, that they should be adding rather than subtracting people from their rolls.

The American Legion recommends a total of $1.3 billion in VBA-GOE funds.

Mr. Chairman, distinguished members of this panel, that concludes my remarks. I would be happy later to answer any questions that you might have.

[The prepared statement of Mr. Fischl appears on p. 104.]

The CHAIRMAN. Thank you very much, Mr. Fischl. Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Mr. Chairman, thank you very much, and we appreciate, at Vietnam Veterans of America, the opportunity to present our views here today on the President's proposed budget.

To cut to the chase on the numbers, we believe that the President had it correct in his news release that $2.7 billion is needed just to maintain services at the Veterans' Health Administration. Unfortunately, fuzzy math was involved about how you get to $2.7 billion.

What we need is not 1.414 hard appropriated dollars, but 2.7 hard appropriated dollars in order to just maintain where we are today.

In addition to that, VVA has approached this committee several times over the last several years about the diminishment of capacity, and must respectfully disagree with the Secretary that he is not getting the straight scoop from his people in the field. We are out of compliance in almost all of the specialized services when compared to the level of effort in 1996.

That is certainly true for neuropsychiatric care and seriously and chronically mentally ill, PTSD, and substance abuse, as well as prosthetics, which will start to show up again this year, and each of the offices of Members of Congress undoubtedly will hear from their constituents in that regard.

Therefore, what we propose is, over and above that $25.5 billion, is an average of $1 billion a year for 3 years to restore that capacity and come back into compliance with the law—half a billion the first year, in other words $500 million for fiscal year 2003; $1 billion on top of inflationary increases for fiscal year 2004; and $1.5 billion for the third year.

In addition to that, we would point out a couple of things.

One is that we do endorse heartily the Independent Budget and are grateful to our colleagues in those four veterans organizations for their extraordinary work in providing a line-by-line base for virtually of the programs that reposit in the various elements of the Federal Government for veterans.

In regard to the $1,500 for non-service-connected benefits, conceptually we do not oppose that. Frankly, we believe that the VA is for he or she who had gone into battle.

However, the cutoff of $24,500, that anybody who makes more than that, who is single, in Washington, DC or Passaic, New Jersey or San Diego, California or Chicago, Illinois, it's preposterous to refer to them as a higher-income vet.

In the briefing last week, we objected to them continuing to use that term. No one in this room would try to live in Washington on $24,500.

Unless we change that law and pull it up to the threshold for Category 7, to $38,000, $39,000, and index it for inflation there-

after, for a single person, and $45,000 a year for a family of four, then we would oppose this provision, certainly as it lays at this moment.

Mr. Fischl was correct when he pointed out that September 11 changed everything, when people started to look around for who had the organizational capability and the expertise when it came to post-traumatic stress disorder with literally tens of thousands of people across the country, not just in the New York City Metropolitan Area, affected as a result of those events and of seeing the horror on TV from one's little child and grandchild to people our age who thought they were pretty seasoned to violence.

Therefore, we are specifically asking that the committee recommend the first increase in over a decade to the VA vet centers of $17 million and an additional FTE, 250 FTE be allocated to put a family counselor in each one of the 206 vet centers across the country, an additional 44 FTE to strengthen some of the vet centers who are operating with too thin a staff. There is no more cost effective program within the VA.

In that same regard, the National Center for Post-traumatic Stress Disorder, which is actually housed at Palo Alto and Stanford, Boston and Harvard, Yale and West Haven VA, and Dartmouth and White River Junction, Vermont, we urge the committee to move to make that a permanent center by statute and to provide line item budget of $20 million for fiscal year 2003 that goes directly to the National Center for Post-traumatic Stress Disorder and work with your colleagues to ensure that this extraordinary, worldwide valued center is, in fact, utilized more.

In regard to research for vets, we ask that you put into the committee language and request of our friends at Budget and Appropriations that all research done by VA be pinned back to the clinical needs of veterans.

A quick example. If you're doing a study on schizophrenia, and there were over 150 of them underway last year, to not take a complete military history and find out if anyone was ever exposed to combat or other hazardous conditions in the military is not only irresponsible for someone to do that with Veterans' Administration dollars, it is also bad science, because you know that there's a covariable out there that may, in fact, have a significant impact on your research, and you're not taking it.

The GI bill, I want to thank everyone on this committee, particularly, Mr. Chairman, you and Mr. Evans, for all of your work on the GI bill, but would point out that we need a raise for the State approving authorities to at least $18 million to be able to make sure that we don't hear about problems later on.

Accountability has been brought up a good deal here today, and there are some steps that the Secretary and the deputy secretary are taking to improve tracking systems of dollars and of measuring performance and demanding that people put it in measurable terms.

We believe very strongly that there is no accountability on the senior civil servants within this system, the 14s and 15s, and the Senior Executive Service.

There's one gentleman, as I've mentioned before, before this committee, who did such a bad job in one VISN he was removed, put

in another; did such a bad job on that VISN that that's why we have 21, not 22 VISNs. He crashed and burned that one, and has got bonuses every year and a new SUV, and has lost not a dime, and now is director of a VA medical center.

This is preposterous. The military would not put up with this, the civilian sector would not put up with this, and our veterans in America should not have to put up with this.

Mr. Chairman, I'm over time. If I may just make a couple of comments about the Veterans' Employment and Training Service.

VVA has testified before this committee numerous time that we are deeply committed to holistic treatment of vets. It must begin with taking a complete military history at the beginning.

If we get it right there, in the preliminary diagnosis and treatment, and it's down in their record, then we step forward to the claim.

If VBA Compensation and Pension Service lays out the standards for filing a claim, if it's done correctly, and there are methodologies that our service officers have adapted and those in other, where you quote the law, cite the evidence, quote the law, cite the evidence, if the treatment is correct at VA, and the diagnosis is correct, and you prepare the claim, a claim like that takes more than half an hour to adjudicate, if you get it right the first time.

We're not getting it right the first time. We're churning people both through the hospitals and through the VBA.

Why do I mention that in terms of a holistic view? For veterans of working age, the flashpoint, the nexus of the readjustment process is the ability to obtain and sustain meaningful employment.

The Veterans' Employment and Training Service is not doing it for us today. I think many of us understand that. It is not necessarily true that the VA could do a better job. Our key point that we have shared and is reflected in that written testimony is wherever it's housed, it must be put on a performance basis with cash American to follow good performance, and that kind of a basis, because otherwise it's going to be left out.

Even then, it may remain to be seen whether or not the system, whether it's set up through the State development agencies contact being the major contact, whether or not they're going to be able to meet the needs of the rest of us.

We spend billions on rehabilitation of veterans and chump change on trying to make sure that they don't backslide. We have to spend more to help people obtain and sustain employment.

I look forward to working with the committee on both sides of the aisle to come up with a construct that will start to do that.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Weidman appears on p. 114.]

The CHAIRMAN. Thank you very much, Mr. Weidman. I appreciate both of your testimonies. It provides us guidance and you being here today certainly helps to amplify the message.

I think, Mr. Weidman, your point about the draconian, the Darwinian class warfare, I was well taken, because I, too, felt that the $24,500 threshold uniformly applied across the country is an absurdity, and when we tried to at least provide the HUD index for different locality cost of living, we ran into a buzzsaw over on the Senate side resulting in a co-payment reduction as our end game

for trying to help these near poor, and what I would argue some places in New Jersey or other metropolitan areas are truly poor, but are just not so classified. So I think your point was very well taken there.

Your testimonies, I think, give us guidance, give us amplification of what we need to be doing and looking at.

So I really don't have any questions, but I do want to thank you for your testimony, and yield to my good friend, Mr. Evans.

I would just note for the record that we do have a bill that we've introduced today—and Mr. Simpson and I'm sure others will join, I know Mr. Evans is a principal co-sponsor—to raise from $14 million to $18 million the authorization for the State approving agencies, a point that you made earlier.

Mr. WEIDMAN. Thank you, sir.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Mr. Chairman, I appreciate the hearing today, and I would ask unanimous consent to allow the members to have ample time to submit written questions and for the witnesses to put into the record such comments that they would like to make.

The CHAIRMAN. Without objection.

(See p. 166.)

Mr. EVANS. Thank you.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. I want to thank both panelists for their testimony and guidance, as the chairman said, and I echo his thanks and his appreciation. The testimony will guide us in this appropriations process as we move along.

As I said earlier, I think the way the President's budget was constructed is going to be misleading to our colleagues, and will make it more difficult for us to fight for the things that both panels have advocated.

I would ask that all the groups get together what I'll call a truth sheet on the Administration's budget—that is, a very simple sheet.

I think probably all of you would agree on how the budget distorts things with the transfers, with the inflationary costs, with the assumptions of legislative action that have all distorted the true budget

I think if you all put out a sheet for our colleagues that showed that, it would make it easier for us when the crunch comes in the appropriations process and they look at that budget and say, hey, you keep asking for more, you got $800 million here, you got $200 million here, which is just a transfer, you got $300 million here, which assumes something else, and it turns out that I don't think the real budget keeps up with inflation, as some other people point out, and doesn't allow us to move forward, and we haven't made up for the shortfall this year and several years before.

If you could get out a sheet like that, simply to show where the budget is and why the distortions took place, it would help us make a case when the crunch comes that we have to significantly raise funding for our veterans.

I hope you all can do that. There are some differences in the way you present your requests, but I think you can all agree on where that budget is not accurate, and I hope you can all do that.

Mr. WEIDMAN. We'll certainly work with the other organizations, and from VVA's point of view, we do intend to do that, plus point out to all the members that every single medical facility, VA medical facility in the country, as we speak, is in a layoff by attrition mode. They are reducing staff right now by not filling positions, and I don't think people realize that we need $750 million right now just to stop the layoffs in their district.

Mr. FILNER. Those are points we got to make, and I know the chairman will, and all of us on this committee, will be fighting very hard.

You might want to, you know, use your grassroots organizations to visit folks and talk to people. That education has got to take place in the districts, so when we get to the votes, there can't be any false information that wasn't dealt with.

I think we have 3 months or 4 months, and we got to use that, I think, to educate our colleagues. Most of us have got some understanding on the budget, but our colleagues don't, and they're the ones that will determine the outcome, no matter how hard we fight.

So if you can get to them in their districts over the next few months, it will help immeasurably and we can do what we have to do for our veterans.

Mr. Chairman, I thank you again for putting this together, and I think we have to fight pretty hard in a bipartisan way to come to an agreement on an appropriate budget that we're going to fight for.

Thank you, sir.

The CHAIRMAN. Thank you very much. Do either of you gentleman want to add anything?

Mr. WEIDMAN. Someone asked us if—Jim and I wanted to know, and asked your staff, Mr. Chairman, if you always save the best for last. They informed us that they always save the last for last. (Laughter.)

Last, but not least. I do want to thank you for your testimony.

You know, we were thinking one of these days we'll shift it so the Secretary goes after the other panels—I mean, we've done that on other committees that I serve on as a way of getting some of the upfront information that really becomes helpful to all the members who may not have had time to ask the Secretary or the assistant secretary. So we'll look forward to doing that in the future.

But again, the importance is really on the written submissions, not to take anything away from your oral presentations, which were excellent, but normally I'll go back, like I did last night, and read through every one of them. I'm sure the other members will do likewise, study it, look for areas where we may be deficient as we make our recommendations to the budget committee and then throughout this entire process as we go forward.

So thank you. My door is always open, as you know. If there's some concern, give me a call, Pat or any of us. I know Lane feels the same way.

So I'd like to thank you again, and the committee is adjourned.

[Whereupon, at 2 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN SMITH

Good morning. I want to thank all of our witnesses for agreeing to testify today. I also want to extend a special welcome to the newest members of the Committee on Veterans' Affairs: Jeff Miller of Florida and John Boozman of Arkansas on the majority side; Stephen Lynch of Massachusetts and Susan Davis of California on the minority side. This Committee has a long history of addressing veterans issues in a bipartisan manner, and I believe We must continue that tradition if we are to be effective in the future.

The Administration's budget proposal for the Department of Veterans Affairs represents the largest increase in spending ever proposed in terms of total dollars, $6 billion over last year for a total of $58 billion. In the most critical area, veterans' health care, the Administration is requesting $22.7 in direct appropriations, in addition to $1.4 billion that is expected to be available through collecting co-payments and third Party insurance payments: an increase of $1.4 billion in appropriated dollars, also a record in terms of total dollars. We all recognize and commend the efforts of the Secretary in fighting for this increase and his commitment to providing the best possible care for our nation's veterans.

Yet despite these large increases, the Administration itself acknowledges that their proposal does not contain enough appropriated dollars to provide care for all of the veterans who are expected to seek care from the VA next year. According to the VA's calculations, an additional $1.1 billion would be needed.

To cover this shortfall, the Administration is proposing a new $1,500 "deductible" that would be applied to Category 7 veterans in order to increase collections and decrease the number of veterans seeking health care through the VA. In fact, the VA has indicated that one result of this proposal will be that 121,000 veterans will leave the VA health Care system. At a time when health care costs continue to rise, and our veterans population Continues to age, Congress should not endorse a policy designed to discourage veterans from obtaining health care from the VA. With all due respect Mr. Secretary, this proposal is a non-starter and I will oppose it.

Ironically, last month the President signed legislation, H.R. 3447, now P.L. 107.135, which contains a provision requiring the VA to *lower* co-payments for near-poor veterans who live in high-cost areas of the country. Thus, I question whether this new $1,500 deductible proposal fits the policy we so recently enacted into law.

It seems to me that the answer is not to turn away veterans and their families, but to provide sufficient resources to the VA in order to meet their needs. Last year, working in a bipartisan manner, the Committee was able to increase health care funding significantly—although not by as much as I or others, including the members of the Independent Budget who will testify later, would have preferred. We succeeded last year by presenting a serious, detailed, and bipartisan estimate of the legitimate needs of the VA health care system. We should do the same this year.

Rather than seek a solution that turns away veterans, we must work together to build a budget proposal based upon the principle: 'leave no veterans behind.'

Let me point out that by keeping veterans inside the VA health care system, we will be investing health care funds in a system that clearly has one of the world's most advanced patient safety programs; one in which the cost of the care may well be 25 to 30 percent less costly than comparable care in the private sector. Judging by the rising enrollments, it also appears that veterans are voting for their favorite health care provider by seeking VA care in record numbers.

In fact, despite their funding limitations, the VA provides excellent health care for almost 5 million veterans and their families. As a Member of the Committee on Veterans' Affairs for over 20 years, I have had the privilege of meeting with thousands of the more than 220,000 VA employees and they are indeed a unique national resource. Unlike other health care systems, most of the employees in the V

A choose to work there out of a commitment to serving our nation and its veterans; many of them are veterans themselves.

Our goal, therefore, must be to put federal health care dollars where veterans are receiving their care. VA already has the authority to collect payments from veterans and third party insurers and they must continue in their efforts to do a better job at that. The Secretary has indicated his' desire to do just that. At the same time, we may need to examine current laws and policies that prevent VA from collecting for the cost of care if enrolled veterans are members of an HMO or are covered by Medicare. We need to see if there are ways to offset some of the cost of their care through innovative approaches to these obstacles. The health care provider actually providing the care should be the one getting the money.

We must also take action to ensure that VA's hospitals, outpatient clinics, research centers and other facilities are properly maintained. Last year, our Committee reported out H.R. 811, that the House later approved, to provide $550 million in emergency funding to repair, retrofit and rehabilitate crumbling VA health care facilities. While I am pleased to see an increase in the Administration's major medical facility construction request, I continue to be concerned that we are failing to properly maintain the aging infrastructure of the VA health care system. I would continue to urge our colleagues in the other body to move this legislation and would hope to have the Administration's support for this effort.

Last year was indeed a productive year for this Committee. Working together with the leadership of our Subcommittee Chairmen, Mr. Moran, Mr. Simpson and Mr. Buyer, our Vice Chairman, Mr. Bilirakis, as well as our colleagues on the other side, including Mr. Evans the Ranking Minority Member, we were able to see five significant new bills signed into law. This year, we must and we will aggressively seek to have these new laws swiftly and faithfully implemented with full funding from Congress.

Of particular urgency are the provisions of H.R. 2716, now P.L. 107–95, the Homeless Veterans Comprehensive Assistance Act of 2001. Every night there are more than 250,000 homeless veterans sleeping on the streets—this is equivalent to 17 infantry divisions, more than the entire United States Marine Corps. It is absolutely imperative that the V A move rapidly to open the 10 new domicillaries authorized by our legislation, establish the new technical assistance grant programs and work with HUD to implement the new Section 8 low-income housing voucher program. We don't have a minute to spare and, again, we have an obligation to "leave no veteran behind."

We also approved legislation, H.R. 1291, now P.L. 107–103, the Veterans Education and Benefits Expansion Act of 2001, providing an historic increase for the Montgomery GI Bill program and we must ensure that it too is fully funded. Finally, as I mentioned before, we also approved H.R. 3447, now P.L. 107–135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, which, in addition to lowering out-of-pocket hospitalization costs for lower income veterans, requires the VA to establish new programs providing chiropractic care and service dogs for severely disabled veterans. This new law also creates new incentives and recruitment programs to attract and retain nurses within the VA. I look forward to the testimony on whether the budget proposal accommodates all of these new and expanded programs.

Another important issue presented to the Congress by this budget concerns the administration of employment assistance to job-seeking veterans. The GAO and numerous others who have examined the Veterans' Employment and Training Service (VETS) agree that it is an agency mired in mismanagement, as evidenced by their lack of vision, accountability, and results. The Administration has proposed that it be transferred from the Department of Labor and that the funding be made available for competitive grants. Whether the Congress is ultimately persuaded that this is the appropriate step, it is my belief that on this issue as well, Congress cannot simply do nothing. I am pleased that our Subcommittee on Benefits Chairman Mike Simpson and Ranking Member Silvestre Reyes have already held a hearing on the need for reform of this program, and that they have pledged to look very carefully at what needs to be done to deliver effective job-finding assistance to veterans. They need and deserve the support of all of us in their quest.

Mr. Secretary, I want to commend you for your stewardship of the Department during the past year. You have been honest and approachable. More importantly, you have seized the helm and laid a very clear course for the Department. I urge my colleagues to pay careful attention to the Secretary's statement and look forward to working with you to ensure that we reach our goal of "leaving no veteran behind."

PREPARED STATEMENT OF HON. JERRY MORAN, CHAIRMAN, SUBCOMMITTEE ON HEALTH

PRESIDENT'S FY 2003 BUDGET FOR VETERANS' HEALTH CARE

I commend the Secretary for his leadership on gaining the President's support in putting forth this budget for $58 billion. This is a great starting point for our debate on the needs of veterans next year.

There are some troubling aspects to the budget that I want to highlight:

- $1500 deductible for veterans with higher incomes is unacceptable.
- I agree with Chairman Smith that this deductible policy, on top of all the existing co-payments (outpatient, inpatient, pharmacy, long term care), will drive veterans away from VA care, not draw them to it.
- This is a totally different direction from policy Congress just enacted in Public Law 107–135, providing a significant reduction in hospital co-payments for near-poor veterans in urban areas.
- I want to work with the Secretary and Chairman to find ways of accommodating veterans' needs while keeping VA viable. Difficult challenge for VA and the Committee, but pledge to continue working toward mutual goals of good stewardship of VA and responsible policy.

Major medical facility construction programs are still focused completely on CARES, rather than addressing problems that are well known and justified. VA needs to continue repairing and doing upkeep on existing and aging VA facilities such as those in Wichita, Leavenworth and Topeka, Kansas, and many others around the nation. I am very concerned about the need to do good upkeep so that these facilities can continue functioning, even while CARES proceeds.

I appreciate Secretary Principi's commitment to VA's biomedical research program. I look forward to gaining this level of support through appropriators. Biomedical research has been an important component in post-Gulf War inquiries. My subcommittee is conducting close monitoring of the armed forces deployment in Afghanistan to ensure that our soldiers are safe and that we might avoid the chaos and the illnesses that afflicted Persian Gulf War veterans.

Again, I want to commend the Secretary for good work on his first "real" Bush Administration Budget. I look forward to working with the Secretary and his staff in VHA to improve care for the nation's veterans.

PREPARED STATEMENT OF HON. SILVESTRE REYES

Secretary Principi, welcome. It is always good to see you, and I would again like to thank you for coming out to EI Paso last year and speaking at my annual Town Hall meeting. I am pleased that the Administration's Budget for the Department of Veterans Affairs (VA) calls for increased staffing to bring performance assessment and accountability to individual employees involved in claims processing. While I am concerned that the requested staffing increase may be insufficient to accomplish the task, I am also concerned that the large number of employees currently in training status may preclude additional hiring until more of the current trainees are more experienced.

Judging by offices which have consistently high rates of reversal and remand from the Board of Veterans' Appeals, it appears that employees at some regional offices are consistently making erroneous decisions. Under VA's duty-to-assist role, claims should not be decided without obtaining critical medical evidence, service medical records, adequate medical examinations and necessary opinions concerning the relationship of a claimed disability to service. I am hopeful that this initiative to increase the number of reviewed claims will enable the VA to take corrective action where such patterns are identified.

As you know, I am very concerned about the backlog of veterans' claims, which has increased by over 50,000 since the start of this fiscal year. While I applaud your desire to improve the timeliness of claims processing, I am very concerned that the backlog is continuing to grow and hope that you will be able to provide me with a detailed description of the reasons for the increase in pending claims since the start of this fiscal year. Reduction of the backlog must not be accomplished at the expenses of long-term goals to improve quality.

Setting mandatory "productivity" goals for individual offices while many employees are still in training status may result in short-term gains with long-term costs. I am particularly concerned that proposed efforts to reduce the backlog by 50 percent over the next 18 months is resulting in productivity goals which can not be met without sacrificing adequate development of claims and quality decisions. Mr.

Secretary, I am concerned that the goal of claim resolution in 100 days by the end of fiscal year 2003 is no longer realistic. During your visit to EI Paso, you conveyed the message to veterans in my district that the claims backlog was your top priority and that you would seek adequate and appropriate solutions to this problem. I intend to work closely with you toward accomplishing this goal with realistic solutions, and would appreciate your input in this matter. Thousands of veterans have been given an opportunity to qualify for compensation benefits as a result of recent legislative and regulatory changes. When a goal becomes unrealistic and unattainable, employees are likely to become discouraged and frustrated rather than motivated. I believe that the VA's goals need to be revised, with perhaps more distinct measurements taking into account the number of issues in a claim to assure that new VA employees are given an adequate opportunity to acquire necessary skills before expecting a substantial increase in their productivity.

Mr. Secretary, no Member of Congress would like to see the backlog reduced more than I. Nonetheless, if timeliness is evaluated as a goal in itself, rather than as one element needed to produce a quality work product, we will be no closer to a solution. In particular, I note that several of VBA's resource centers, which are assisting in rating "fully developed claims", are offices which have traditionally had a very high remand and reversal rates. Having an office serve as a resource under these circumstances, suggests that quantity is being put before quality. Before an office is designated to assist other offices in rating claims, better assurance needs to be provided that the resource office has the ability to consistently issue correct ratings. A more deliberate, well-developed correct initial decision is vastly superior to a fast, wrong one.

In this regard Mr. Secretary, I am also questioning the speed at which the Administration is approaching its stated objective of restructuring the way the federal government provides employment and training services to veterans. These services are currently provided to veterans by the Department of labor through its Veterans' Employment and Training Service (VETS). The budget submission has proposed two major changes—to transfer responsibilities and funding for veterans' employment services and the Homeless Veterans Reintegration Program (HVRP) to VA—and to increase accountability for those various services through a "competitive grants program."

Without any details as to how this can realistically be accomplished and become operational by October 1, 2001, I fear that we would be buying a pig in a poke. To date, we have seen no hard evidence that the VA is equipped to administer employment services that will produce superior results to those currently produced at VETS. For this reason, I am not sure it is prudent at this time to dismantle the current infrastructures in place to help our job-ready veterans find employment or those to help our homeless veterans regain their independence. Moreover, the term "competitive grants" is not defined by the budget submission. I am wondering what all this really means—who would be able to compete for money to provide these vital services to our veterans? What qualifications would they have? How would the grants be administered? How would these programs fit into the VA's organizational structure? Would these grants become a cash cow, for some private industry without any of the safeguards accorded government employment?

I have some questions concerning the Minimum Income for Widows Program. You are at least the fourth Secretary to wrestle with the mandate to move this program from the Department of Defense to the Department of Veterans Affairs by July 1st of 1997. According to the budget submission, this transfer has still not occurred and discussions as to how to most efficiently handle these accounts are still on-going. Given the declining number of widows eligible to receive this benefit, would it be more effective to enact legislation restoring responsibility to the Department of Defense where it has apparently remained?

I also have some very serious reservations concerning the proposal to eliminate the vendee loan program. The Department has proposed legislation to eliminate this program in the last several Congresses. Despite Congress' refusal to enact such legislation, the Administration now proposes to eliminate the program, without specific Congressional authorization. Although the program theoretically extends the government's liability for some time, available data suggests that VA realizes a greater return on investment from vendee loans than from cash sales. Where VA is able to realize a greater return, the original liability of the veteran whose home has been foreclosed on is lessened. With the great need for funding of VA programs, I am opposed to eliminating a program that appears to be improving VA's ability to obtain a return on its investment.

Finally, although I share our Ranking Member's concern at the inadequacy of the health care request, given the many veterans who are waiting months for appointments. I do want to commend you for the increase in the funding for State Home

grants. We have a great need in Texas and particularly in EI Paso for a state veterans' home. I hope that this additional funding will help to address that need.

I am sure that you have fought hard to obtain the funding needed to provide benefits to our Nation's veterans. In some areas, additional funding will be needed to fulfill our commitment to our Nation's veterans. I stand ready to assist you in seeking that funding from the appropriate Congressional Committees.

PREPARED STATEMENT OF HON. STEVE BUYER

Thank you, Chairman Smith, for holding this important hearing to review the VA budget of the Department of Veterans Affairs for fiscal year 2003.

Thank you, Mr. Secretary, for your leadership and your proactive stance on several issues that are of particular importance to me—medical claims recovery and improving management information systems.

This budget reflects your commitment to ensuring that our nation's veterans receive the benefits they deserve. The fifty eight billion dollar request for veterans benefits and services represents an increase of 6.1 billion dollars over last year's level of funding and provides the largest increase ever proposed.

This budget also breaks new ground because it includes a one hundred and ninety seven million grant to administer the Disabled Veterans Outreach Program (DVOP) and the Local Veterans Employment Representatives grants that are currently administered by the Department of Labor. I look forward to hearing more about this initiative.

Last September my Subcommittee held a follow-up hearing to evaluate the progress that is being made in third-party payment collections by the VA's Medical Care Collections Fund (MCCF). What we heard wasn't very promising.

This year's budget requests twenty five billion dollars for health care, including $1.5 billion in collections. However, I must express my grave reservations about relying on third-party payer collections because except for one year between 1995–2001, the VA has not met its projected goal. Therefore, I hope the Secretary will provide us with an update on what, if any, of the 24 recommendations made by Price Waterhouse in its 2001 report have been implemented.

Let's keep in mind that the fiscal year 2001 increase in collections was largely the result of VA's implementation of "reasonable charges" billing. Nonetheless, longstanding problems continue to persist. VA takes 14 times longer to bill, on average than the private sector. VA's collections information systems continue to be weak. The Veterans Health Administration Revenue Cycle Improvement Plan in September of 2001 stated that the collections system lacked "standardization of policy, technology, data capture, measurement, and training and education." While I might sound skeptical, I'm not convinced that VA will actually capture the entire $1.5 billion and that we may need to pass some type of supplemental funding to avoid a shortfall.

The VA assured members of the Committee that it would initiate four pilot projects to outsource its MCCF collections. However, upon careful review of the "much anticipated" pilot projects, we find that only one of them outsourcing collections. I'm not sure this will provide us with the type of outcome data we need—outsourcing looms as a strong antidote to what ails the MCCF system.

Last September I held a field hearing in Indianapolis to examine the delivery of benefits to Indiana veterans. During our hearing we learned that appeals, on average, take up to 597.4 days. Mr. Secretary, I am pleased that reducing the backlog of claims is a top priority with you. We must eliminate this backlog, which is currently a staggering 600,000 claims.

In that regard, your VA Claims Processing Task Force made several recommendations, including "the Tiger Team" initiative that was specifically given the job of expediting the processing of older compensation and benefit claims for veterans over 70 years of age that have been languishing for a year or longer.

Over the past five years the VA has received approximately one billion a year for its information technology projects. I intend to hold a fifth oversight hearing in the Spring to ascertain where we are in our move towards "one VA."

After September 11, we all recognize the importance of having our medical personnel fully able to diagnose and treat incidents where biological, chemical, or radiological agents were used. I am hopeful that the "seed" money necessary to implement my legislation, H. R. 3254, the "Medical Education for National Defense Act of the 21st Century," is made available since the VA has the infrastructure to make the USUHS curriculum available to medical schools.

Again, I look forward to hearing from our distinguished panel about their vision for nation's veterans.

STATEMENT OF THE HONORABLE ANTHONY J. PRINCIPI

SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS

February 13, 2002

Mr. Chairman, and members of the Committee, good morning. I am pleased to be here today to discuss the President's 2003 budget proposal for the Department of Veterans Affairs (VA) and tell you about the significant progress we are making on behalf of the Nation's veterans.

Our budget reflects the largest increase ever proposed for veterans' discretionary programs. It ensures more veterans will receive high-quality health care, that we will provide more timely and accurate benefit claim determinations, and that we will maintain a dignified and respectful setting for deceased veterans. Our proposal reflects the debt of gratitude we owe to those who have served our country with honor. It also signals our enduring commitment to the men and women in uniform who today defend our freedom many miles away.

We are requesting $58 billion for veterans' benefits and services - $30.1 billion for entitlement programs and $27.9 billion for discretionary programs. This is an increase of $6.1 billion over the 2002 enacted level. Our budget increases VA's discretionary funding by $3.1 billion over the 2002 level, including medical care collections. Increases for specific programs are as follows: $2.7 billion for medical programs; $17 million for burial services; $94 million for the administration of veterans' benefits; and $64 million for capital programs and other departmental administration.

Our budget request includes $197 million for a new grant activity that replaces programs currently administered by the Department of Labor and $892 million for certain Federal retiree and health benefits as proposed by the Administration's Managerial Flexibility Act of 2001. Excluding these new activities, our budget for discretionary programs reflects an increase of $1.9 billion, or 7.8 percent over last year's funding level.

Medical Care

For Medical Care, we are requesting budgetary resources of $25 billion, including $1.5 billion in collections. This increase will provide health care for nearly 4.9 million unique patients - an increase of 156 thousand, or 3.3 percent, over the current 2002 estimate.

Mr. Chairman, I'm pleased to report that we are making substantial improvements to our billing and collection from third party insurers. In a collaborative effort with an external contractor, we have identified 24 actions that will yield significant enhancements to our ability to collect revenue. While many of these actions require time and investment, we have already begun improvements to the revenue collection process. I have directed that we begin the process of consolidating billing and collection services, and that we explore the cost and benefits of outsourcing these services. In addition, we are aggressively pursuing insurance identification by obtaining new HIPAA compliant software to facilitate exchange of medical information with non-VA entities. We are also mounting increased veteran and employee awareness and training campaigns. Further, we have developed a web-based performance metrics program that is used by central office and medical center staff to monitor and evaluate the critical steps in the revenue cycle. Following the original implementation of reasonable charges in September 1999, we have implemented two updates. Work is nearly complete on the next reasonable charges update, which we expect to publish in the Federal Register as an Interim Final Rule and implement during Spring 2002. We expect to collect over $1 billion this year

with continuing increases in 2003 and beyond. We are committed to maximizing our revenue opportunities from this source.

VA has experienced unprecedented growth in the medical system workload over the past few years. The total number of patients treated increased by over 11 percent from 2000 to 2001 – more than twice the prior year's rate of growth. For the first quarter of 2002, we experienced a similar growth rate when compared to the same period last year. The growth rate for Priority 7 medical care users has averaged more than 30 percent annually for the last 6 years, and they now comprise 33 percent of enrollees in the VA health care system. Based on current law, this percentage is expected to increase to 42 percent by 2010.

I am proud that an increasing number of veterans are choosing to receive their health care in the VA system. Despite this success, we have much to accomplish. Patient access to our medical facilities must be improved and this budget reaffirms our commitment to do so. Our goal is for veterans to receive non-urgent appointments for primary and specialty care in 30 days or less, while being seen within 20 minutes of their scheduled appointment. We have included an additional $159 million in our request to work toward this goal.

Mr. Chairman, I know you agree that VA's health care system should maintain timely, high quality care for service-connected and low income veterans and remain open to all veterans. To effectively manage participation in the system, we are proposing a $1,500 medical deductible for Priority 7 veterans. With no change in policy, the cost of care for Priority 7 veterans would grow from $1 billion in 2000 to over $5 billion in 2007. To assure that rising workload does not dilute the quality of care, Priority 7 veterans are being asked to pay for a greater portion of their health care than in the past. We are recommending that these veterans be assessed a deductible for their health care at a percentage of the reasonable charges up to a $1,500 annual ceiling. This is not a standard deductible that must be paid upfront and veterans' insurance may cover all charges. If all projections, funding levels, and the new deductible are realized, VA anticipates continued open enrollment to all veterans in 2003 without detriment to our traditional core patients – those with service-connected disabilities and lower incomes.

VA is working to meet the challenges in long-term care for veterans. However, we believe that a literal interpretation of P.L. 106-117, the "Veteran's Millennium Health Care and Benefits Act of 1999" will result in less than optimal solutions for increasing our long-term care capacity. The number of individual veterans who received care in VA increased from more than 3 million veterans in 1998 to more than 4 million veterans in 2001, due primarily to VA's efforts to expand access for primary care. During that same time period, efforts have been made to meet the increased demand for long-term care. Although the average daily census in VA nursing homes declined, veterans mandated under P.L. 106-117 to receive such care are being served in VA and contract community nursing homes. VA is also supporting a significantly increased census of veterans in state veterans nursing homes. At the same time, VA has been expanding care for veterans in home and community-based extended care, consistent with the mandates of P.L. 106-117. Indications we have received from veterans show that they are pleased with options providing long-term care closer to home, as well as alternatives to more traditional skilled-nursing environments. We look forward to working with Congress to pursue the best options to provide veterans with long-term care.

Our rapidly aging veteran population requires more health care services. Our request includes $817 million to address this rising demand. These funds will support our emphasis on access and service delivery, pharmaceutical support, prosthetics, CHAMPVA for Life, and information technology. Management savings of over $316 million will partially offset resource needs. For example, I am establishing a program across the VA system that will implement "best practice" standards for dispensing and prescribing pharmaceuticals.

The 2003 budget supports our cooperative efforts with the Department of Defense (DoD) to improve federal health care delivery services. Over the past year, we have

undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a reinvigorated VA and DoD Executive Council. VA and DoD entered into a Memorandum of Understanding (MOU) in December 1999, with the objective of reducing contract duplication. The first addendum to that MOU resulted in the conversion of DoD's Pharmacuetical Distribution and Pricing Agreements (DAPAs) to reliance on VA's Federal Supply Schedule (FSS) contracts for pharmaceuticals, which was completed in December 2000. The second addendum is an agreement to convert DoD's DAPAs for medical/surgical products to reliance on VA's FSS. This effort was completed in December 2001. To address some of the remaining challenges, the Departments have identified four high-priority items for improved coordination: veteran enrollment, computerized patient records, cooperation on air transportation of patients, and facility sharing instead of construction.

Medical and Prosthetic Research

VA's clinical research program is funded at the highest level in history with a partnership of government, universities and the private sector. Over $1.46 billion will be invested in 2003: $409 million in direct appropriation; $401 million in support from the VA Medical Care appropriation primarily in the form of salary support for the clinical researchers; $460 million from federal organizations such as DoD and NIH; and $196 million from universities and other private institutions. This investment will allow VA to expand knowledge in areas critical to veterans' and other citizens' health care needs including schizophrenia, diabetes, further implementation of cholesterol and other guidelines, aging, renal failure treatment, and clinical drug treatment evaluations. This investment is relevant to the medical needs of the entire Nation and will enhance future quality of life.

Capital Asset Realignment for Enhanced Services (CARES)

We continue our effort to transform the veterans' health care system under the Capital Asset Realignment for Enhanced Services (CARES) initiative. We are evaluating the health care services we provide, identifying the best ways to meet veterans' future medical needs, and realigning our facilities and services to meet those needs more effectively.

Mr. Chairman, this initiative is not a perfunctory exercise. The CARES process has already had a significant impact on our planning process. Last week, I announced my decision on realigning VA health care facilities in VISN 12. For example, we will shift inpatient services to a remodeled Chicago West Side Division, and maintain a Lakeside Division multi-specialty outpatient clinic in the downtown area. The Hines VA Medical Center will be renovated, including the Blind Rehabilitation and Spinal Cord Injury Centers. Sharing opportunities between the North Chicago VA Medical Center and the adjacent Naval Hospital Great Lakes will be enhanced.

CARES is critical to the future of VA health care. It will allow us to redirect funds from the maintenance and operation of facilities we no longer need to direct patient care. I am prepared to make the difficult choices necessary to ensure accessible care to more veterans in the most convenient and appropriate settings. We will complete CARES studies of our remaining health care networks within two years. Any savings that result from CARES will be put back into the community to provide higher quality care and more services to veterans. Changes will affect only the way VA delivers care – health care services will not be reduced.

Major and Minor Construction Programs

For all capital programs (construction and grants) this is the largest request since 1996. Specifically for major construction, new budget authority of $194 million is requested.

We are requesting funds for four seismic projects in exceptionally high-risk areas: two in Palo Alto, one in San Francisco, and one in West Los Angeles, CA. These projects involve primary care buildings and a consolidated research facility – all of which will be part of any service delivery option resulting from the CARES process. Seismic improvements will ensure veterans and their families, and VA staff, will continue to be cared for, and work in a safe environment. The 2003 Major request also addresses critical National Cemetery needs. Resources are included for new cemeteries in Pittsburgh, PA and Southern Florida and a columbaria and cemetery improvements project at the Willamette National Cemetery, OR. Design funds are provided in the amount of $3.4 million for the design of new cemeteries in Detroit, MI and Sacramento, CA. We are also requesting funds to remove hazardous waste and asbestos from Department-owned buildings, perform an emergency response security study, reimburse the judgment fund, and support other construction-related activities.

To date, we have received $80 million in Major Construction funding to support the design and construction of projects that result from CARES studies. Our Major request for 2003 includes $5 million to continue efforts to realign our facilities.

New budget authority in the amount of $211 million is requested for the Minor Construction program. Particular emphasis will be placed on outpatient improvements, patient environment, and infrastructure improvements. A total of $35 million is earmarked for CARES-related design and construction needs. These funds have been proposed to allow VA to immediately implement CARES options that can be accomplished through the minor construction program (i.e., capital projects costing more than $500 thousand and a total project cost less than $4 million). In addition, $20 million is dedicated to a newly created category to fund minor seismic projects, which will allow VA to further address its seismic corrections needs.

Veterans' Benefits

For the administration of veterans' benefits, we are requesting $1.2 billion and an additional 125 employees over the 2002 level. The President has promised to improve the timeliness and quality of claims processing. Last year, I established a claims processing task force to recommend changes that would improve the time it takes to process claims. The results of that task force, as well as implementation plans, have been presented to me and we have already begun to execute many of the recommendations.

I have set a goal of reaching 100 days to process compensation and pension claims by the summer of 2003. While the annual average number of days for these claims is projected to be 165 for 2003, we expect to achieve the 100-day goal by the last quarter of the year. Four months ago, we began a major effort to resolve 81,000 of the oldest Compensation and Pension claims. A key element of this effort involves a "Tiger Team" at the Cleveland Regional Office that will tackle many of these claims over an 18-month period. The team became fully operational in November 2001. Additionally, consolidation of pension benefit maintenance at three sites will allow VBA to free up employees to focus on rating compensation claims.

At the same time we are reducing the time it takes to process claims, we continue to improve the quality of claims processing. During 2003, the national accuracy rate for compensation and pension claims is projected to grow to 88 percent – a significant improvement from the 59 percent rate evidenced in 2000. This budget contains $3.5 million to support 64 additional employees dedicated to the Systematic Individual Performance Assessment (SIPA) initiative. This is an important contribution to enhance internal control mechanisms and bring accountability to the accuracy of claims processing.

This budget provides additional staff and resources to continue the development of information technology tools to support improved claims processing. Over the last several years, VBA has developed and implemented major initiatives, established

cooperative ventures with other agencies, and used technology and training to address accuracy and timeliness. This budget continues to focus on initiatives in these high payoff areas. For example, this budget requests $6 million in support of the Virtual VA initiative. This effort, when complete, will replace the current intensive paper-based claims folder with electronic images and data that can be accessed and transferred through a web-based application.

Our budget also addresses the mandate to ensure that Montgomery GI Bill (MGIB) education benefits provide meaningful transition assistance and aid in the recruitment and retention of our Armed Forces. Recent legislation has improved these benefits and our priority is to deliver them as efficiently as possible. I am pleased to report that the Imaging Management System (TIMS) is now functioning in all four Regional Processing Offices. The electronic folders that result from this effort have expanded access points, improved data access, and enhanced customer satisfaction. This budget requests $6.2 million to develop and install the Education Expert System (TEES). Among other benefits, this expert system will enable us to automate a greater portion of the education claims process and expand enrollment certification. In 2003, we will continue to improve the accuracy and timeliness of education claims and improve blocked call rates.

Mr. Chairman, I would like to take this opportunity to mention one of VA's great success stories – the administration of more than 4 million insurance policies in force. The American Customer Satisfaction Index (ASCI) and the University of Michigan conducted a study of the insurance death claims process and the satisfaction of beneficiaries who received awards. This study gave the VA's insurance program a score of 90 on a scale of 100. This is one of the highest scores ever recorded for either government or private industry. This budget provides funding to continue the Insurance Center's history of excellence. Our request includes a paperless processing initiative, which improves timeliness and quality of service while reducing the cost to policyholders.

New Veterans Employment Grants Program

Veterans represent a unique and invaluable human resource for American society and the economy. Service personnel leave the military knowing they have made a vital contribution to their country. Veterans want to continue making meaningful contributions as they return to civilian life. However, in 21 states, fewer than 10 percent of veterans between the ages of 22 and 44 were placed in employment after seeking job search assistance from state service providers; during 2001, there was an average of 519,000 unemployed veterans, and in the same time period, 32 percent of unemployed veterans experienced 15 or more consecutive weeks of unemployment.

America's labor exchange market has evolved in the time since the foundation for current programs was laid. This budget proposes legislation that will allow VA to create a new competitive grant program to help veterans obtain employment. VA is working with the Department of Labor (DOL), veterans' service organizations and others to propose a veterans' employment program tailored to the needs of 21st century veterans seeking assistance in finding suitable employment. The details of the legislative proposal to implement this initiative are not yet final. If authorized by Congress, the new program will broaden our ability to assist veterans with employment and training services. Our first priority will be serving unemployed service-connected disabled veterans and those recently separated from military service. We will also help other veterans searching for employment. Our budget request for discretionary programs includes $197 million for the grant initiative.

We have the flexibility to design a program that will incorporate elements currently contained in the DOL grant program – transition assistance; disabled veterans' outreach; local veterans' employment representatives; and homeless veterans reintegration. Veterans look to the VA for education benefits, home loan assistance and, in some instances, rehabilitation and employment, medical care and compensation benefits in the transition years after leaving active duty. Later in life, many veterans

may return to the VA for health care and ultimately burial benefits. Adding an enhanced employment opportunity program to the spectrum of care and services provided by VA would provide veterans with a single access point to a full continuum of benefits and services throughout their lifetime.

I know there are many questions left unanswered regarding this new program. We are in the process of finalizing our legislative proposal within the Administration and will submit it to you in the near future. At that time, we will be prepared to address your questions in greater detail.

National Cemetery Administration

The budget proposal includes $138 million to operate the National Cemetery Administration. The request preserves our commitment to maintain VA's cemeteries as National shrines, dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of our veterans. It provides a total of $10 million to continue renovation of gravesites, as well as clean, raise, and realign headstones and markers.

As noted earlier in my testimony, our budget request for Major Construction includes funds for the development of two new national cemeteries in the vicinity of Pittsburgh, PA and Miami, FL. Operating funds also are requested to prepare for interment operations in 2004 at these two locations and to begin interment operations at new cemeteries at Fort Sill, OK, and near Atlanta, GA.

Management Improvements

Mr. Chairman, last year I stated my commitment to reform VA's use of information technology. I am pleased to report that we have made substantial progress in this area and will continue our reform efforts. As VA moves forward with implementation of the One-VA Enterprise Architecture developed in 2001, we will manage information technology resources to account for all expenditures and ensure our scarce resources are spent in compliance with this Enterprise Architecture. A strong program is under development for Cyber Security. We are re-engineering our IT workforce to ensure we have the proper skill sets to support our program needs. I have recently approved a comprehensive change in how we manage our IT projects to ensure they deliver high quality products, meet performance requirements, and are delivered on time and within budget.

VA is bringing enterprise-wide discipline and integration of our telecommunications capability to increase security, performance, and value. Command and control capabilities are being established to support the Department in times of emergency. Electronic government will be expanded and internet capabilities will be enhanced to improve the delivery of services and the sharing of knowledge for the benefit of the veteran. All of these efforts will focus on meeting the objectives of the President's Management Agenda.

We are pursuing other important initiatives that will promote better management practices throughout the Department. For example, I recently convened the VA Procurement Reform Task Force to examine our acquisition process and develop recommendations for improvement. The Task Force has presented 60 recommendations to accomplish several major goals that will enhance our ability to: 1) leverage purchasing power; 2) obtain comprehensive VA procurement information; 3) improve VA procurement organizational effectiveness; and 4) ensure a sufficient and talented VA acquisition workforce. Mandatory use of the Federal Supply Schedule, reorganization and elevation of the VHA logistics function to more quickly standardize medical and surgical supplies, and establishment of a National Item File are some of the more prominent recommendations being made in order to maximize savings in our

medical care procurements. We are well on our way to achieving savings and increased effectiveness in VA's acquisition arena.

Finally, our 2003 request includes funds for a new Office of Operations, Security and Preparedness (OS&P). Since the tragic events of September 11, 2001, we have made substantial investments to address the Department's security and preparedness, and to meet our primary and critical emergency response missions. VA is the only pre-deployed nationwide health care system. We must be prepared for any disaster response. OS&P will play an important role in the Federal government's continuity of operations in the event of an emergency situation. The new office is formed with the specific intent of improving VA's ability to respond to any contingency with minimal disruption to services for veterans and their families. This office will coordinate all VA involvement with the Office of Homeland Security, FEMA, the Department of Health and Human Services and DoD.

Mr. Chairman, that concludes my formal remarks. Although many challenges lie ahead, I am proud of the accomplishments that have taken place over the past year. Our budget request for 2003 is a good budget for veterans and positions us for continued success. I thank you and the members of this Committee for your dedication to our Nation's veterans. I look forward to working with you. My staff and I would be pleased to answer any questions.

STATEMENT OF FREDERICO JUARBE JR.
ASSISTANT SECRETARY OF LABOR FOR
VETERANS' EMPLOYMENT AND TRAINING
BEFORE THE
VETERANS' AFFAIRS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 13, 2002

Good morning, Mr. Chairman and members of the Committee. Thank you for the opportunity to discuss the initiative contained in the Administration's proposed fiscal year 2003 budget that would transfer three grant programs currently administered by the Labor Department's Veterans' Employment and Training Service (VETS) to the Department of Veterans Affairs (VA).

As we confront a world profoundly changed by the events of September 11, Americans are looking at the men and women of our Armed Forces with a renewed sense of respect and pride. Someday, many of these men and women will exchange their uniforms for civilian attire. Many will be looking to the government for training, job search, and placement assistance to help them successfully make a transition into the civilian economy.

The Bush Administration is deeply committed to helping our veterans find high-quality jobs. Our Nation's veterans deserve nothing less than access to quality services in both employment and training. This Administration understands and deeply appreciates their patriotism, their dedication, and the skills and experiences they bring to the civilian labor force.

Veterans, especially those with service-connected disabilities, deserve the best and most up-to-date services that we can devise. That is why President Bush has tasked the Departments of Labor and Veterans Affairs to work in close partnership to transfer some of the important programs presently administered by the Veterans' Employment and Training Service to the Department of Veterans Affairs.

This transfer is part of the President's overall strategy to increase the effectiveness and accountability of all government programs. It is designed to provide the inter-related services of education, training, vocational rehabilitation, homeless veterans reintegration, and employment as part of an integrated, seamless continuum of services. By operating all of these programs in

the VA – one government agency dedicated to serving the single constituency of veterans – the duplication of effort can be minimized and services can be strengthened.

In particular, the President's FY 2003 budget submission would transfer to the VA three grant programs: (1) the Local Veterans Employment Representatives grants; (2) the Disabled Veterans Outreach Program; and (3) the Homeless Veterans Reintegration Program. In addition, the Transition Assistance Program, which provides job training, employment assistance, and other transitional services to separating veterans, will also be transferred to VA.

The agencies are coordinating on the Administration's initiative. The Office of Management and Budget, VETS, and VA have working groups focusing on various administrative, financial, and legislative implications of the proposed transfer. The total budget transfer to the VA would amount to $197 million.

The transfer also includes shifting 199 VETS employees to the VA and clearly this aspect of the proposal needs to be conducted with sensitivity to the individuals involved. DOL and VA are jointly working on the legislative language to accomplish this transfer, which will soon be sent to Congress.

We intend that this transfer be a smooth one. We will work with our partners in the states and veterans' community in a manner that will assure all of their concerns are considered, and that the best system for delivering these services is designed. It is our goal that no veterans will encounter a gap or a reduction in service while these changes take place. We cannot afford to allow any veteran to be left behind. The Department of Labor will continue to do whatever we can to support our veterans fully, and we pledge to work cooperatively with the Committee to ensure that America's veterans receive the best employment and training services possible.

Thank you. I will be pleased to answer any questions you may have.

SERVING
WITH
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Opening Statement

of

Bob Jones
AMVETS National Executive Director and
Chairman of *The Independent Budget*

before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

The Independent Budget

and

The Department of Veterans' Affairs Budget
for Fiscal Year 2003

Wednesday, February 13, 2002, 10:00 AM
334 Cannon House Office Building

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Mr. Chairman, Ranking Member Evans, and Members of the Committee.

I am Mr. Bob Jones, Executive Director of AMVETS and Chairman of *The Independent Budget* for Fiscal Year 2003.

Thank you for the opportunity to be here today to present *The Independent Budget*, co-authored AMVETS, Disabled American Veterans, Paralyzed American Veterans and the Veterans of Foreign Wars. As you know, this is the 16th annual budget presented by our coalition, and we are proud that more than 40 veteran, military and medical service organizations endorse these recommendations. In whole, these recommendations provide Congress with a rational, rigorous and sound review of the budget required to support the vital programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality healthcare. Veterans must be guaranteed access to a full continuation of healthcare services, including long-term care. And, veterans must be assured burial in state or national cemetery in every state.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, it must be recognized that VA trains most of the nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of federal healthcare dollars, providing benefits at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA. In the State of the Union Address, the President stated his support for increased funding for VA healthcare services.

After mentioning the important mission of the VA, I must now point to the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must also address VA's large casework backlog. There are severely disabled

veterans and those needing home-based healthcare in those backlogs and I think we can all agree that this situation should be reversed.

Without adequate funding, healthcare services may need to be rationed. The funding shortfall of the FY '02 budget, paired with continued open enrollment makes it very difficult for VA to provide quality healthcare in a timely manner.

On the administration's legislative proposal, we call on Congress to provide adequate funding to avoid implementation of the $1,500 deductible on priority seven veterans.

The bottom line Mr. Chairman is that VA is an excellent investment for America. Proper funding levels for the VA makes good fiscal sense to maintain a well functioning system. To this end, the administration must increase VA medicalcare funding to $24.5B for FY '03, an increase of $3 billion over last year's VA budget.

One more point that deserves comment is the proposed transfer of the Veterans Employment and Training Services (VETS) to VA. Clearly, VA has its own challenges with healthcare waiting lists and backlogs in claims processing. VA is ill prepared to accept a program, which is so naturally suited to the Department of Labor (DOL). DOL has the departmental knowledge regarding the job-market. It knows where the jobs are and the skill required to fill them. Shifting VETS from one department to another is not a "magic bullet," and it will not serve veterans better. Now is not the time to cut VETS programs from DOL.

Mr. Chairman, this concludes my remarks. I will now introduce the gentleman who will testify to specific recommendations of *The Independent Budget* for FY '03. Rick Surratt, representing the Disabled Americans Veterans, will brief you on *The Independent Budget's* benefits priorities. Harley Thomas, of the Paralyzed Veterans of America, will address the vital needs in the VA healthcare system. Fred Burns, of the Veterans of Foreign Wars, will inform you of the critical problems of the VA's infrastructure and construction needs, and Rick Jones, of AMVETS, will offer you *The Independent Budget* concerns regarding our nation's veterans cemeteries.

Robert L. Jones
AMVETS National Executive Director

Robert L. Jones was appointed national executive director of the nation's fourth largest veterans service organization on October 17, 2001. As executive director, he is responsible for the management of AMVETS nationwide operations supporting veterans and the issues affecting their welfare and quality of life. Bob previously was AMVETS executive director from 1989 to 1993.

The disabled Vietnam combat veteran served in the U.S. Army after enlisting as a private in 1961 and later retired as a major following assignments in Infantry, Airborne, Ranger and Special Forces units. He was a ground liaison officer with the Air Force's 50th Tactical Fighter Wing and has flown approximately 200 hours in the F-4 Phantom aircraft.

Prior to his appointment in AMVETS, Bob was the deputy assistant secretary of defense for prisoner of war/missing personnel affairs. Other positions he has held include special assistant to the assistant secretary for public and intergovernmental affairs in the Department of Veterans Affairs, special assistant for veteran's employment at the Veterans of Foreign Wars and a variety of volunteer positions including the executive committee of the President's Committee on Employment of People with Disabilities and the Secretary of Labor's Veterans Employment Advisory Committee.

Bob received the Secretary of Veterans Affairs Award for Volunteer Service, AMVETS Silver Helmet as the 1999 Civil Servant of the Year, the Maryland Free State Veterans Award and the Secretary of Defense Award for Outstanding Public Service. He has also been inducted into the Army's Officer Candidate School Hall of Fame at Ft. Benning, Ga.

Bob was born in Decatur, Ill., and holds a bachelor's degree from Methodist College, N.C., and a master's degree from Troy State University, Ala. He and his wife, Nancy, reside in Severn, Md. They have three grown children.

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SERVING
WITH
PRIDE

TESTIMONY

of

Richard Jones
AMVETS National Legislative Director

before the

Committee on Veterans' Affairs
U.S. House of Representatives

on

The Independent Budget

and

The Department of Veterans' Affairs Budget for Fiscal Year 2003

Wednesday, February 13, 2002, 10:00 AM
334 Cannon House Office Building

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Mr. Chairman, Ranking Member Evans, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations in providing you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2003 programs of the Department of Veterans Affairs.

AMVETS—a leader since 1944 in preserving the freedoms secured by America's Armed Forces—provides, not only support for veterans and the active military in procuring their earned entitlements, but also community services that enhance the quality of life for this nation's citizens.

AMVETS testifies before you today as a co-author of *The Independent Budget*. For over 16 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Besides working with our coauthors on the overall development and publication of *The Independent Budget*, AMVETS' primary focus is on developing the recommendations for funding the National Cemetery Administration in the new year.

Before I address budget recommendations for the National Cemetery Administration, I would like to say that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the House Veterans Affairs Committee. AMVETS is truly grateful to the members who serve on this important committee. Clearly, your achievements in the first session of this Congress demonstrate you have at heart the best interests of veterans and their families. You have distinguished yourselves as willing to work in a bipartisan manner to address numerous issues of great importance to the Nation's veterans.

Since its establishment, the National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries in 39 states, the District of Columbia, and Puerto Rico. A year ago, NCA opened cemeteries in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX. Late last year, fast-track operations were started at Ft. Sill, OK, and Atlanta, GA. And development will continue, with adequate funding for design and construction, for future facilities in Miami, Pittsburgh, Detroit, and Sacramento.

While the National Cemetery Administration maintains more than 2.5 million gravesites on nearly 14,000 acres of cemetery land, there remains a need to establish additional national cemeteries in some critically needed areas. AMVETS supports the Committee's active review of this matter and its continued encouragement of the Administration to meet the growing demand for space. Clearly, without the strong commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

The members of *The Independent Budget* recommend that Congress provide $138 million and 1,525 full time employees for the operational requirements of NCA in fiscal year 2003. This is an increase of $17 million and 65 FTE over the 2002 current estimate level.

Currently, the NCA provides more than 83,000 interments annually, an eight percent jump over last year. The aging veteran population has created great demands on NCA operations and actuarial projections do not suggest a decline in these demands for many years. To ensure that the burial needs of veterans and eligible family members are met, the IBVSOs believe the budget must be increased to provide new staff and equipment improvements. Maintaining quality service with an accelerating workload will require additional resources. $138 million for the NCA will provide the additional full-time employees and necessary supplies and equipment for grounds maintenance and program operations.

For funding the State Cemetery Grants Program, the members of *The Independent Budget* recommend $32 million for the new fiscal year. The State Cemetery Grants Program works in complement with the NCA to establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the states. At the start of the current year, there were 10 new cemeteries under design and 11 new cemeteries in planning. There are also scheduled fast-track openings in central Indiana, northern Wisconsin, Arkansas, Massachusetts, Maine, and Montana. Through the State Grants Program, NCA can provide up to 100 percent of the planning, design, and construction of an approved new cemetery.

To properly support veterans who desire burial in state facilities, members of *The Independent Budget* support increasing the plot allowance to $670 from the current level of $300. The plot allowance now covers only 6 percent of funeral costs. Increasing the burial benefit to $670 would make the amount proportionally equal to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The IBVSOs also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $3,700. Prior to action in the last session of Congress, increasing the amount $500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the nonservice-connected benefit from $300 to $1,135, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs recommend changing current law to provide a headstone to mark the grave of all honorably discharged veterans upon request of the family. The current code, allowing a headstone only for unmarked graves, causes unnecessary confusion and unsettling aggravation to the families who see VA headstones at nearby marked sites and cannot understand why their loved one cannot likewise be distinguished. Providing a headstone is a small price to pay for commemorating the service of a veteran to our Nation.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Finally, the IBVSOs note that the National Cemetery Administration's greatest challenge is yet ahead. Based on statistics projecting a dramatic increase in the interment rate until 2010, members of *The Independent Budget* recommend that the National Cemetery Administration establish a strategic plan for the period 2003 to 2008. We must plan for a truly national system, and it must have congressional and administrative budgetary support. We call on Congress to make funds available for planning and fast-track construction of needed national cemeteries.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

www.independentbudget.org

FY 2003 Administration Request Compared to *Independent Budget*

(In Thousands)

	FY 2002	FY 2003 Request	FY 2003 IB	Difference 2003 & 2002	Difference IB & 2002	Difference IB & 2003
Medical Care	21,331,164	22,744,000	24,468,000	+1,412,836	+3,136,836	+1,724,000
Medical Research	371,000	394,000	460,000	+23,000	+89,000	+66,000
MAMOE	66,731	70,000	76,000	+3,269	+9,269	+6,000
4th Mission (DOD Backup)	0	0	250,000	0	+250,000	+250,000
GOE	1,195,728	1,256,000	1,264,000	+60,272	+68,272	+8,000
Inspector General	52,308	55,000	59,000	+2,692	+6,692	+4,000
National Cemetery	121,169	133,000	138,000	+11,831	+16,831	+5,000
Construction, Major	183,180	193,740	400,600	+10,560	+217,420	+206,860
Construction, Minor	210,900	210,700	400,000	-200	+189,100	+189,300
Grants, State Homes	100,000	100,000	110,000	0	+10,000	+10,000
Grants, State Cemeteries	25,000	32,000	32,000	+7,000	+7,000	0

N.B. Amounts exclude Administration's legislative proposal of "full funding for federal retiree costs." Medical Care figures exclude MCCF and Health Services Improvement Fund monies.

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STATEMENT OF

JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE *INDEPENDENT BUDGET*

AND THE DEPARTMENT OF VETERANS AFFAIRS BUDGET

FOR FISCAL YEAR 2003

FEBRUARY 13, 2002

Mr. Chairman, Ranking Democratic Member Evans, members of the Committee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members and the *Independent Budget*, to present our views on the Department of Veterans Affairs' (VA) budget for fiscal year (FY) 2003. We are proud to be one of the four co-authors, along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars, of the 16th *Independent Budget*, a comprehensive policy document created by veterans for veterans.

The *Independent Budget* is an annual budget and policy review for veterans programs and represents an unprecedented joint effort by the veterans' community to identify the major issues facing the veterans' community today while serving as an independent assessment

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of the true resource and policy needs facing veterans. As we have for the past 16 years, it is our distinct pleasure, once again, to be responsible for the health care recommendations and analysis, and I shall address these in my testimony today.

For FY 2003, the *Independent Budget* recommends a medical care appropriation of $24.468 billion, an increase of $3.1 billion over FY 2002. This proposed increase does not assume any new initiatives or workload increases. Unfortunately, we are seeing the effects of an inadequate budget for FY 2002, a budget that we estimate to be $1.5 billion less than the amount required. To address this shortfall, and to provide for the current services requirements of the VA, the *Independent Budget* has requested this $3.1billion increase.

This amount is a realistic assessment of what the VA must have in order to meet its obligations, both statutorily and morally. This recommended increase addresses the "current services" requirements of VA health care for FY 2003, while recognizing the cumulative funding shortfalls faced by the system over the last two years.

Over the last five years, the VA has served a constantly growing number of veterans with appropriations that have steadily declined in purchasing power. The FY 2001 health care appropriation was $564 million short of the amount recommended by the *Independent Budget*, and the FY 2002 budget falls $1.5 billion short. Already, a few months into FY 2002, the Administration has reported a shortfall of close to $500 million, and is seeking supplementary funding, a step we fully support.

Nationally, we are witnessing an explosion in health care costs, especially in pharmaceutical costs. The VA has not been immune to this national trend. According to a report from the Department of Health and Human Services, national health care spending increased 6.9 percent in 2000. The fastest growing segment of health care spending is prescription drugs, which increased 17.3 percent in 2000. This represents the sixth consecutive year of double-digit increases. Spending on prescription drugs has

doubled between 1995 to 2000, and has tripled between 1990 and 2000. VA health care budgets have not kept pace with this explosive spending growth.

The real effect of inadequate health care appropriations is felt by sick and disabled veterans every day. Inadequate appropriations force the VA to ration care by lengthening waiting times and delaying services.

The Administration has proposed a medical care appropriation of $22.744 billion[1], an increase of $1.4 billion over FY 2002. Although veterans appreciate any increase, we are also cognizant of the fact that this does not meet the needs of the VA in the coming fiscal year, and does not provide the resources necessary to ameliorate the effects of recent inadequate appropriations. Unless additional resources are provided, the current situation, as intolerable as it is, will continue into the foreseeable future, and sick and disabled veterans will once again be shortchanged by the very government they have served, and rely upon to care for them.

Again, we note that the Administration's budget relies upon "management efficiencies" to address real budgetary needs. It seems that every year "management efficiencies" are a handy way of making the budgets seemingly balance. As the *Independent Budget* states, "there are no more 'efficiencies' to be wrung out of the system. For the last five years, VHA [Veterans Health Administration] has served a constantly growing number of veterans with appropriations that have been steadily declining in purchasing power."

Again this year we have not included collections as part of our recommendations concerning appropriated dollars. As we state in the *Independent Budget*, we recognize "that nonappropriated funding may be available to expand VHA operations and ultimately improve care for veterans, we are strongly committed to the principle that the cost of VA health care is a federal responsibility that must be met in full by Congress and the Administration through adequate appropriations. VA must not be forced to rely on subsidies from veterans or their insurers to cover the costs of caring for veterans."

Veterans must not be held hostage through collection estimates that very well may be far-fetched or issued solely to cover budgetary holes left by inadequate appropriations.

The *Independent Budget* is opposed to the Administration's proposal to begin charging a $1500 deductible for health care for category 7 veterans. The primary reason we can see for the imposition of a deductible requirement is to discourage currently eligible veterans from seeking VA health care. Recently, the Administration announced that it would continue enrolling category 7 veterans. It said that it would find the resources to cover the costs of these health care services. Instead of providing the additional resources, it has proposed to have veterans pay for this care out of their own pockets. The VA itself estimates that a deductible will deter 121,000 veterans from seeking health care. Requiring a $1500 deductible could adversely affect lower-income veterans, veterans whose insurance will not pay the deductible, and who want and need to go to the VA particularly to provide services they cannot find elsewhere in the private sector or on Medicare, for instance long-term care, prescription drugs, or specialized services. Finally, we are concerned about the perverse disincentive that this deductible scheme could have on veterans who represent the core mission of the VA. *The Independent Budget* proposal fully covers the cost of providing care for these category 7 veterans.

We are very concerned that the Administration has failed to provide funding for the VA to meet its critical fourth mission – to serve as a backup to the Department of Defense in times of war or national emergency. The VA is also a critical component of the federal government's emergency response capabilities, and an integral part of our national homeland defense efforts. Headlines read "Bush's Budget Doubles Homeland Funds," and "Bush to Request Big Spending Push on Bioterrorism," but there are no resources made available to the VA. As the *Washington Post* reports, "while police and firefighters, border security agents, bioterrorism experts and intelligence agencies understandably were among the biggest winners in the new budget – which contains nearly $38 billion for domestic security activities – agencies that once had only the most remote links to homeland security would be showered with funds for that purpose."

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[1] We have subtracted, from all Administration requests, amounts attributable to the legislative proposal put

Pianin and Miller, "Security Permeates Budget," *Washington Post*, February 5, 2002, A7. But the VA has been forgotten

This national emergency entails not only a crisis abroad, but a crisis here at home. As the VA serves as a backup to our Armed forces, it also serves as a backup to, and an integral part of, our Nation's health care system. When terrorists struck New York City, the VA was there, caring for victims. In fact, the Government Accounting Office, in its January 2001 report entitled "Major Management Challenges and Program Risks" (GAO-01-255) characterizes the VA's role as the "primary backup to other federal agencies during national emergencies." The VA must be prepared, and provided with the resources it needs, to accomplish this comprehensive and vital mission.

Taking its lead from requirements detailed in Congressional testimony by Secretary Principi, the *Independent Budget* has requested $250 million to meet its duties in this area.

The stresses on the VA system will only become more severe. The VA plays an indispensable role as part of the federal commitment to states and local communities in times of national emergency and disaster. The VA does not have the resources to meet its responsibilities to sick and disabled veterans, and the *Independent Budget* fears that the VA will not be able to fulfill its important responsibilities under this critical fourth mission.

The *Independent Budget* has recommended an increase for Medical Administration and Miscellaneous Operating Expenses (MAMOE) of $9 million, bringing this account up to $76 million. The Administration has requested $70 million, an increase of only $3 million. Funding shortfalls in the MAMOE account have left the VA unable to adequately implement quality assurance efforts or to provide adequate policy guidance within the 22 Veterans Integrated Service Networks (VISN). Veterans Health Administration headquarters staff play the essential role of providing leadership, policy

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forth by the Administration that would include accrual costs for pension and post-retirement benefits for

guidance, and quality assurance monitoring under the decentralized VA health care system. It is important that these important roles be strengthened.

Although VA Medical and Prosthetic Research has not suffered the same budget pressures that have beset health care, it is still suffering from the uncertainty it faces each budget cycle. Research, which is essential to VA's continuing partnerships with medical schools and universities, requires a long-term commitment and stable, reliable funding. This needed stability is undermined by the annual budget game, where the Administration submits an unreasonably low budget for this vital program and relies upon Congress to partially redress the shortfall. This has a direct impact upon the research community, hampering its planning and funding decisions as it tries to adjust to this yearly funding whiplash. This game must stop. VA research must receive consistent and adequate budget increases in order to keep pace with our national research effort. For FY 2003, the *Independent Budget* recommends an appropriation of $460 million, an increase of $89 million over FY 2002.

The Administration has proposed $394 million for VA research, an increase of $23 million over the amount provided in FY 2002, but a full $66 million below the $460 million recommended by the *Independent Budget*.

We recognize that this Committee does not appropriate dollars, but you do authorize them. You serve as a resource, and as advocates, to the appropriators as they fashion budgetary policy. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues and to the public.

The VA is facing a crucial hour in a critical time. As a Nation we must not forget the sacrifices, and the service, of the men and women who served on the ramparts of freedom. If we provide inadequate budgets we are sending a clear message concerning

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federal retirees. For medical care, this figure is estimated to be $793 million for FY 2003.

what we value as a society. Let us make sure that the message we send is consistent with what we believe ourselves to be.

We need your help, and we offer our assistance, to ensure that the VA receives the funding it needs to ensure that veterans receive the health care they have earned, and the health care they have been promised. Let us move forward from our accomplishments of the last couple of years and build a strong, and continuing base, for the national asset that is the VA.

On behalf of the co-authors of the *Independent Budget*, I thank you for this opportunity to testify concerning the resource requirements of VA health care for FY 2003. I will be happy to answer any questions you might have.

STATEMENT OF
RICK SURRATT
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 13, 2002

Mr. Chairman and Members of the Committee:

On behalf of the Disabled American Veterans (DAV), I am pleased to appear before you to discuss the President's fiscal year (FY) 2003 budget proposal for the Department of Veterans Affairs (VA). The budget is, of course, a matter of paramount importance to the more than one million disabled veterans who are members of our organization and to the members of our Women's Auxiliary. The effectiveness of essentially all veterans' programs—and therefore the welfare of veterans and their families—is dependent upon full funding for the benefits and services and resources adequate to allow for their timely, efficient delivery.

Joining with AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW), the DAV incorporates its annual recommendations for funding of veterans' programs, and many of its legislative and policy proposals, in *The Independent Budget* (*IB*). With the shared goal of ensuring that the needs of America's veterans are adequately addressed, the four organizations pool their resources and work together to assess and present the budgetary requirements and related issues facing veterans' programs.

Each of the four organizations takes primary responsibility for selected portions of the *IB*. Here, I will focus on Benefit Programs, General Operating Expenses (GOE), and Judicial Review in Veterans' Benefits, the DAV's assigned areas of the *IB*. The members of the *IB* group appreciate the courtesy this Committee has extended in permitting us to present our views together in this format.

The President's total budget of $58 billion includes nearly $1.5 billion VA projects it will realize from medical care collections, $892 million to pay a newly assumed obligation to fund employee health care and retirement costs, and $197 million for a new grant program for veterans' employment services to replace those veterans' employment programs now administered by the Department of Labor. The $58 billion in budget authority for VA includes $29.6 billion for the benefit programs and $1.3 billion for GOE. Within the GOE appropriation, the President's budget would provide $1.2 billion for the delivery of benefits in the Veterans Benefits Administration (VBA) and $278 million in budget authority for General Administration.

For the benefit programs, the President's budget includes funding for its legislative recommendation to increase compensation, which includes dependency and indemnity compensation and the clothing allowance, to meet a projected increase in the cost of living of 1.8% this year. The *IB* also recommends a cost-of-living adjustment (COLA) for these benefits and urges Congress not to extend provisions for rounding down the compensation COLA beyond the current sunset date.

Regrettably, the President's budget does not propose any other improvements to compensation and related benefits, readjustment benefits, or insurance programs. For these benefit programs, the *IB* makes the following recommendations for legislation:

- to exclude compensation from countable income for Federal Programs
- to repeal the prohibition of service connection for disabilities related to tobacco use
- to authorize a presumption of service connection for noise-induced hearing loss and tinnitus suffered by combat veterans and veterans who had military duties with typically high levels of noise exposure

- to repeal delayed beginning dates for payment of increased compensation based on temporary total disability
- to authorize payment of fees under the Equal Access to Justice Act (EAJA) to nonattorneys who represent appellants before the United States Court of Appeals for Veterans Claims
- to authorize refund of contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under honorable conditions"
- to increase the amount of the specially adapted housing grants and to provide for automatic annual adjustments for increased costs
- to provide a grant for adaptations to a home that replaces the first specially adapted home
- to increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs
- to exempt the dividends and proceeds from and cash value of VA life insurance policies from consideration in determining entitlement under other Federal programs
- to authorize VA to use modern mortality tables instead of 1941 mortality tables to determine life expectancy for purposes of computing premiums for Service-Disabled Veterans' Insurance
- to increase the face value of Veterans' Mortgage Life Insurance
- to repeal the 2-year limitation on payment of accrued benefits
- to protect veterans' benefits from unwarranted court-ordered awards to third parties in divorce actions

The *IB* also recommends legislation to remove the offset between military retired pay and disability compensation and legislation to extend the 3-year limitation on recovery of taxes withheld from disability severance pay and military retired pay later determined exempt from taxable income.

The coauthors of the *IB* carefully identify areas in the benefit programs that need adjustment or improvement to make the benefits more effectively or equitably fulfill the purposes for which Congress established them. Last year, Congress enacted legislation that addressed several *IB* recommendations. We appreciate your action on these matters. Although it is in a position to know where beneficial legislative changes could better serve our Nation's veterans, the Administration has not taken the lead in recommending legislation to improve veterans' programs. Therefore, if meritorious improvements are to be made, the members of this Committee must initiate action on them. In developing your legislative agenda this year, we ask that you again give thorough consideration to the recommendations we have included in this year's *IB*.

Unlike the lack of positive recommendations in the budget to improve the benefit programs, VA Secretary Principi has made improving VA's administration of the benefit programs, especially compensation and pension claims processing, one of his foremost priorities. We are confident of his sincerity and determination on this issue. We have not seen great progress in this area to date, however, and despite this budget's stated focus on improving claims processing, it does not request resources to match actions with words.

Although the President's budget recommends a $94-million increase in funding for VBA under the GOE account, $53.9 million of that would cover a new obligation to fund employees' retirement and health benefits. With the net increase of $40.2 million above last year's funding, the increase for VBA is approximately 3.6%, which is well below the average increase of approximately 10% requested by the President over the past 5 years. The President's budget

recommends only 96 additional employees for compensation and pension (C&P) service. Within this budget, VA promises to reduce the average time for rating actions on C&P claims from 208 days to 100 days in the last quarter of FY 2003, while improving training for claims processors and increasing the accuracy rate for core rating work from 78% in FY 2001 to 88% in FY 2003. Other initiatives in C&P include:

- begin to transition from a paper-based to an electronic claims record
- consolidate pension cases in three pension centers
- continue the implementation of four new training and support systems for adjudicators
- analyze the needs of the C&P claims development and adjudication process and design a new system known as C&P Evaluation Redesign (CAPER)
- deploy an individual performance assessment program to measure and enforce employee proficiency, known as the Systematic Individual Performance Assessment (SIPA)
- pursue development of a modern system to replace the existing benefit payment system
- expand the Veterans On-Line Application program, which allows veterans to apply for benefits over the Internet

While improved processes, new technology, better training, and real accountability for legally correct decisions—if properly, timely, and completely implemented—will enable VA to eventually increase efficiency and overcome its intolerable claims backlog, VA still needs additional employees for C&P in the short term. Training new employees, retraining VA's existing workforce, and conducting quality reviews of the work of individual adjudicators will require substantial numbers of employees who will not be devoted to production and reducing the backlog. We believe the President's request for only 96 additional employees for C&P is tied more to budget targets than to the real needs of VA. The *IB* recommends funding for 350 additional employees in C&P Service. Additionally, based on unofficial estimates, the *IB* recommends $4.5 million, instead of the $2 million requested in the President's budget, to fund CAPER.

Unless VA makes other reforms in management and takes a more direct and decisive approach to tackling the claims backlog, it is likely to continue to fail in its efforts to make meaningful improvements in the accuracy and timeliness of its claims processing. Currently, the head of VA's C&P service and VBA's other program directors do not have management authority over their employees in VA field offices. The C&P director is powerless to enforce quality standards and C&P policy. Higher-level officials in VA's Central Office are more removed from and do not have the daily hands-on experience that the C&P director has in the C&P programs. The *IB* recommends that the C&P director and other VBA program directors be given line authority over field offices to strengthen VBA's management structure and allow for more effective enforcement of quality and performance standards.

Those who have witnessed C&P's repeated failures to overcome its claims processing deficiencies know that those failures involve repetitive patterns in which VA develops plans but fails to follow through with decisive steps to solve the difficult problems. VA attempts to overcome its serious deficiencies by fine-tuning its procedures and employing new technology. While those efforts may aid in improving claims processing, alone or in combination they are not enough to enable VA to overcome its longstanding problem. The coauthors of the *IB* believe that it is obvious VA must resolve to focus primarily on eliminating the root causes of its claims backlog if it is to ever succeed in restoring the system to acceptable levels of performance and service. As noted, we believe that adequate resources are key to the effort. However, VA's adjudicators make erroneous decisions because they have not been properly trained in the law, they have operated in a culture that tolerated indifference to the law, and they have not been held accountable for poor performance and proficiency. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decisionmakers and managers truly accountable.

If VA's ambitious goal of improving timeliness takes precedence over its goal of improving quality, VA will merely repeat the failures of the past. Speeding up the process with the single goal of reducing claims processing times and claims backlogs is self-defeating if, because quality is compromised, a substantial portion of the cases must be reworked. In this respect, VA has shown some inability to learn from its past mistakes.

VA has made similar mistakes in its efforts to avoid meeting some of the obligations Congress has imposed upon it and in its efforts to avoid fully implementing legislation enacted by Congress. In exploiting an erroneous line of decisions by the courts to avoid its duty to assist claimants in developing and prosecuting claims, VA made additional work for itself in the end because it had to rework thousands of these claims after Congress intervened and restored the duty to assist. Several veterans' organizations have now challenged in court VA's rules to implement this legislation. While courts tend to indulge agencies in rulemaking, the veterans' organizations challenging the validity of VA's regulation in this instance have a high level of confidence about the prospects for having VA's regulations set aside because of their clearly arbitrary nature and conflict with the law. If the Court of Appeals for the Federal Circuit finds that VA's regulations do not fulfill the mandates of the law, VA may once again be saddled with the task or reviewing thousands of cases to apply the law properly. These self-inflicted setbacks complicate VA's efforts to overcome its claims backlog. In this vein and because of the adverse effects upon veterans' rights, the *IB* has urged the VA Secretary to reform his department's rulemaking. Court challenges to what is viewed as self-serving VA rules are becoming commonplace.

Under the VBA portion of the GOE appropriation, the *IB* also includes a recommendation to fund new information technology for VBA's Education Service. Administration of VA's education programs involves the routine exchange of massive amounts of data between educational institutions and VA. This routine exchange of correspondence and data is particularly well suited to automated systems, which can greatly reduce personnel costs and processing times. The *IB* therefore recommends that Congress provide $16 million for upgrading and expanding the limited application and capabilities of the existing system. For this VA initiative, known as The Education Expert System (TEES), the President's budget requests only $6.3 million. Again, information not revised to meet the objectives of the Administration's budget process indicates that $16 million is the real funding level needed for this project.

The President's budget proposes legislation to establish a new program in VBA for providing grants to states for employment and training services for veterans. This new VA program would replace the veterans' employment and training services of the Department of Labor. The *IB* has taken no position on this issue, but the DAV and other veterans' organizations have mandates from their membership to oppose the transfer of veterans' employment and training services to VA from the Department of Labor. The President's proposal raises many questions about the nature and effectiveness of such a program. When the details of this proposal are made available, the *IB* will give it additional consideration.

The President's budget request would reduce the number of employees authorized for the Board of Veterans' Appeals (BVA) from 464 to 451. The caseload at the Board is temporarily down because VA regional offices have directed their resources to reducing the backlog of claims and neglected work on their appellate workload. However, new VA regulations recently assigned BVA the added responsibility for correcting the regional offices' failure to obtain all necessary evidence. Eventually, VA regional offices must resume work on their pending appeals, and BVA will begin receiving large numbers of appeals that have been allowed to accumulate in regional offices. With this added responsibility and expected influx of cases, reduced staffing may adversely impact BVA and protract the time for resolution of appeals beyond its already unacceptable FY 2001 average of 595 days. Many of VA's problems stem from improvident reductions in staff in the face of impending increases in workload. We therefore recommend caution in considering any reduction in BVA's workforce at this time.

In enacting legislation in 1988 to authorize veterans to challenge VA decisions in court, Congress recognized the importance of the right to have VA's decisions reviewed by an independent body. Judicial review has had the beneficial effect of exposing administrative departure from the law and forcing reforms within VA. However, the judicial review process needs some adjustments itself to make it serve veterans in the manner envisioned by Congress.

The *IB* recommends legislation to change the standard under which the Court of Appeals for Veterans Claims (CAVC) reviews VA's findings of fact in claims decisions. The current "clearly erroneous" standard conflicts with and undermines the benefit-of-the-doubt rule. Under the statutory benefit-of-the-doubt rule, VA is mandated to resolve factual questions in the veteran's favor unless the evidence against the veteran is stronger than the evidence for him or her. However, CAVC will uphold a VA decision if there is any evidence to support it, and this renders the benefit-of-the-doubt rule unenforceable.

Currently, VA regulations, with the exception of provisions in the *Schedule for Rating Disabilities,* are subject to challenge in the Court of Appeals for the Federal Circuit (CAFC). The *IB* recommends expanding CAFC jurisdiction to permit it to review challenges to the validity of the rating schedule on the narrow basis of whether the rating is contrary to law or is arbitrary and capricious. The coauthors of the *IB* believe that no unlawful or arbitrary and capricious rating schedule provision should be immune to review and correction.

The jurisdiction of CAFC is restricted in another manner that does not serve the cause of justice well. While CAFC has jurisdiction to consider an appeal that involves a dispute about the proper interpretation of a law or regulation, it has no jurisdiction to consider an appeal that involves a dispute about the proper application of the law to the facts in a case. The *IB* recommends that CAFC jurisdiction be expanded to cover these so-called ordinary questions of law.

Much of what this Committee will seek to accomplish on behalf of veterans this year will be subject to what Congress appropriates for veterans' programs. We urge the Committee to press for a budget that is adequate for existing programs and allows for some improvement in benefits and services for veterans. We hope our independent analysis of the resources necessary for veterans' programs and our legislative and policy recommendations are helpful to you, and we sincerely appreciate the opportunity to present our views and recommendations to the Committee.

STATEMENT OF

DENNIS M. CULLINAN, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS' CONSTRUCTION
BUDGET REQUEST FOR FISCAL YEAR 2003

WASHINGTON, D.C. FEBRUARY 13, 2002

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and its Ladies Auxiliary, I would like to thank you for the opportunity to participate in today's hearing. The VFW's primary contribution as a member of the *Independent Budget* is an assiduous analysis of the Department of Veterans Affairs' (VA) construction programs. Therefore, as in years past, I will confine my remarks to this particular area of the VA budget.

As this committee is well aware, VA possesses an immense, aged infrastructure that is in need of urgent funding. We applaud you, Mr. Chairman, the members of this committee, and the full House of Representatives for actions undertaken to correct VA's construction budget shortfalls. The *Independent Budget* was pleased to endorse H. R. 811, *Veterans Hospital Emergency Repair Act*. We can assure you that we will continue to fight for its passage in the Senate this session.

Unhappily, we again find that VA's budget request for fiscal year (FY) 2003 as it pertains to construction programs is inadequate. The administration is requesting $194 million (numbers are rounded up or down) for major construction, up $11 million over FY 2002 funding, while funding for minor construction remains nearly flat-lined at $211 million. An $11 million increase is hardly sufficient to sustain and improve nearly 1,300 care facilities, including 163 hospitals, 800 ambulatory care and community-based outpatient clinics, 206 counseling centers, 135 nursing homes, and 43 domiciliary facilities.

In fact, VA's capital asset value is in a constant state of deterioration. For nearly five years we have cited an independent study conducted by Price Waterhouse that concluded VA should be investing an amount equal from 2 to 4 percent of the value of its facilities to maintain (nonrecurring maintenance) and another 2 to 4 percent to improve them. That means VA should be investing roughly a minimum of $700 million annually on just upkeep. Yet a quick analysis of VA's construction budgets since the 1998 study was published show us that VA received an average of $291 million a year for both major and minor construction since FY 1999; and if we figure in the FY 2003 proposal, it would bring the five-year average to $314 million. These figures represent less than half the recommended investment and have forced VA to delay high priority projects and other renovations to meet basic patient safety standards.

Recognizing that VA has undergone a major transformation in its health care delivery process (primarily inpatient-based to outpatient-based) and noting a Government Accounting Office (GAO) report that "without major restructuring, billions of dollars will be used in the operation of hundreds of unneeded VA buildings" and "restructuring... could reduce budget

pressures or generate revenues that could be used to enhance veterans' health care benefits" we continue to be supportive of VA's Capital Assets Realignment for Enhanced Services (CARES) process.

We note that CARES remains behind schedule while needed construction is being held hostage. The *Independent Budget* recommends that VA immediately identify all the facilities that will certainly be retained and allow construction of already approved and/or urgently needed projects to improve patient safety and environment. Further, property divestures should be placed on hold until a comprehensive capital assets plan is formulated. As always, stakeholders need to be included and consulted in every step of the process.

Of great concern to the *Independent Budget* is that veterans and staff continue to occupy high-risk buildings. We have identified and expanded our list to 73 facilities that are subject to collapse or serious structural damage from an earthquake. We commend VA for funding seismic corrections in four of its California-based facilities in its FY 2003 budget request. We, however, remain perplexed that one year after experiencing a 6.8 magnitude earthquake, the American Lake VA Medical Center in Washington has yet to receive a dime for structural repairs to its main hospital and nursing home.

In order for VA to properly operate, maintain and improve its facilities, the *Independent Budget* recommends a minimum of $800 million for major and minor construction projects for FY 2003. It is important to keep in mind that the administration's request is $400 million for FY 2003.

For major construction, we recommend that Congress appropriate $400 million, $217 million higher than FY 2002. A majority of this funding request, $250 million, is needed for seismic corrections. Earlier in our testimony we noted our pleasure that VA is requesting major construction funds for seismic corrections, and we are also happy to see funding requests for national cemetery expansion.

We have also recommended $400 million for VA's minor construction account. This represents an increase of $190 million. This increase will support construction projects for inpatient and outpatient care support, infrastructure and physical plant improvements, research infrastructure upgrades, and an historic preservation grant program to protect VA's most important historic buildings. In order for VA to more effectively carry out these projects we recommend raising the ceiling on minor construction projects from the current $4 million per project to $16 million per project. As we have testified in the past, the current limitation results in a piecemeal approach to design and completion of projects that adds unnecessary delays, facility disruptions, and promotes poor fiscal management practices.

Other construction items recommended for increased funding include grants for state extended care facilities and state veterans' cemeteries.

As stated previously, we believe the administration's request is inadequate as it pertains to VA's construction programs. Further, we believe we have presented compelling evidence such as patient safety, asset management, and continued access to support our proposed increase. Therefore, we look to Congress to correct this shortfall. The passage of H. R. 811 is a good step in that direction and a valid attempt to forestall the continued deterioration of VA's infrastructure. Yet without continued increases in construction appropriations to sustain VA facilities during the CARES process, there will be a need for legislation such as H. R. 811 every year in addition to appropriations. We look to the leadership of this committee to ensure adequate funding for Major and Minor Construction so that VA may realize its potential without compromising veterans' services.

Mr. Chairman, this concludes my statement and I will be pleased to answer any questions you or members of the committee may have.

STATEMENT OF
JAMES R. FISCHL, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE PRESIDENT'S BUDGET REQUEST FOR FISCAL YEAR (FY) 2003
FOR THE DEPARTMENT OF VETERANS AFFAIRS (VA)

FEBRUARY 13, 2002

Thank you for the opportunity to appear before you today to express the views of The American Legion concerning the President's budget request for FY 2003 for VA.

On September 11, 2001, The American Legion National Commander, Richard J. Santos, was preparing to present testimony before a joint session of the Veterans' Affairs Committees, when America was attacked by terrorists. Although the National Commander did not testify, he submitted his written testimony to both Committees. In that testimony, The American Legion outlined its FY 2003 budget recommendations for VA. Copies of this congressional testimony were shared with the Administration.

The American Legion continues to believe that the primary mission of the Veterans Health Administration is to meet the health care needs of America's veterans. The American Legion greatly appreciates the actions of all Members of Congress regarding the $1.3 billion increase in VA medical care funding for FY 2002.

Congress, like The American Legion, quickly recognized that the President's budget request for FY 2002 was totally inadequate. Immediately after the President signed the FY 2002 budget, Secretary Principi was prepared to end the enrollment of additional Priority Group 7 veterans. Many of these veterans would have included recently separated service personnel from the Persian Gulf War, Kosovo and even Afghanistan. Fortunately, President Bush intervened and agreed to seek supplemental appropriations to allow VHA to continue its enrollment of additional Priority Group 7 veterans. Recently, VA briefed The American Legion that the Administration will seek a $142 million supplement to the FY 2002 appropriations. The American Legion still believes this additional request will not cover the anticipated shortfall.

The American Legion recommends increasing the proposed supplemental to $300 million reflecting The American Legion's original FY 2002 funding level for VA medical care.

VETERANS HEALTH ADMINISTRATION (VHA)

The American Legion finds it hard to contemplate the President's FY 2003 budget request without a clear vision of FY 2002 funding. Focusing ahead, The American Legion is very concerned with VA's approach to the veterans' medical care budget in FY 2003.

The major reason for Secretary Principi's inadequate FY 2002 estimates was the dramatic increase of new patients choosing to enroll in VA. Many factors are driving more veterans to use VHA as their primary health care provider:

- Many Medicare+Choice health maintenance organizations (HMOs) withdrew from the program;
- Many HMOs have collapsed;
- VHA has opened community based outpatient clinics;
- Double-digit increase in health care premiums;
- The dramatic fluctuations in the national economy make VHA a more cost-effective option for veterans; and

- VHA's reputation for quality of care and patient safety is attracting new patients.

Where comparable data exists, VHA continues to outperform the private sector in all indicators in health promotion and disease prevention. The American Legion adamantly believes VHA is the best health care investment of tax dollars. The average cost per patient treated within VHA is unmatched by any other major health care delivery system, especially with comparable quality of care.

The reason VHA medical care continues to increase annually is not due to uncontrollable cost increases or poor cost estimates, but rather because thousands of veterans are voting with their feet. More and more veterans are choosing to use their earned benefit – access to VHA. However, enrollment in VHA is clearly limited by existing discretionary appropriations. The American Legion urges Congress to evaluate several options that would assure every veteran that wants to enroll in VHA can enjoy that earned benefit. The key factor driving the increases in medical care funding requirements is the unexpected and dramatic increase in demand for care from VHA.

The American Legion does not oppose veterans paying for the treatment of nonservice-connected medical conditions. In fact, The American Legion's GI Bill of Health (a blueprint for VA health care for the 21st Century) advocates collecting from veterans and all third-party insurers, including Federal health insurers. This plan also recommends VA provide health care benefits packages on a premium basis for those veterans with no health care coverage.

To cover the cost of the dramatic increase in the enrolled Priority Group 7 veterans population, VA proposes a $1500 deductible for the Priority Group 7 veterans. The American Legion questions the President's logic behind this new initiative to collect $363 million. The VA shows an "accounting adjustment" of $892 million, (cost of the Civil Service Retirement System and Federal Employees Health Benefit Program accrual for employees) as an increase in the medical care funding. Add to that the first-party and third-party collections from the Medical Care Collection Fund (MCCF), which VA estimates will reach nearly $1.5 billion. This budget picture presented to veterans is seriously skewed. After stripping away all of these "increases" the *actual* request for increase in medical care funding is $1.4 billion, barely covering the cost of inflation. In essence, veterans will be paying the cost of the "increase" out of their pocket.

Under the President's plan, VA would charge Priority Group 7 veterans 45 percent of reasonable charges until the deductible amount of $1500 is reached. After the deductible is met, the inpatient and outpatient co-payments will resume. According to VA, approximately 25 percent of Priority Group 7 veterans report having billable insurance. According to VA, 55-60 percent of Priority Group 7 veterans are over the age of 65, and thus Medicare-eligible. , VA is prohibited from billing the Centers for Medicare and Medicaid Services (CMS), but can bill the Medicare supplemental insurers. Only the remaining 15-20 percent of Priority Group 7 will be expected to generate over $500 million in medical care costs.

In FY 2002, VHA estimates first-party collections will reach $228 million. VHA estimates that in FY 2003 it will collect $192 million in first-party collections. In FY 2002, VHA estimates third-party collections will reach $577 million. VHA predicts FY 2003 will generate $529 million in third-party reimbursements. VHA expects to collect $363 million in deductibles in FY 2003. This new proposal calls for fewer first-party reimbursements, fewer third-party reimbursements, but more in deductibles.

The American Legion believes these are optimistic estimates, at best. VHA's past MCCF performance in meeting collection expectations is a major concern to The American Legion. VHA's billing and collection reputation is rather embarrassing.

The American Legion believes in order for billing and collections to improve VA must be provided with the resources to obtain the necessary technology and to properly train MCCF personnel or consider contracting out the entire process.

Unlike in the private sector, Medicare-eligible veterans cannot use their Medicare benefits in a VHA facility. When Medicare-eligible veterans receive health care treatment for any medical condition in the private sector, the federal government reimburses the health care provider for a portion of that service. When Medicare-eligible veterans receive health care treatment for the

same medical conditions within VHA, the federal government will not reimburse VHA for any portion of that service. This equates to a restriction on veterans' right to access health care of their choice and using their Medicare insurance coverage.

The American Legion believes that Medicare subvention will result in more accessible, quality health care for all Medicare-eligible veterans. Furthermore, Medicare subvention should greatly reduce incidents of fraud, waste and abuse in billing because it will occur between two Federal agencies with congressional oversight. Today's fiscal realities requires VHA to seek other revenue streams to supplement the growing demand for service and not simply rely on saving more dollars to serve more veterans. The American Legion strongly recommends allowing Medicare subvention for Medicare-eligible veterans enrolled in VHA.

While there is much dialogue concerning the tremendous patient population growth, very little has been mentioned about the addition of health care professionals to meet the growing demand for health care. The American Legion understands that there are currently many veterans waiting to enroll in VHA. Additional health care professionals will also help reduce the long waiting periods for appointments, especially for specialized care. In the private health care industry, there is great concern over the growing nursing shortage, yet this budget fails to address any recruitment or retention proposal, much less, funding.

The American Legion recommends VHA medical care receive $23.1 billion in FY 2003 and that all third-party reimbursement, to include Medicare, be considered as a supplement rather than an offset.

MEDICAL AND PROSTHETIC RESEARCH

The contributions of VA medical research include many landmark advances, such as the successful treatment of tuberculosis, the first successful liver and kidney transplants, the concept that led to the development of the CT scan, drugs for treatment of mental illness, and development of the cardiac pacemaker. The VA biomedical researchers of today continue this tradition of accomplishment. Among the latest notable advances are identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, and potential genetic therapy for heart disease. Many more important potentially groundbreaking research initiatives are underway in spinal cord injury, aging, brain tumor treatment, diabetes and insulin research, and heart disease. The American Legion views these research advances as so significant that it has devoted a column in its magazine to VA Research and Development.

Dollar for dollar, others recognize VA as conducting an extraordinarily productive research program. Currently the VA devotes 75 percent of its research funding to direct clinical investigations and 25 percent to bioscience.

The Quality Enhancement Research Initiative (QUERI) is the highest priority within the VA's Research and Development program. The Institute of Medicine has recognized this program as the best of its kind. QUERI is a multidisciplinary, data-driven national quality improvement program designed to promote the systematic translation of evidence into practice. In other words, "putting research results to work." Currently, QUERI focuses on 10 priority conditions. These conditions include congestive heart failure, heart disease, mental health, substance abuse, HIV/AIDS, diabetes, stroke, spinal cord injury, dementia/Alzheimer's and prostate cancer. Without sufficient funding, VA will not be able to continue all of the QUERI initiatives that involve new technology and the cutting edge of scientific advances. This will have a direct impact on the rapidly aging veteran population.

VA's overall research program requires a significant increase in funding above current levels in each of the next several years to perform important research and evaluation studies. The President's budget request of $409 million is inadequate and should be increased, especially with the growing threats of nuclear, biological and chemical terrorism.

The American Legion recommends $420 million for the research budget in FY 2003.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

MAJOR CONSTRUCTION

The VA major construction program continues to be under funded. The major construction appropriation over the past few years has allowed for only one or two projects per year. For FY 2001, 16 major ambulatory care or seismic correction projects were submitted to OMB. Of this number, only one major VHA project was recommended. For FY 2002, 28 major projects have been submitted for funding.

Over the past several years, The American Legion has testified that VA's major and minor construction appropriation must include all infrastructure priorities. Unfortunately, over the past several years, VA has not received appropriate funding

Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse. Currently, the VHA has identified 890 buildings in its inventory as being at risk. Of those 890, 560 are identified as essential – defined as bed, clinic, psychiatric, research, boiler plant, etc. Additionally, VHA has identified 67 patient care and other related use buildings as Extremely High Risk – danger of collapse or heavy damage. Along with the necessary ambulatory care and patient safety projects, it will require well over $250 million to address VHA's current major construction requirements.

The Capital Asset Realignment for Enhanced Services (CARES) program has impeded construction projects throughout VHA. Many much needed construction projects that would maintain and update VHA's infrastructure are being put on the back burner while CARES awaits full implementation. The American Legion fears that the CARES process does not allow for the local VA managers to implement the facility improvement projects that they know are necessary to maintain a functional service delivery system. The President's budget request for only $194 million severely inhibits VHA's ability to properly care for America's veterans.

The American Legion recommends $310 million for major construction in FY 2003.

MINOR CONSTRUCTION

The American Legion believes that Congress must be consistent from year to year in the amount invested in VHA's infrastructure. Annually, VHA must meet the infrastructure requirements of a system with approximately 5,000 buildings that support 600,000 admissions and over 35 million outpatient visits. This accomplishment requires a substantial inventory investment. The FY 2001 appropriation of $166 million for minor construction was not nearly enough to meet future physical improvement needs. With the added cost of the CARES program recommendations and the nearly $42 million request for minor upgrades in the research facilities, it is essential that funding be increased considerably from that of past fiscal years. It would be foolish to reduce this investment. The President's budget request for $211 million falls short of VHA's minor construction needs.

The American Legion recommends $219 million for minor construction in FY 2003.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The State Extended Care Facilities Grant Program continues to be a cost-effective provider of quality care services to the nations' veterans who require domiciliary, nursing home, and hospital care. The State Veterans Home Program must continue, and even expand its role as an integral vital asset to VA. State homes are in a unique position to help meet the long-term care requirements of the Veterans' Millennium Health Care and Benefits Act (Public Law 106-117). By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half of that number over 5 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan.

The Veterans Millennium Health Care and Benefits Act requires VA to provide long-term nursing care to veterans rated 70 percent disabled or greater. The new law also requires VA to provide long-term nursing care to all other veterans for service-connected disabilities and to those willing to make a co-payment to offset the cost of care. Further, it requires VHA to provide veterans greater access to alternative community-based long-term care programs. These long-term care provisions have placed greater demand on VHA and on the State Extended Care Facilities Grant Program. This legislation has been on the books for almost 2 years and it is time for full implementation.

The American Legion believes it makes economic sense for VA to look to State governments to help fully implement the provisions of PL 106-117. VA spends on average $225 per day to care for each of their nursing care patients and pays private-sector contract facilities an average per diem of $149 per contract veteran. The national average daily cost of care for a State Veterans Home nursing care resident is about $140. VA reimburses State Veterans Homes a per diem of $40 per nursing care resident. Over the long term, VA saves millions of dollars through the State Extended Care Facilities Grant Program.

The American Legion supports the State Extended Care Facilities Grant Program and believes the federal government must provide sufficient construction funding to allow for the expected increase in long-term care veteran patients. The President's budget request for $100 million should be increased to help meet the growing demand for care by veterans of the "Greatest Generation."

The American Legion recommends $110 million for the Grants for the State Extended Care Facilities for FY 2003.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) is making great strides in meeting the interment needs of the nation's veterans and their dependents. As of October 31, 2001, NCA maintains more than 2.4 million gravesites at 120 national cemeteries in 39 states (and Puerto Rico). Currently, 75 percent of all veterans live within 75 miles of open national or state veterans' cemeteries. The ultimate goal is to have 90 percent of all veterans living within 75 miles of open national or state veterans' cemeteries.

NCA's workload is increasing by nearly five percent per year, with cremations accounting for the majority of new interments. The peak years for the interment of World War II veterans is expected to be 2006 to 2010. Over the next decade, new national cemeteries are planned for Atlanta, GA; Miami, Fl; Pittsburgh, PA; Detroit, MI; and Sacramento, CA. P.L. 106-117 requires NCA to contract a study to determine where additional national and state veterans' cemeteries will be required through 2020.

NCA is preparing "fast track" construction projects to open new national cemeteries. This allows burials to occur in each section of a new cemetery as it is being constructed. Instead of taking the conventional approach to new cemetery construction, "fast track" authority would permit the planned new national cemeteries to open in less than half the normal time, which is

seven years. The most recent cemetery to open under the "fast track" authority is the Fort Sill, Oklahoma National Cemetery. Burials began on November 5, 2001.

The National Shrine Initiative continues to be one of the highest priorities of the NCA. This is an ongoing commitment and scheduling continues to fulfill the pledge of aesthetically improving the national cemeteries. Major improvements and renovations have started at several cemeteries with wonderful results. However, there is much that remains to be done. A tremendous amount of time and money is needed to continue this commitment.

The American Legion recommends $140 million for NCA in FY 2003.

STATE CEMETERY GRANTS PROGRAM

The State Cemetery Grants Program, which provides 100 percent federal funding for new state veterans' cemeteries, has received a significant increase in the number of state cemetery applications. Within the next several years, NCA is hopeful that up to 30 new state veterans' cemeteries will be opened. The workload and budgetary requirements of NCA will continue to grow over the next 15-20 years. The American Legion continues to fully support the further development of the State Cemetery Grants Program.

The American Legion recommends $30 million for the State Cemetery Grants Program in FY 2003.

VETERANS' EMPLOYMENT AND TRAINING PROGRAMS (VETS)

The American Legion adamantly opposes the President's new initiative to transfer VETS from the Department of Labor (DoL) to VA.

In the President's budget request for FY 2003, he proposes to add $197 million to VA budget for a new competitive grant program that replaces programs currently administered by DoL. The American Legion expressed opposition to a similar recommendation proposed by the Congressional Commission on Servicemembers and Veterans Transition Assistance back in 1999. The American Legion strongly suggests this Committee consider oversight hearings before such an initiative is allowed to prevail. DoL has all of the expertise and resources for effective job placement and training. The National Veterans Training Institute (NVTI) provides standardized training for all veterans' employment advocates in an array of employment and training functions.

Some suggest that moving VETS to VA would improve the overall performance of VA's Vocational Rehabilitation Program (Voc Rehab). Others would argue that moving Voc Rehab to VETS in DoL would be a much better approach. Nearly all VETS employees attend NVTI and receive continuing training, few (if any) Voc Rehab employees have attended NVTI training. The American Legion perceives the relationship between VETS and DoL much more germane than VETS and VA.

The American Legion welcomes the opportunity to work with the Assistant Secretary for Veterans' Employment and Training (ASVET) and his staff to improve and enhance the overall performance of VETS. However, The American Legion believes reinventing the wheel within VA would be counterproductive and ineffective. The American Legion believes that many of VETS problems stem from persistent inadequate Federal funding, failure to be staffed at Federally mandated levels, and inconsistent national leadership.

The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment.

Annually, DoD discharges approximately 250,000 service members. These recently separated service personnel are actively seeking immediate employment or preparing to continue their formal or vocational education. The veterans' advocates in VETS program play a significant role in helping the recently separated service personnel (veterans) reach their employment goals.

1) VETS continues to improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.

2) VETS provides employers with a labor pool of quality applicants with marketable and transferable job skills.
3) VETS took the initiative in identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.
4) VETS helps to eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market.

VETS started an information technology project with the Computing Technologies Industry Association, to recruit veterans recently separated from the military; assess their interest and skill level for a career in information technology; provide occupational skills training and certification; and place these veterans into information technology jobs. VETS continues to expand its PROVET (Providing Re-employment Opportunities for Veterans) program. PROVET is an employer-focused job development and placement program that focuses on screening, matching and placing job ready transitioning service members into career-building jobs. PROVET programs are currently operating in several states. In addition to employment services, VETS also supports the Transition Assistance Program (TAP), the Disabled Transition Assistance Program (DTAP), Veterans Preference in the Federal workplace, and the Uniformed Services Employment and Re-employment Rights Act (USERRA).

The American Legion strongly recommends restoring funding for the ASVET within DoL's FY 2003 budget at a funding level of $300 million. Staffing levels for Disabled Veterans Employment Program Specialists and Local Veterans Employment Representatives should match the Federal mandates or those statutes should be rewritten. The American Legion recommends an increase in the NVTI budget to $3 million annually. The American Legion further recommends that VA send Voc Rehab employees to NVTI training.

VETERANS BENEFITS ADMINISTRATION

Under the proposed budget for FY 2003, mandatory spending for compensation, pension, education, burial, and other benefit programs is expected to be $31.5 billion. This is an increase of $ 3.4 billion over the level approved for FY 2002. It represents the funding requirements for ongoing statutory benefit payments to some 3.25 million veterans, dependents, and survivors, as well as the impact of recent, expanded statutory and regulatory entitlements, higher average benefit payments, and certain new legislative proposals. It also includes an estimated 1.8 percent cost-of-living adjustment.

Under General Operating Expenses (GOE), the budget request for FY 2003 includes a total of $1.2 billion for discretionary spending to cover staffing and other costs associated with the administration of the various benefits and service programs within the Veterans Benefits Administration (VBA). This represents a net increase of $94 million over the amount approved for FY 2002. It includes an additional 125 FTE to support current efforts to bring the case backlog under control and support a new case development program at the Board of Veterans Appeals. The budget request also includes funding for a number of information technology initiatives that will provide much needed direct and indirect support toward improving the claims process.

In addition to this modest staffing increase, the FY 2003 budget request for VBA describes a number of steps that, over time, are expected to steadily reduce the backlog of pending cases to about 250,000 and the claims processing time to 100 days by the end of FY 2003. As part of the strategy to reach these rather ambitious goals, VBA has implemented a broad spectrum of regulatory, programmatic, and administrative changes, in addition to its long-term strategic plan initiatives, that are intended to improve the regional offices' operational efficiency and decision-making. Also, recommendations of the Secretary's Claims Processing Task Force have been accepted and are in the process of being implemented over the next year. VA expects these changes to produce both near-term and long-term improvements in the quality and timeliness of the decision-making process.

The data upon which VBA's budget request is predicated shows a continued overall increase, rather than a decrease, in the volume of incoming claims. With more complex claims per case and the level of available adjudication expertise, it is doubtful that regional offices will be able to achieve the dramatic increases in production and improvements in quality that will be necessary to reach the claims processing goal of 100 days with a backlog of 250,000 cases. In an effort to

achieve such ambitious production goals, The American Legion is concerned that regional offices will emphasize expediency rather than ensuring full compliance with the due process and assistance requirements of the Veterans Claims Assistance Act and other provisions of the law. Even with the implementation of the many changes and efficiencies described, claims development and adjudication will continue to be a very labor intensive and time-consuming process.

The American Legion believes that the requested staffing increase is insufficient to meet the expected workload demand in FY 2003.

BENEFIT PROGRAMS

The American Legion is pleased to see some special attention being given to expediting the 81,000 oldest claims by the nation's oldest veterans. No veteran or survivor should have to wait a year or longer for a decision on their claim, least of all elderly claimants. Tragically, many die before receiving a decision and the long-awaited benefits to which they were entitled. The Tiger Team initiative at the Cleveland VA Regional Office and the nine Service Delivery Network (SDN) Resource Centers will go a long way toward alleviating much of the hardship and frustration that thousands of veterans experience while waiting for their claim to be decided.

The FY 2003 budget proposal outlines the various internal changes VBA is making and intends to make in order to improve the level and quality of the service it provides veterans. However, there are a number of external factors that have an ongoing impact on VBA's ability to drastically improve regional office performance and production. In FY 2003, while there will be a slight decrease in the number of pension claims, this will be more than offset by the substantial increase in the overall number of compensation claims. Most of this increase is expected to come from the continued influx of new and reopened claims. The number of Agent Orange-related diabetes claims is expected to be up substantially over FY 2002. VBA must also rework thousands of cases as a result of *Nehmer v. United States Veterans' Administration.*

Congress has recently expanded entitlement to service connection for radiation-related diseases as well as disabilities affecting veterans who served in the Persian Gulf War. The requirements of the Veterans Claims Assistance Act of 2000 have greatly increased the regional office's workload and processing time. The United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit have continued to issue precedent decisions requiring frequent and often far-reaching changes in adjudication procedures and the reworking of thousands of previously decided and pending cases.

The American Legion tentatively supports VBA's proposed initiatives for FY 2003. We hope these will enable substantial progress to be made toward the overall goal of providing veterans proper and timely decisions on their benefit claims.

The American Legion is deeply concerned that the 125 additional staff for VBA in FY 2003 may not be adequate, if VBA is to be even partially successful in meeting its stated claims processing goal of 100 days.

BOARD OF VETERANS APPEALS

Veterans or other claimants must have the right to appeal any decision by the regional office to the Board of Veterans Appeals (BVA or the Board). BVA staffing for FY 2002 is 464 FTE. In FY 2003, however, it is projected to further decline to 451 FTE. The American Legion is again concerned by this reduction. Given the current number of initial appeals and remands pending in the regional offices coupled with the fact that the Board will soon begin a major new initiative to do the development work that the regional offices would have normally done pursuant to a BVA remand, manpower shortages may adversely impact on the timeliness of decisions.

In FY 2001 and for the first quarter of FY 2002, the number of new appeals filed in the regional offices has continued to rise. This reflects a high level of dissatisfaction with regional office actions. However, over the same period of time, the number of cases transferred to the Board has steadily declined, due to the overall slow down in claims processing. In particular, regional office compliance with the requirements of the Veterans Claims Assistance Act has prolonged the development of appeals and their eventual transfer to the Board.

The American Legion's longstanding concern with the appeals process is with those factors that contribute to an annual influx of 60,000 to 70,000 new appeals. Veterans and other claimants feel they are not treated fairly or properly by a system that is very complex, highly bureaucratic, and legalistic. They feel very strongly that the process is basically adversarial and not "user friendly." This perception is reinforced by the fact that, in FY 2001, the BVA allowed the claimant's appeal in 22.3 percent of the cases and remanded 48.8 percent of the appeals for further required action. The Board only affirmed regional office decisions 27 percent of the time.

Of the approximately 60,000 appeals decided in FY 2000 and 2001, the Board remanded about 32,000 cases for additional development and readjudication. Unfortunately, most of the appellants in these cases are still waiting on action by the regional offices. Some of these appeals date from 1997 and 1998, and as noted previously, the issue on appeal in these cases is much older still.

Remands involve substantial additional work for the regional offices. To try and reduce this portion of their workload as well as provide more timely decisions on all appeals, VA regulations will go into effect later this month authorizing the BVA to fully develop appeals without the necessity of remanding them back to the regional office of such action. This will involve reorganization of the BVA staff and the reassignment of a limited number of FTE from the Compensation and Pension Service to assist in the additional development work.

Under this new program, it's expected that the Board will be able to provide more expeditious and complete development of appeals. In FY 2001, with a staff of 454 FTE, the BVA issued approximately 31,000 decisions. Of these decisions, approximately 8,500 or 48.8 percent were remands. Now, the Board itself will undertake this development in the majority of those cases, which would have otherwise been remanded. The American Legion believes that more, rather than fewer staff at the Board will be needed in FY 2003 to handle this additional workload.

By substantially reducing the number of remands, the regional offices should be able to concentrate on completing more pending benefit claims and completing the outstanding remands. While The American Legion believes this new procedure will ultimately benefit veterans and provide more timely service, we are concerned that, in the interest of expediency, the regional offices may try and use this program as a way around full compliance with their responsibilities under the Veterans Claims Assistance Act. In our view, the high remand rate of the past several years is a direct reflection of poor decision-making and the lack of an effective quality assurance program. Since the BVA will be assuming the responsibility for correcting errors and mistakes by the regional offices, there will be an incentive for the regional offices to try and shift as much of the appellate workload onto the Board as possible. VBA must ensure this does not happen. More stringent quality assurance standards and performance measures must be promptly implemented. To make this program a success there must also be a closer working relationship and improved communication between VBA and the Board at all levels.

The American Legion recommends a total of $1.3 billion in VBA-GOE.

HOMELAND SECURITY

The important role of VA in Homeland Security is not highlighted in the President's budget request. The American Legion saw the critical actions of VA in response to the September 11, 2001 disasters. VA employees sprang into action to assist response personnel, victims, and surviving family members. Yet, VA was not actually a part of any emergency response plans immediately implemented, but rather acted unilaterally. VA employees provided medical care, counseling, and claims processing. VA was prepared to do even more if called into action.

The Director of Homeland Security, Tom Ridge, will need the cooperation of an array of Federal agencies. Since VA medical facilities are geographically diverse, VHA is a logical partner for the pre-positioning of inoculations and medical supplies needed to address acts of terrorist or natural disasters. Currently, every VA campus is scheduled to undergo an evaluation under CARES. Homeland Security requirements must be included in the criteria used to determine possible utilization of physical plants that may currently be considered underutilized.

In the event of a nuclear, chemical, or biological terrorist attack, each VA campus may become a key element in the care and treatment of mass causalities. As national emergency plans are reviewed at every level of government – local, state, and national – VA must be seen as valuable resource. Whether housing response workers, military forces, or law enforcement personnel; providing quality medical care; or serving as a command, control and communications center, VA must have the resources to meet the assigned mission as back up to DoD and the National Disaster Medical System.

SUMMARY

Mr. Chairman and Members of this Committee, The American Legion applauds the leadership of President Bush and his Administration, especially under the current wartime conditions. As an organization of wartime veterans, we continue to stand shoulder-to-shoulder with the President, Congress, and our comrades-in-arms – past, present, and future.

The American Legion knows that the President's budget request is focused on winning the war on terrorism. Therefore, adequate defense spending is extremely critical and The American Legion fully supports the direction the President has chosen. However, the cost of waging war continues long after the dead are buried, the guns are silenced, and the treaties are signed. The war continues to rage in the hearts and minds of its veterans. No combat veteran completely walks away from any war untouched, physically or mentally.

The cost of freedom rests in this nation's ability to recruit and retain young men and women willing to pay the ultimate sacrifice in the name of liberty. This nation has been blessed since its inception with similar citizen-soldiers, sailors, airmen, and Marines that have set a standard of excellence for others to follow. Recently, a new generation of Purple Heart recipients demonstrated on the field of battle the courage, determination, and loyalty exhibited by -- the Minutemen, the Roughriders, the doughboys, the GIs – that preceded them in protecting and defending America against all enemies, foreign or domestic.

Mr. Chairman and Members of this Committee, The American Legion doesn't ask for much, just another installment in the ongoing cost of freedom.

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A Not-For-Profit Veterans Service Organazation Chartered by the United States Congress

Testimony of

VIETNAM VETERANS OF AMERICA

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Before the

House Committee on Veterans Affairs

Regarding

The President's FY 2003 Budget Request for Veterans

February 13, 2002

Chairman Smith, Ranking Member Evans, and other distinguished members of the committee, Vietnam Veterans of America (VVA) is grateful for this opportunity to provide testimony on the administration's fiscal year 2003 budget request for vitally needed veterans services.

I want to preface my remarks by saying that VVA continues to hold Secretary Principi in the highest regard. He has worked with us to address a number of issues of concern to VVA, its membership, and all veterans. We believe that his commitment to helping veterans is genuine. In contrast, VVA believes that some permanent members of the bureaucracy at the Office of Management and Budget (OMB) may not share his understanding or concern for veterans, particularly low-income and other economically disadvantaged veterans.

When President Bush announced in his State of the Union speech that he would seek "an historic increase" in funding for veterans health care, VVA's leaders and members were left with the impression that the President was about to make a clean break with the past, that veterans could expect full and honest funding of real appropriated dollars for real health care. Having examined the budget in some detail, we have found budget gimmicks built into the overall request, making it less of an "historic increase" than it might seem at first glance.

The President has asked for $1.414 billion more for FY2003 than the level set for FY2002, and this is a significant increase in comparison to some other programs. While the President was correct when he and the U. S. Department of Veterans Affairs (VA) stated in their press release of February 4 that the FY 2003 proposed budget was the largest overall increase in recent memory, it would in fact be the *second* largest increase ever provided for veterans health care in purely *appropriated* dollars. In ordinary times, this would be a major achievement. These are not ordinary times, however.

We believe that the Veterans Health Administration (VHA) needs at least another $1.3 billion in addition to the $1.414 that the President requested. However, that additional $2.7 billion for veterans health care over the FY2002 level must be "real" appropriated dollars. An appropriation of this magnitude is vitally needed partly because of the significant shortfall this year, which made the starting base too low. Indeed, it is clear that a supplemental appropriation of approximately $750 million is needed to stop the reductions in force now occurring at every VA medical facility in the nation. A $2.7 billion increase in the appropriated dollars is vitally needed to advance meaningful and permanent improvements in veterans health care.

VVA would also point out that one cannot speak realistically of preparedness for further attacks from our enemies on American soil and of homeland security without ensuring that the VA healthcare system is restored enough funding and positions for the VHA to be able to rebuild the organizational capacity lost since 1996. Put quite simply, in case of an attack resulting in 5,000 or more casualties at one time in any given congressional district, the civilian medical system would be overwhelmed and the VHA medical facilities would implode. Many American citizens would suffer and die needlessly in such a scenario. Currently the VA cannot properly meet its first three missions, much less adequately meet the vital "Fourth Mission" of acting as a backup to the National Disaster Medical System.

I will spend the balance of my testimony providing specific examples that I think help illustrate this brutal reality.

"Fuzzy Math"

The VA press release touting the President's budget request claimed that it was "the largest increase ever for the Department of Veterans Affairs." As Ranking Member Evans has pointed out, of the $25.5 billion the Bush administration claims the budget will provide for veterans medical care, $794 million will simply shift personnel-related costs to VA from the Office of Personnel Management (OPM). Another $1.28 billion is to offset unavoidable cost increases like inflation, higher pharmaceutical prices, and federal pay raises. It was this type of budgetary sleight-of-hand that helped produce the VA's current FY 2002 budget shortfall, which even the most conservative estimates place at $492 million. If the same accounting gimmicks are allowed to pass as "realistic" budget policy for FY 2003, we can expect even larger shortfalls by this time next year.

What is especially disturbing about the administration's rosy claims over the FY 2003 budget is their belief that they will be able to achieve significant revenue increases through the Medical Care Collection Fund (MCCF), the third-party payer billing mechanism used by the VA to recover costs for treating service-connected veterans for nonservice-connected ailments. Every year between 1995 and 2000, MCCF collections consistently fell far short of the Executive branch projections—often by hundreds of millions of dollars. VVA is highly skeptical that this trend will suddenly reverse unless fundamental management reforms are implemented that lead to genuine increases in MCCF collections.

The VA has an equally undistinguished track record of collecting from private insurers. As GAO reported in 1999, VA collections from insurers declined in every fiscal year from 1995 through 1999. From a peak of $532 million in 1995, VA third-party collections declined to roughly $400 million by the end of fiscal year 1999. While we understand that there was some slight improvement during 2001, GAO has reported that the increase was largely due to a shift from a flat-rate to "reasonable charges" billing model. The billing model change allowed the VA to do a better job of collecting reimbursements for treating roughly the same number of veterans as in FY 2001. Thus, unless other improvements in billing occur, MCCF collections are likely to level off or even decline in future years, invalidating OMB's optimistic assumptions about this revenue stream.

VVA believes that the entire concept of using co-payments and third-party collections as an integral part of the VA budget request is a fundamentally flawed accounting gimmick, in addition to putting a significant part of the burden of paying for veterans health care on the backs of the veterans themselves. OMB's penchant for "discounting" the Veterans Health Administration's budget request by the amount in collections anticipated inevitably makes the collections a wash in terms of bringing more revenue into the chronically starved veterans health

care system. OMB has repeated this practice in the FY 2003 budget, with what we believe will be predictably bad results.

Additionally, VA's shift from an inpatient-based to an outpatient-based healthcare model has dramatically reduced the number of opportunities to bill insurers for medical services; outpatient treatment episodes are almost always less costly than inpatient encounters. GAO reported in September 1999 that the annual number of VA inpatient episodes dropped by more than 250,000 between 1995 and 1998, while the number of outpatient episodes climbed by nearly 7 million. One could argue that this has made the system more "efficient," although VVA would argue that in many instances veterans should be hospitalized, but there simply is no capacity for that clinically indicated inpatient care available at that facility or in the Veterans Integrated Service Network (VISN).

VVA does not at present have figures on the numbers of outpatient encounters involving over-65 veterans. We would suggest to the committee that this is an area requiring further study and investigation, because another key problem facing the MCCF—and one completely outside of the VA's control—is the aging veteran population. An increasing number of veterans are over 65 and thus Medicare eligible. At present, however, there is no Medicare subvention program available to the VA through which the VA could bill Medicare for veteran's health care. Because the VA is not an authorized provider under any existing HMO plan, VA cannot bill those plans for services provided to veterans.

This issue is becoming more acute due to the VA's Capital Asset Realignment for Enhanced Services (CARES) process. In essence, CARES serves as a vehicle for the VA to shut down aging medical centers, shift functions and services to more modern facilities, and expand the number of community-based outpatient clinics (CBOCs) within the VA system. We have testified before the full committee on previous occasions about our growing concerns over the decline in access to VA health care for hundreds of thousands of veterans across America.

On September 17, VVA filed comments with the VA opposing their proposed CARES-driven reorganization of VISN 12 for a number of substantial reasons, including the VA's refusal to contract for medical service for veterans living in regions not within an easy drive of a VAMC or even a CBOC. Similarly, the VA's inability to bill Medicare for services compromises health care for elderly veterans by tying over-65 veterans to VAMCs that are often hours from their homes. These issues are closely linked, and require a comprehensive Congressional response.

Co-payment Deductibles: Draconian and Discriminatory

The Administration's proposed $1,500 per year deductible for "high income" veterans (i.e., Category 7 veterans) can most charitably be described as a form of Darwinian class warfare, an attempt to force out of the VA system some of the most economically and socially disadvantaged members of the veteran community.

What constitutes a "high income veteran" by VA standards? A single veteran earning more than $24,500 per year, or a veteran with a family of four making more than $28,800 per year. Both of these figures are well below the national poverty level. That most certainly is the

case in any metropolitan area in the country, whether the veteran lives in New Jersey, Illinois, or Texas.

Tens of thousands of veterans nationwide are living at or just slightly above the current VA Category 7 means test threshold. We can assure this committee and the American public that if the administration's proposal is adopted, tens of thousands of veterans will effectively be priced out of health care altogether. Given the decline in state health care budgets, these low-income veterans and their families will plunge straight through the remaining shreds of a very tattered social and economic safety net, perhaps to a future of homelessness and steadily declining health for themselves and their families.

We remind this committee that many veterans who begin as Category 7's move to higher categories once their claims have been approved. While they wait for their claims to be approved, these veterans are paying much more out of pocket for their medical care than would otherwise be the case. How many veterans have slipped into poverty in this way, by losing their ability to hold down a job as their health declined, all the while having to make significant co-payments as their claims sat for months or even years?

What also happens in some cases is that veterans simply do not seek any medical care until they are so sick that they cannot work at all, therefore needing much more extensive and intensive care than if they had sought the care earlier. You can be sure that if the administration's proposal is adopted, without the Congress adjusting the means test to at least conform with the Federal poverty guidelines in a given area, the number of veterans who slip into poverty will increase as they are forced to choose between paying for health care or buying food or paying rent. Then the VA healthcare facilities will treat them, but those same veterans will cost a great deal more to treat.

VVA is fully committed to the VA acting as the primary health care system for service-disabled veterans. We recognize that those veterans who wish to receive health care from the VA for nonservice-connected conditions should pay for those services, ***if their economic circumstances allow them to do so***. Accordingly, VVA believes that the means test threshold for Category 7 veterans should be raised to not less than $38,000 per year for single veterans, and not less than $45,000 per year for a family of four. We also believe that the deductibles should be set on a sliding scale, with veterans at the lower economic end of the scale paying no more than a $250 per year deductible. We believe that these figures are far more realistic, affordable, and fair for the average veteran and/or veteran and family.

VVA also urges this distinguished Committee to begin seriously examining the concept of making veterans health care for service-connected disabled or potentially service-related illnesses a legally mandated right, and not merely a discretionary expenditure.

Vet Centers: Cost Effective and Vital

One critical VA program that received no substantive coverage in the administration announcement of the budget was the Readjustment Counseling Service Vet Centers. As this committee knows, the Vet Centers provide a nationwide system of community-based centers designed to provide counseling for psychological war trauma. VA operates 206 Vet Centers in all 50 states, Puerto Rico, the Virgin Islands, the District of Columbia, and Guam. In 2000, Vet Centers saw more than 131,000 veterans and provided more than 890,000 visits to veterans and family members, according to the VA.

Many have expressed surprise at the sheer number of persons exhibiting Post-Traumatic Stress subsequent to the attacks of last September 11. Many also seem surprised by the acuity and the persistence of both the symptoms and of the condition itself. VVA and many of the distinguished Members on this panel were not surprised. It is now time to recognize that the Vet Centers have a vital, unique, and positive role to play in the mix of services that is so needed by today's veterans, as well as those now serving in uniform when they return to civilian life.

Interdisciplinary teams that include psychologists, nurses, and social workers staff the centers. Readjustment counseling features a non-medical setting, a mix of social services, community outreach activities, psychological counseling for war-related experiences and family counseling. These services are designed to assist combat-affected veterans and other veterans have well-adjusted lives. In other words, the Vet Centers help families stay together, help veterans surmount problems that threaten their job, and help those unemployed to become more job ready. The Vet Centers are the only element of the VA that is authorized to treat family members, even when the veteran refuses to come in for treatment. This service is part of the holistic approach to health care that VVA has been advocating for many years.

VVA knows from our members and from talking to Vet Center staff across the country that the Vet Centers have been inundated with "new" veterans and their family members seeking counseling, as well as previously treated veterans and their families seeking additional counseling and assistance in the wake of the September 2001 terrorist attacks on the United States. We believe that this program needs a minimum increase of $17 million to both enhance organizational capacity and to be able to deal even more effectively with the new influx of cases related to the terrorist attacks. In addition, an additional 250 FTEE must be added. Most of the $17 million would be used to pay for a family services counselor in each of the 206 Vet Centers, and to augment those Centers with the most overwhelming needs. This is a very modest increase that will pay very large dividends in assisting veterans, and indeed whole communities by extension.

National Center for Post-traumatic Stress Disorder

Related to our concerns regarding funding for the Vet Centers, VVA also believe that the National Center for Post-traumatic Stress Disorder (NCPTSD) must be expressly authorized and mandated in statute, and that NCPTSD should receive a line item funding directly in the appropriations bill of not less than $20 million each year. This is necessary in order to ensure that this invaluable national asset remains a viable research, repository, and consultation center for

clinicians at VHA, FEMA, and other clinicians in the public and private sector. This national asset not only benefits combat veterans, but also many others who can benefit from its research into the effects of trauma such as the attacks on September 11 on the physical and emotional health.

Medical Research

The administration has requested $409 million for the VA research budget in FY 2003, an approximately $38 million increase from FY 2002. VVA will support this request only if the committee issues report language mandating that VA approve only those research projects that are directly relevant to the specific health concerns or service-related exposures of veterans.

Moreover, new research projects should only be funded if the researchers collect the full military medical history of veteran subjects and patients involved in the study. We believe such prescriptive measures are the only way to begin changing the VA Research and Development Office's corporate culture, which currently seems to view the VA's research mission as one largely dedicated to general medical research, rather than one focused on medical research specific to and relevant for veterans. Despite continuing efforts of VVA leaders to help this section of VHA to understand the vital importance of this refocusing of their efforts, persuasion and intellectual arguments have not worked. Therefore, we ask the Congress to mandate such a proper focus.

Moreover, VVA believes that it is long past time to end the DoD-VA monopoly on the control of funds allocated for military and veteran-related medical research.

As we testified before the Health subcommittee last month, for the last decade, Congress has allowed the agency that most likely created the Gulf War illness problem (DoD), and the agency charged with paying for the problem (i.e., the VA, through health care and disability payments to sick veterans), to investigate Gulf War illnesses and their own role in responding to sick Desert Storm veterans. This is an obvious conflict of interest, one that has prolonged the suffering of veterans, destroyed their trust in the federal government, and resulted in the waste of at least $150 million over the past five years through OSAGWI, as the Defense Department has "investigated" its own response to Gulf War illnesses. It is also how the Pentagon and the Air Force have managed to squander over $180 million on Agent Orange-related Ranch Hand research that has produced less than half-a-dozen peer-reviewed scientific papers over the last 15 years.

A National Institute for Veterans Health (NIVH) is needed

To end this conflict of interest and restore integrity to the process of investigating and treating veteran's medical conditions, last year VVA called for the creation of a National Institute of Veterans Health (NIVH) within the NIH. NIVH would not only eliminate the conflict-of-interest problem outlined above, it would provide a vehicle for establishing a medical research corporate culture focused on ***veteran health care***, in contrast to the current VA medical corporate culture of "health care that happens to be for veterans."

VVA recognizes that the VA has established a reputation for providing advanced care for blinded veterans and those with severe ambulatory impairments. ***However, the VA has never truly developed a corporate culture focused on the diagnosis and treatment of the full range of environmental and occupational hazards that are unique to military service***. This is especially true of the VA's Research and Development Office, where the overwhelming majority of VA-funded research programs are geared towards medical problems found in the general population, not those specific to the veteran patient population or those with military service. Many of the current projects could, at virtually no additional cost, be restructured to benefit veterans specifically, as well as the general population. This is not only proper for the VA's role, but it is also better science, since the impact of toxic exposures of war-related neuropsychiatric conditions may significantly affect both diagnosis and treatment modalities that are being investigated.

We urge this distinguished Committee to work with other jurisdictional elements of the Congress to establish a new section of the National Institutes of Health to be known as NIVH, with veteran advocates serving along with scientists who understand veteran health issues on the peer-review panels that make research funding decisions. VVA believes that by so doing the Congress would be creating a research institute that would be truly focused on the unique medical needs of veterans. Locating the NIVH within NIH would ensure that the full medical resources of the federal government and private sector could be marshaled in a rational, veteran-friendly environment, free of the politicizing and conflict-ridden influences that have for more than 20 years precluded effective research into the unique environmental and occupational hazards that have impacted the health of American veterans.

Additionally, this proposed NIVH must be supplemented by the creation of a Congressionally directed mandatory declassification review panel, whose purpose would be to screen (on both a historical ***and*** an ongoing basis) and declassify any operational or intelligence records for evidence of data that would have an impact on the health and welfare of American veterans. The need for such an entity—completely independent from the Pentagon and the U.S. intelligence community—is obvious.

Even today, thousands of pages of Gulf War-related records remain classified. In January 1998, the CIA admitted that its own internal review had identified over ***one million*** classified documents with potential relevance to Gulf War illnesses. Virtually no documents associated with the 1960's era Shipboard Hazard and Defense (SHAD) program have been declassified, and DoD has thus far rebuffed VVA's FOIA requests that the documents be made public. Through the experience of the Kennedy Assassination Review Commission, we have learned that such specialized declassification panels work well. If we are to be certain that ***all*** data that may affect the health of American veterans is to be available for the veterans and their physicians, Congress must create such a standing declassification review panel immediately. Such a move would also help to restore trust and confidence among veterans in the federal government and its response to veteran's health issues.

Needed: More Funds for Veterans Health Care *and* Greater Accountability

Mr. Chairman, while VVA believes that an increase of at least $2.7 billion in appropriated dollars must be approved for FY2003 over the current FY2002 budget, there also must be additional steps taken towards assuring greater accountability for how these funds are used. Further, in order to stop further erosion of organizational capacity and prevent further reductions in vitally needed services at the VA, we must have a $750 million emergency supplemental appropriation immediately.

While Secretary Principi deserves high marks for his initial efforts to better track use of funds within the VA, especially within VHA, much more needs to be done. As one example, there is yet to be a full accounting of what happened to the $350 million appropriated for screening, testing, and treating hepatitis C, which Congress authorized last spring, of the 80% of veterans who do not use VA veteran health care facilities at all.

Additionally, VVA believes that the VA has a long way to go even to be able to tell who they have at each facility and what their function might be in the care of veterans. We would not tolerate this within the military. We should not tolerate it within the VA. If Secretary Principi needs more funds—in addition to those described above in order to speed his determined effort to develop and implement a viable management information system that will allow top leadership to make better and more timely decisions—then the Congress should provide said funds.

VVA believes that the VA, as well as other executive departments and entities, need additional tools to hold GS14, 15, and Senior Executive Service employees more accountable for both performance and their compliance with the law. VVA National President Tom Corey has written to the President, with copies to Secretary Principi and Director of the Office of Personnel Management, pledging VVA's full support in seeking legislation to allow elected and duly appointed officials to be able to rein in the sometimes rogue fourth branch of government – namely, the permanent most senior civil service and excepted personnel.

In the interim, VVA urges the Congress to require VA to post the criteria they will use to award bonuses at the beginning of each fiscal year in a given area. At the end of the year the amount of the dollar amount of each bonus and the specific reasons for awarding that amount to each recipient should be posted freely for public knowledge. If the size and reasons for these bonuses cannot stand the light of daylight and the sunshine, then said bonuses should not be awarded.

Other Key Veteran Issues

VVA is grateful to all in Congress (but particularly to the distinguished leaders and Members on this Committee) for the increases in the Montgomery GI Bill. These increases will make it possible for many more young veterans to acquire the education that will not only help

them personally as a reward for a job well done in military service, but will greatly benefit our nation's economy in the future. VVA continues to believe strongly that what is called for is a GI Bill modeled on that accorded to World War II veterans, as we are currently engaged in a world wide war against terrorist. The accomplishment of this largest ever increase in the Montgomery GI Bill for educational benefits is something of which all of you can and should be very proud.

To ensure that all of the programs that can be utilized by eligible veterans for furthering their educations are sound and accredited, there must be an increase in the funding for the State Approving Authorities, which have the duty and expertise to accomplish this mission. VVA believes that these agencies need at least $18 million in appropriated dollars for FY2003, with increases for inflation in every year, as long as the use of these benefits stays at the current volume of usage.

In regard to the Veterans Employment & Training Service at the United States Department of Labor, the Congress should increase the amount requested for the overall activities of this function to approximately $252 million appropriated dollars for FY2003. No matter where this vital employment function ultimately is housed, additional funds are needed to provide incentives for placement (not "obtained employment") of special disabled veterans, disabled veterans, and veterans who are at risk. Further, the specific line item for the National Veterans Training Institute (NVTI), currently at the University of Colorado at Denver, should be funded at least at the $3 million mark. NVTI is one of the best elements of this entire operation, where excellence is not only taught but consistently practiced.

The vital role of small business, especially very small businesses and self-employment, must not be overlooked. The President has only asked for $750,000 for the SBA Office of Veterans Business Development for FY2003. VVA points out that most of the provisions of Public Law 106-50 have yet to be implemented some three and one half years after enactment. The Small Business Administration (SBA) appropriation for this function must be increased to at least $ 4 mission for FY 2003.

While VVA recognizes that the SBA is outside the jurisdiction of this Committee, many of the Members of this panel, as well as staff on both sides of the aisle, played a most key role in formulation and passage of this vital legislation. Proper funding is necessary to ensure that the potential of this law is realized.

VVA also notes that the Center for Veterans Enterprise (CVE), founded last year based on the recommendations of the "Principi Report," has been something of a help in this area. While there is a great deal more that could and should be done by the VA to augment that which is done by the SBA and other entities (such as the National Veterans Business Development Corporation), Secretary Principi is to be congratulated for his work in developing the CVE, and rewarded with additional funds targeted to augment current efforts in this area.

Mr. Chairman, on behalf of Vietnam Veterans of America and our national leadership I thank you for this opportunity to express our views on the vital subject of the President's budget request for veterans services in FY2003.

February 13, 2002

Statement By

James E. Lokovic
CHIEF MASTER SERGEANT,
USAF (RET.)
Deputy Executive Director and
Director, Military and Government
Relations

House Committee on Veterans' Affairs

FISCAL YEAR 2003 VETERANS' AFFAIRS BUDGET

Air Force Sergeants Association
INTERNATIONAL HEADQUARTERS, POST OFFICE BOX 50, TEMPLE HILLS, MD 20757-0050

A participating organization in the Military Coalition, the AD HOC Committee, and the Council of Military Organizations

Mr. Chairman and distinguished committee members, on behalf of the 135,000 members of the Air Force Sergeants Association (AFSA) and those it represents, I welcome this opportunity to present what we believe should be among your Fiscal Year 2003 budget priorities for the Department of Veterans Affairs (VA). This committee has always served in a singularly nonpartisan way to act as the conscience of this nation to ensure our veterans are viewed as a vital national resource rather than a financial burden. Our decisions in this regard as a nation should *not* be based on the bottom line, but on what is right. Building on the great successes you achieved once again last year, we ask you to continue the momentum in addressing the needs of those who serve.

As each of you have often indicated, we owe our servicemen and women an immeasurable debt of gratitude. In order to preserve the day-to-day peace and prosperity of the citizens of this nation, those who serve in the military turn their mortal beings over to the dictates of their country -- prepared to die, if need be. Their terms of service are always arduous, and the job they do for all of us is fantastic. We owe them – perhaps more than any other segment of our society. This committee among all segments of our national leadership holds the key to protecting and honoring these warriors who are driven by no more than selflessly contributing to the preservation of freedom and liberty.

AFSA believes that we owe our veterans a solid educational program in return for their service; we owe them short- and long-term health care to deal with any physical conditions that resulted from the period during which they served their nation; we owe them other programs such as home loans to enhance their lives; and we owe the survivors of veterans a debt of gratitude. Finally, we must remember that veterans who go on to military retirement are veterans and, therefore, are entitled to the full range of veterans benefits afforded to those who serve for less than a career.

Yours is not an easy job in deliberating how best to honor those who serve and, at the same time, protect the people's money. But we ask that you keep in mind that as I comment on veterans' programs, that these programs also send a powerful message to those considering a military career. As such, funding in all of these programs should be a national priority. This nation's response for service should be based on certain principles that this association urges these committees to use as a guide during your deliberations. These imperatives provide foundation upon which we feel the decisions of these committees should be based.

GUIDING PRINCIPLES

1. *PROVIDE A SOLID TRANSITION BACK INTO SOCIETY.* Clearly, a debt is owed those who serve. The United States of America owes its veterans dignified, transitional, recovery assistance. . . not based on rank or status, but simply because they served in the most lethal of professions. In effect, they signed their physical and spiritual beings over to this nation.

2. *ALWAYS REMEMBER THAT MOST VETERANS ARE ENLISTED.* Any decisions on veterans' benefits must factor in a realization that most veterans are *enlisted* veterans. These veterans served with lower pay, generally reentered the civilian populace with non-transferrable military skills, probably had relatively little civilian education, and served in skills that are less marketable. Certainly, "a vet is a vet," but enlisted veterans bring a different economic equation to the table; we must factor in that situation as we make important decisions about veterans' futures.

3. *ALWAYS BASE DECISIONS FOR VETERANS ON "THE RIGHT THING TO DO" -- NOT COST.* This nation's commitment cannot waver simply because of the large number of veterans. Congress and (in turn) the VA must never make determinations simply because "the money is just not there" or because there are now "to many" veterans. Our national will and the correlative response should be based on doing what is right.

4. *REMEMBER RESERVISTS.* Our enlisted guardsmen and reservists are full-time players. They are part of the total force. *Any differences between reserve component members and the full-time force, in terms of VA programs or availability of services, need to be systematically erased.* Their commitment is no less real. Their subjection to unlimited liability is just as absolute. Their love of country is just as intense. We urge you to act to bring our guardsmen and reservists in as full beneficiaries.

5. *HONESTLY COMMIT TO TREAT THE MALADIES OF WAR.* It is important that the commitment of our troops to combat or high-risk situations also involves an *absolute commitment to care for any malady that may have resulted from that service.* Many veterans call and write to this association about our government's denial, waffling, then reluctant recognition of illnesses caused by conditions during the Persian Gulf conflict. Many point out that our government agencies responsible to our veterans acted in the same manner following the Vietnam Conflict in reference to Agent Orange. We ask you to reinforce a commitment to unconditional care after service.

This statement will focus on three general areas: education, health care, and general issues that we hope you will consider as you deliberate the budget and policies that should be a part of the program offered to our veterans for the upcoming fiscal year.

EDUCATION

In recent years, this committee has done a masterful job of increasing the value of the Montgomery G.I. Bill (MGIB). As a member of the Partnership for Veterans Education, we

continue to ask that you transform the program to something similar to the post-WW II G.I. Bill. We ask that you work toward funding a program that pays for books, tuition, and fees, and that the benefit be annually indexed to reflect the actual costs of education. We ask you to consider funding for FY 2003 in the following area:

- *CONTINUE TO MAKE THE BENEFIT A LEGITIMATE, VALUABLE ONE.* Despite recent increases in the MGIB which will bring the value up to $985 per month for 36 months starting in FY 2004, more needs to be done. If this nation is going to have a program that sincerely intends to satisfy the purpose of the program, it certainly should mirror civilian industry by providing a real educational program and not a token, non-sufficient one. According to the "College Report," an annual evaluative report published by the education "industry," that cost is approximately $1,100 at this time. By 2004, that value will most likely be higher due to inflation. This figure reflects the cost of books, tuition, and fees at the average college or university for a commuter student. We ask that you fully fund the already-authorized increase, but look toward further increases in the program.

- *FUND AN OPEN-ENROLLMENT WINDOW FOR ALL MILITARY MEMBERS NOT CURRENTLY ENROLLED IN THE MGIB.* The first effort should be to provide an open enrollment opportunity for any military member who is not currently enrolled in the MGIB. There are tens of thousands of military members who declined the opportunity to enroll in VEAP. Many did so because VEAP was a relatively poor, two-for-one matching program. Under VEAP, the member would contribute up to $2,700 dollars, and the government would match it with up to $5,400. Others declined enrollment in VEAP because they were counseled that a better program was forthcoming. Since the end of the VEAP program, tens of thousands more have declined enrollment in the MGIB (3 to 5 percent of eligibles each year) for a variety of reasons. Many decide that they simply cannot afford to give up $100 per month for the first 12 months of their career. Others turned down the MGIB because it, too, was historically a relatively poor program that did not keep pace with the increased cost of education. As I said earlier, thanks to the fine work of this committee, the MGIB value has been dramatically increased each year for the past few years. Although more work needs to be done, the benefit is now a very "lucrative" benefit – a far cry from that which most VEAP and MGIB non-enrollees turned down. For that reason alone, we believe that fairness would dictate an open window for any military member not currently enrolled in the MGIB.

- *ELIMINATE THE $1,200 MGIB ENROLLMENT FEE.* This fee is often the determinant that causes young servicemembers to decline enrollment. They are given a one-time, irrevocable decision when they are making the least pay -- under the pressure of initial training. Those who decline enrollment – many due to financial necessity – they do not have a second change to enroll in the program. As we travel to military bases around the world, this is one of the biggest complaints we get from young airmen. They feel that in a sense it is a dirty trick to offer such an important program when it is a financial burden to enroll in the program. This sends a very poor message to those who enter service expecting a world-class

educational benefit. While it cannot be expected that the Department of Defense will work to correct this very poor situation, we ask that you exercise your oversight role and eliminate the $1,200 enrollment fee. This alone will eliminate the non-enrollment problem. At the same time, it will reintroduce some honesty into the educational benefit recruitment promises.

MEDICAL CARE

Without question, the health care system administered by the veterans administration impacts, in one way or another, those who served. As we look at the VA medical system as it applies to our members, I wish to briefly touch on some issues that have been reflected in the many phone calls we have received from the field. Of course, we tend to hear most loudly and frequently from those who are not happy with the adjudication of their claims or the treatment they have received. Clearly, the perception in the field is that VA decisions are driven by budgeting concerns, rather than benefit protection. It is perceived that the very strong VA push in recent times to "share" in the DoD health care system focuses on getting approval to improve one program by taking advantage of the strengths of another. Recent administration efforts to force retirees to make a DoD or VA health care choice further communicates that the government expects these veterans to relinquish some earned benefit because they chose to devote themselves to a full career of government service. During this statement, I am not going to go into isolated problems, because anecdotal information is just that. Rather, I want to briefly touch, instead, on some specific health-related situations that need to be addressed.

- *RESIST FORCED CHOICE INITIATIVES OF THE ADMINISTRATION, INCLUDING PROHIBITIVE USER FEES FOR VA HEALTH CARE.* We applaud Congress' prohibition in last year's NDAA against a forced DoD-VA health care choice. However, now that you have done so, in the Administration's FY 2003 Budget Plan, we see another Administration initiative that could serve to thwart the will of Congress. Now the Administration is calling for a $1,500 annual deductible for care provided in VA facilities for Category 7 veterans. Some perceive that this is an alternate strategy: having failed to achieve forced choice, in effect this initiative would force it. Just last year, the Secretary of Veterans Affairs announced increased no-cost, low-cost care (including preventative) for all veterans. In the space of only a few months, we once again see that the focus in on the "bottom line" and not on the recognition and welfare of the troops.

- *PROVIDE A FULL CONTINUUM OF CARE.* We ask you to provide funding for full access to VA health care for all veterans. All honorably discharged veterans must have the full continuum of care mandated by law. In the minds of many, the VA health care system is there to serve only paupers. This image and the underlying reality must be upgraded. AFSA believes there should be a full national commitment toward expanded health care opportunities for veterans. Funding must be identified to provide this range of care.

- *SUPPORT VA SUBVENTION.* VA-Medicare subvention is very promising, and we offer

full support for this effort. The VA has an infra-structural network to handle this, so we anticipate the effort will be successful. Under this plan, Medicare would reimburse the VA for care it provides to non-disabled Medicare-eligible veterans at VA medical facilities. Just as in the case of DoD Medicare subvention, this is an opportunity to ensure that those who served are not lumped in with all those who never chose to do so. Because Medicare would reimburse the VA system, cost to the government would be minimal.

- *WISELY SUPPORT VA-DOD SHARING ARRANGEMENTS.* The enlisted force is pleased with judicious use of VA-DoD sharing arrangements involving network inclusion in the DoD health care program, and especially, the practice of consolidating physicals at the time of separation. This decision represents a good, common sense approach that should eliminate problems of inconsistency, save time, and take care of our veterans in a more timely manner. In that sense, these initiatives may actually save funding dollars. Our only caveat – albeit a crucial one -- would be that DoD beneficiary participation in VA facilities must never endanger the scope or availability of care for our traditional VA patients, nor should any VA-DoD sharing arrangement jeopardize access and/or treatment of DoD health services beneficiaries.

- *PROVIDE LONG-TERM CARE.* The VA must be fully funded to provide for long-term care including nursing home care; care for chronically mentally ill veterans; and home care aid, support and services. While recent legislation took us a great deal closer to this end, it will only come about if adequate, earmarked, consistent funding is identified.

- *CARE FOR WOMEN VETERANS.* Another dimension of this nation's veterans' demographics that has significantly increased in recent years is the number of women who serve. The VA must be funded to provide the resources and legal authority to care for women to include obstetric services and after-birth care for the mother and child. Funding needs to be earmarked to make this important health care a reality.

GENERAL ISSUES

- *PROVIDE A WRITTEN GUARANTEE.* Many veterans are frustrated and disappointed because promises that were made during their careers are simply not being kept. *They feel that the covenant between the nation and the veteran was one-sided, with honor on the side of the veteran.* We urge this committee to support a guarantee in writing of benefits to which veterans are legally entitled by virtue of their service. To refuse to do so is to say that this nation is not prepared to be honest with its servicemembers.

- *SUPPORT ADMINISTRATION EFFORTS TOWARD SPEEDIER PROCESSING.* Congressman Lane Evans recently pointed out that during the first four months of fiscal year 2002, the number of rating cases awaiting a decision for over 180 days increased from172,294 to 204,006. Full funding must be identified, as he indicated, to "reduce claims processing

time without sacrificing decision-making quality or VA's statutory duty to assist veterans develop their claims." We urge full funding to facilitate progress made toward the reduction in the time required to process claims and adjudicate appeals, and urge this committee to facilitate the Administration's efforts in this regard. We urge you to do all that you can to push the VA to continue this progress and to fund initiatives that will make the system more efficient and user-friendly.

- *LEGITIMATE, SINCERE VETERANS PREFERENCE.* Over the last few years you have made great strides toward making "Veterans' Preference" a reality. We urge this committees to continue to support and fund any improvement that will put "teeth" into such programs so that those who have served have a leg up when transitioning back into the civilian workforce.

- *ELIMINATE HOME LOAN FEES.* The best way to attract new veterans to use this valuable benefit is to *eliminate fees and make the program as attractive a possible.* However, if other home loan programs are made available, liberal qualification criteria and *the "no down payment" feature should be maintained for all sources.*

- *MAKE THE RESERVE HOME LOAN PERMANENT.* For our reserve component members, the Selected Reserve Home Loan Program was extended once again last year. *Congress should permanently extend this program.* Those members who serve in the guard and reserve deserve full, year-round benefits. The concept of "weekend warriors" is certainly an unfair, inaccurate misnomer. Our nation owes them a great deal, the least of which is provision of a full benefits package for their service. Continuing to revisit this issue and approve it for limited time periods sends a very poor signal to these patriots. We ask this committee to endorse making the program permanent.

- *FULLY FUND PROGRAMS IN SUPPORT OF SURVIVORS.* Programs such as Dependency and Indemnity Compensation, pensions, and burial rights for the survivors of veterans is in keeping with highest traditions of the motto of the Veterans Administration. We ask you to fully support funding of programs for these family members who also valiantly served.

Mr. Chairman, in conclusion, I thank you for this opportunity to present the views of the Air Force enlisted community. AFSA believes that the work of this committee is among the most important done on the Hill. Your job is not only to protect and reward those who served; it is to demonstrate to those currently serving and who someday will serve that this nation is committed to honor those who give a portion of their lives to their nation. After all, the nation's peace and current prosperity is in no small measure due to their noble efforts. On behalf of all AFSA members, we appreciate your efforts and, as always, are ready to support you in matters of mutual concern.

FOVA

Friends of VA Medical Care and Health Research

A coalition of national organizations committed to quality care for America's veterans

Executive Committee

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Statement for the Record
of the
Committee on Veterans Affairs
Hearing on the
FY 2003 Budget of the Department of Veterans Affairs
Submitted by
Friends of VA Medical Care and Health Research
February 13, 2002

The Friends of VA Medical Care and Health Research (FOVA), a coalition of 78 medical research, specialty, physician, academic, patient advocacy and industry organizations committed to quality care for veterans, is pleased to provide recommendations regarding FY 2003 funding for the Department of Veterans Affairs (VA) medical and prosthetics research program. FOVA strongly encourages the Committee on Veterans Affairs to support VA research by recommending an FY 2003 appropriation of at least $460 million.

FOVA's FY 2003 recommendations build on the $20 million increase provided for the current year. FOVA thanks the Committee for recognizing that the less-than-inflationary increase requested by the Bush Administration last year would have been detrimental to the long-term viability of the program. We are grateful for the Committee's leadership in securing a final outcome that was a significant improvement.

The Administration's FY 2003 budget request for a $23 million (6%) increase in research program dollars* is notable for being the first time in many years that an administration has proposed funding sufficient to maintain VA's current level of effort in advancing treatments for conditions particularly prevalent in the veteran population including prostate cancer, diabetes, heart diseases, Parkinson's disease, mental illnesses, spinal cord injury and aging related conditions. We applaud the Bush Administration and Department of Veterans Affairs Secretary Anthony J. Principi for recognizing the invaluable contribution VA research makes to delivering high quality care for veterans and toward improving the health of veterans and the nation.

However, a $23 million increase would not allow VA to expand its efforts to improve care for veterans, nor to meet the new challenges presented by the tragedies of September 11 and subsequent events. FOVA strongly encourages the Committee

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*The Administration's budget request for a $38 million increase for VA research includes a shift from OPM to VA of $15 million in accrued government health and retirement benefit funds. Consequently, the Administration's budget proposes a $23 million (6%) increase in **research program funds** plus $15 million in **benefit expenses** previously paid by an OPM account, for a total increase of $38 million (10%) over current year funding of $371 million.

on Veterans Affairs to recommend an FY 2003 appropriation of at least $460 million for the VA medical and prosthetics research program. This represents growth in program dollars of $74 million (19%).

Four core needs justify the FOVA recommendation of $460 million:

1. **Investments in investigator-initiated research projects** at the VA have led to an explosion of knowledge that promises to advance our knowledge of disease and unlock new strategies for prevention, treatment and cures. Attachment 1 is a list of just a few of VA's recent achievements and initiatives. However, many health challenges still confront the veteran community. Additional funding is needed to take advantage of the burgeoning scientific opportunities and to improve quality of life for our nation's veterans as well as the general public. FOVA urges the Committee to support additional funding for the following research priority areas identified by the VA for FY 2003:

   - **Quality of Care**: Additional funding for the Quality Enhancement Research Initiative (QUERI) program would be used to fund centers in prostate cancer and dementia/Alzheimer's.

   - **Special Populations**: VA would expand research in quality of care, community access and restoration of function to achieve greater understanding of existing racial, ethnic and gender disparities in health care.

   - **Diseases of the Brain**: Additional studies are needed on the impact of different classes of psychiatric drugs on cognitive and behavioral function.

   - **Treatment Strategies in Chronic Progressive Multiple Sclerosis**: Recent studies have shown that immunotherapy of acute MS can reduce disability. More studies are needed to determine the optimal therapy for patients.

   - **Micro Technology**: In the area of low vision, work in retinal prostheses is an emerging science and may restore sight lost as a result of a variety of disorders including age-related macular degeneration and retinal pigmentosa.

   - **Patient Outcomes in Rehabilitative Care**: Specific areas of emphasis include long-term care strategies to enhance patients' independence and activities of daily life, consequences of community reintegration and the impact of assistive technology on quality and functionality of life.

   - **Chronic Disease Management**: VA is proposing two major initiatives in comparing clinical efficacy of 1) vascular surgery conducted on and off cardiopulmonary bypass machines, and 2) open versus endovascular surgery for abdominal aortic aneurysms.

2. The complexity of research combined with biomedical research inflation has increased the costs of research. The average cost of each VA research project is now $150,000, a 9% increase in just two years. As a result, **VA requires an increase of at least $15 million just to maintain a stable number of programs.**

3. In response to the events of September 11, **VA seeks to establish a research portfolio to address the threats of bio-terrorism.** This objective is consistent with VA's statutory obligation to provide medical back-up services in times of national emergencies. VA has an established history of research accomplishments in the areas of infectious diseases and immunology, including vaccine development. The laboratories of VA research scientists are disseminated nationwide, and are affiliated with top-flight universities. VA research provides a unique national resource that can be readily adapted and quickly mobilized in response to diverse biological threats.

   To meet this emerging challenge, consistent with H.R. 3253, the *National Medical Emergency Medical Preparedness Act of 2001*, FOVA strongly supports VA's proposal to establish four new centers of research excellence focusing on fundamental issues critical for responding to chemical, biological and radiological threats to public safety. The targeted research portfolio would include pathogen detection, disease diagnosis and treatment, protection, and vaccine development. The mission of these centers would also encompass the evaluation and management of illnesses consequent to military service, especially in our current conflict.

4. **VA's career development programs** are a national resource for training the next generation of clinician scientists, those doctors who treat patients and address questions that have a direct impact on patient care. Additional funding is needed to expand this program in order to address the growing national shortage of clinician-investigators.

Separate from its recommendations for the VA research appropriation, FOVA strongly encourages the Committee to address the increasingly urgent need for improvements in VA's research facilities.

In 1997, NIH conducted site visits of six VA research facilities and concluded that, "VA has had increasing difficulty in providing sufficient resources via its congressional appropriation to satisfactorily fund the infrastructure necessary to support research at the VAMCs." It is FOVA's understanding that VA has made no significant, centrally administered investment in its existing research facilities since this finding. Ventilation, electrical supply and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Substandard facilities make VA a less attractive partner in research collaborations with affiliated universities; reduce VA's ability to leverage the R&D appropriation with other federal and private sector funding; and make it difficult to attract cutting edge researchers, both clinician investigators and laboratory scientists, to careers in VA. Facility R&D Committees regularly disapprove projects for funding consideration because the facility does not have the necessary infrastructure and has little prospect of acquiring it.

Under the current system, research must compete with other medical facility and clinical needs for basic infrastructure and physical plant support. Unfortunately, the minor construction appropriation is chronically inadequate to meet facility needs for clinical improvements much less research upgrades, and year after year the list of urgently needed research repairs and upgrades grows longer. VA has identified 18 sites in urgent need of minor construction funding to upgrade their research facilities. These sites plus the many facilities with smaller, but no less important needs, provide more than sufficient justification for an appropriation of $45 million specifically for research facility improvements.

FOVA recommends that a new funding mechanism, such as a minor construction appropriation specifically for research facilities, be developed to provide a permanent, steady stream of resources dedicated to upgrading and renovating existing research facilities. **State-of-the-art research requires state-of-the-art facilities.**

FOVA thanks the Committee for consideration of its views. For questions or additional information, please contact any member of the FOVA executive committee listed on this letterhead. Thank you for your consideration.

Organizations that have endorsed FOVA's FY 2003 recommendations (as of February 7, 2002):

Administrators of Internal Medicine
Alliance for Aging Research
Alzheimer's Association
American Academy of Child and Adolescent Psychiatry
American Academy of Neurology
American Academy of Opthalmology
American Academy of Orthopaedic Surgeons
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Neurological Surgeons
American Association of Spinal Cord Injury Nurses
American Association of Spinal Cord Injury Psychologists and Social Workers
American College of Clinical Pharmacology
American College of Physicians-American Society of Internal Medicine
American College of Rheumatology
American Dental Education Association
American Federation for Medical Research
American Gastroenterological Association
American Geriatrics Society
American Gold Star Mothers of America
American Heart Association
American Lung Association
American Military Retirees Association
American Optometric Association
American Osteopathic Association
American Paraplegia Society
American Physiological Society

American Psychiatric Association
American Psychological Association
American Society for Pharmacology and Experimental Therapeutics
American Society of Hematology
American Society of Nephrology
American Thoracic Society
American War Mothers
Association for Assessment and Accreditation of Laboratory Animal Care International
Association for Research in Vision and Ophthalmology
Association of Academic Health Centers
Association of American Medical Colleges
Association of Pathology Chairs
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Schools and Colleges of Optometry
Association of Subspecialty Professors
Association of VA Chiefs of Medicine
Blinded Veterans Association
Blue Star Mothers of America
Clerkship Directors in Internal Medicine
Coalition for American Trauma Care
Coalition for Heath Services Research
Congress of Neurological Surgeons
Digestive Disease National Coalition
Gerontological Society of America
Independence Technology, Inc.
Johnson & Johnson
Juvenile Diabetes Research Foundation International
Legion of Valor
Medicine-Pediatrics Program Directors Association
National Alliance for the Mentally Ill
National Association for Biomedical Research
National Association for the Advancement of Orthotics and Prosthetics
National Association for Uniformed Services
National Association of State Universities and Land Grant Colleges
National Association of VA Dermatologists
National Association of VA Physicians and Dentists
National Association of Veterans' Research and Education Foundations
National Mental Health Association
National Multiple Sclerosis Society
National Organization of Rare Disorders
Nurses Organization of Veterans Affairs
Paralyzed Veterans of America
Partnership Foundation for Optometric Education
Research Society on Alcoholism
ResearchIAmerica
Society for Investigative Dermatology
Society for Neuroscience
Society of General Internal Medicine
Veterans Affairs Physician Assistant Association
Veterans of the Vietnam War

Attachment 1

VA Research – Recent Achievements and Initiatives

Promise for TB Vaccine
Researchers at the Portland VA have found a unique mechanism by which human T cells recognize cells infected with Mycobacterium tuberculosis, the bacteria that cause TB. They have found that the molecule HLA-E can present TB antigens to cytotoxic T cells. A further understanding of this mechanism may facilitate the development of an improved TB vaccine. Worldwide, over 2 million people die each year from TB. Advancement towards an effective TB vaccine has significant potential to improve both national and global health.

New Centers to Study Parkinson's Disease
VA created six new centers specializing in research, education and clinical care for Parkinson's disease. The centers—in Houston, Philadelphia, Portland (Ore.), Richmond (Va.), San Francisco and West Los Angeles—will conduct research covering basic biomedicine, clinical trials, rehabilitation, and health services. In addition, each center will take part in a major VA clinical trial to assess the effectiveness of surgical implantation of deep brain stimulators to reduce symptoms. (Feb. 2001)

Key to Wasting Syndrome Discovered
Researchers at the San Diego VA Medical Center have unraveled the biological chain of events that causes wasting syndrome in mice, and identified the same process in liver and tissue from cancer patients. Wasting syndrome or cachexia, affects about half of all cancer and HIV/AIDS patients, as well as those with bacterial and parasitic diseases, rheumatoid arthritis, and chronic diseases of the bowel, liver, lungs and heart. By noting the similarities between animal and human models, researchers hope to expedite the development of treatments to help patients. (Dec. 2001)

VA Evaluating Robotic Walker for Vision-Impaired
VA researchers in Pittsburgh and Atlanta are testing a new high-tech walking frame designed to promote mobility and independence for the vision-impaired frail elderly. Using laser range finders, sonar sensors, steering motors and a motion controller, the Personal Adaptive Mobility Aid (PAM-AID) seeks to build the functionality of a guide dog into a robust walking frame. (Oct. 2001)

VA Establishes New HIV Research Center
VA is the nation's largest single provider of health care to HIV-infected persons. A new Center of HIV Research Resources at the Palo Alto VA Health Care System seeks to improve health care for veterans by assessing research and clinical trials throughout VA and other agencies and determining their potential for further research and clinical application. (Oct. 2001)

Rehab Researchers Collaborate in Artificial Retina Trials
VA researchers from the Rehabilitation Research and Development Service have recently collaborated with colleagues at the Louisiana State University Medical Center on studies to implant silicon-chip retinas in the eyes of patients blinded by retinal disease. About the size of a pinhead, the artificial silicon retinas are completely self-contained and require no wires or batteries. They contain 3,500 microscopic solar cells that generate electrical current in response to light. The implants stimulate healthy retinal cells underneath the retina in a pattern that resembles the light images focused on the chips. These images are then transmitted to the brain via the optic nerve. The implants are designed to treat retinitis pigmentosa and macular degeneration. (Sept. 2001)

New Blood Test Speeds Diagnosis of Heart Attacks
Researchers at the San Diego VA Medical Center have developed a simple, inexpensive blood test to increase the speed at which heart attacks are diagnosed in hospital emergency rooms. The new blood tests can rule out a heart attack with 100% accuracy within 90 minutes by looking for

three cardiac enzymes released by distressed heart tissue during an attack. Ruling out a heart attack by traditional methods usually takes 6 to 24 hours. As a result, critical care admissions dropped 40% and overall hospital admissions dropped 20%. (Sept. 2001)

Chronic Lymphocytic Leukemia May Be Underestimated
VA researchers at the Central Arkansas Veterans Healthcare System have found that the true incidence of Chronic Lymphocytic Leukemia (CLL) is substantially higher than estimated from the tumor registry database. Researchers credited the VA's Computerized Patient Record System (CPRS) as making the study possible by allowing researchers to review data from a large patient population without handling paper records. Revision in the data may show CLL to be the most common lymphoid malignancy in the United States. (Sept. 2001)

Friendly Virus May Slow Replication of HIV
VA researchers at the University of Iowa have shown that a form of the hepatitis virus called GPV-C may prolong the life of patients with HIV by preventing the HIV from replicating. GPV-C does not appear to cause any symptoms and may provide future therapy options for HIV. Specifically, the VA team showed that infecting human blood cells with GPV-C in the laboratory slowed the rate at which HIV multiplies. (Sept. 2001)

Higher Estrogen Doses May Enhance Memory for Alzheimer's Patients
VA researchers have found that higher doses of estrogen may enhance memory and attention for post-menopausal women with Alzheimer's Disease. Building on previous research showing the positive effects of estrogen administered by a skin patch, the researchers showed that a short-term administration of a higher dose of estrogen was found to significantly improve verbal and visual memory as well as attention in post-menopausal women. Although estrogen therapy does not show improved brain function for patients with mild to moderate Alzheimer's, it may slow the progression or prevent the disease. (Aug. 2001)

Diet and Exercise Reduce Risk and Delay Onset of Type 2 Diabetes
As part of the Diabetes Prevention Program (DPP), researchers at the VA Puget Sound Health Care System and the University of Washington have collaborated in a major clinical trial that showed at least 10 million Americans can reduce their risk of contracting Type 2 diabetes with a regimen of diet and exercise. Funded by a wide group of federal agencies, private associations, pharmaceutical companies and product manufacturers, the DPP was ended a year early because the data had clearly answered the major research questions. (Aug. 2001)

VA Researcher Identifies Breast Cancer Gene
A VA researcher at the San Francisco VA Medical Center and the University of California at San Francisco led a study that showed that women who have a specific sequence of a transforming growth-factor gene have a 60% lower risk of developing breast cancer. (June 2001)

Increased "Good" Cholesterol Reduces Rate of Strokes
A VA Cooperative Study at 20 VA Medical Centers has found that treatment aimed at raising levels of high-density lipoproteins (HDL), commonly called "good" cholesterol, substantially reduces the incidence of strokes in some patients. Patients who received the drug Gemfibrozil had a 31% lower incidence of stroke. The result is part of a larger study aimed at showing that higher HDL levels reduce the risk of major cardiovascular events. (June 2001)

Brain Development Continues into Late-40's
An inter-agency study led by a VA researcher at the Central Arkansas Veterans Healthcare System has shown that the brain continues to develop in late 40-year olds. This view contradicts the current view that brain maturation ends before age 20 and may shed light on brain ailments such as Alzheimer's Disease, schizophrenia and drug addiction. Using magnetic resonance imaging (MRI)

to measure brain development, the study showed that so-called white matter – where memory, higher reasoning, and impulse functions take place – continues to develop until the age of 48, on average. (May 2001)

Reduced Opiate Treatment May Increase Efficacy of Chronic Pain Treatment
Researchers at the Tampa VA Medical Center have found that patients taking opiates for chronic pain conditions reported no greater pain intensity than those not taking the drugs. Those receiving opiate treatment did report increased impairment. The program gradually phased out opiate use and those who remained off the drugs reported less pain and increased functionality and reduced depression. (May 2001)

New Technique to Evaluate Corneal Tissue for Implants
Researchers at the Central Arkansas Veterans Healthcare System and the Jones Eye Institute at the University of Arkansas for Medical Sciences have developed a new technique to evaluate the surface of a cornea to determine suitability for transplantation. The new technique allows for evaluation of the entire surface of the cornea; current inspection is done visually or by methods that detect only large lesions. (May 2001)

Old Drug Resists Pull of Cocaine
Researchers at the Philadelphia VA Medical Center and the University of Pennsylvania report that Propranolol, a drug currently used to treat high blood pressure, helps addicts remain in treatment when the withdrawal effects of cocaine are especially high and treatment dropout rates are otherwise high. The research suggests that the drug reduces withdrawal symptoms by lowering the anxiety causing effects of adrenaline. (April 2001)

New Method to Treat Osteoporosis, Grow Bone Tissue
By using a synthetic form of estrogen that promotes bone growth without affecting the reproductive system, researchers at the Central Arkansas Veterans Healthcare System and the University of Arkansas for Medical Sciences may have discovered a new way to treat osteoporosis. Existing estrogen replacement therapy for osteoporosis is associated with several side effects including uterine cancer. This conceptual breakthrough could lead to a new generation of drugs and hormone therapies. (March 2001)

Natural Recovery from Spinal Cord Injury Shown in Rats
Researchers at the San Diego VA Medical Center have found that rats with spinal cord injuries develop some spontaneous re-growth of nerves leading to increased motor function. In rats where 97% of the spinal cord connections are severed, rats were able to regain function within four weeks of surgery. Further research in continuing to determine how this process of "sprouting" can be enhanced. (March 2001)

Flu Vaccines Could Save the Nation $1.3 Billion Annually
Routine influenza vaccinations of all working adults could save the nation as much as $1.3 billion each year according to a study led by researchers at the Minneapolis VA Medical Center and the University of Minnesota Medical School. By examining both the direct and indirect costs associated with influenza, researchers estimated that health care costs could be reduced by an average of $13.66 per person vaccinated. (March 2001)

Implanted Electrodes Help Stroke Patients Walk
Using a technique known as Functional Neuromuscular Stimulation (FNS), VA scientists implanted electrodes in the leg muscles of stroke patients and used sophisticated software to electrically stimulate the muscles over a six-month course of treatment. The patients experienced significant improvements in gait and other abilities, with no adverse effects. The research was described in the *Journal of Rehabilitation Research and Development* and other journals. (Feb. 2001)

PREHEARING WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SMITH TO DEPARTMENT OF VETERANS AFFAIRS

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 15, 2002

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the Department of Veterans Affairs responses to the pre-hearing questions submitted in your letter of February 5, 2002, on the FY 2003 budget. I apologize for the delay in providing our formal response.

We provided an informal response to the Committee in advance of the February 13 hearing. I am providing the formal response to complete the record.

I look forward to continuing our work together.

Sincerely yours,

Anthony J. Principi

Enclosure

Chairman Christopher H. Smith

Question 1: This Committee is concerned about the apparent decline in VA bed resources available for long-term care of disabled veterans. The Chairman and Ranking Member wrote to the Secretary of Veterans Affairs in April 2001 to ask that he address what appears to be a decline in the number of VA nursing home care beds, in violation of the capacity restrictions imposed on VA by law. The Committee has not yet received a reply. Please respond before our hearing on the President's proposed budget for fiscal year 2003.

Answer: Our reply to Chairman Smith and Ranking Member Evans of February 11, 2002 is attached. We are advocating a broader definition of long-term care capacity so that non-institutional care and care delivered under contract or by state facilities can be included in monitoring the expansion of VA's long-term care services for veterans.

Question 2: The budget overview indicates a need for $194 million in major medical facility construction, $211 million in minor construction and $132 million in "other" construction. What are the VA's top 20 medical construction priorities and how does this funding level comport with them?

Answer: VA's List of 20 Priority Major Medical Construction Projects is currently under final review by the Administration and will be forwarded to the Committees in the near future.

Question: Does this funding consider the CARES initiative, and, in particular, any construction for VA facilities in Chicago and Boston?

Answer: Available major and minor CARES funds from FY 2000 and our proposed FY 2003 request provide $145 million for CARES initiatives. Included in this total is $40 million that was conditionally appropriated in FY 2002 for the Spinal Cord Injury and Blind Center at Hines VA Medical Center in Chicago. As CARES service delivery options are selected, implementation plans will be developed to use these funds and for future budget requests.

Question 3: The Secretary of Veterans Affairs made a presentation to the Veterans' Affairs Committees shortly before the holiday period about a plan to cease enrolling priority 7 veterans in the VA health care system. The President reportedly decided to identify a funding source that would enable VA to continue providing healthcare to all veterans who desire to enroll. What is the status of the funding needed to continue providing this care in fiscal year 2002?

Answer: A supplemental request was sent to Congress on March 21, 2002.

Question 4: The budget request of the Department of Health and Human Services (HHS) for the Medicare program recognizes the high costs to the government for obtaining durable medical equipment, oxygen, prosthetics and other specialty items for beneficiaries. The budget proposes to establish a "nationwide competitive bidding system" to obtain better pricing on such items. Is the VA working with HHS to develop its new purchasing strategies? Will such policies at HHS be consistent with the VA's highly successful practices?

Answer: VA has a long history of working successfully with HHS and the Centers for Disease Control. However, we are not currently working with HHS on this initiative, but would be happy to assist and work with them.

Question 5: Another initiative by the Department of Health and Human Services deals with the procurement of pharmaceuticals within the Medicare program. The proposed budget indicates the Department will "improve the payment system" in its dealings with suppliers of such drugs in Medicare—with the implication that price reductions will be sought. In its Medicaid submission, the budget request reviews the drug price rebate that Medicaid has had in place for over 10 years and proposes improvements. The VA's pharmaceutical procurement programs are

tied to the Medicaid best price program, so how is the VA involved in these prospective changes in a sister department's policies that may bear on VA's success?

Answer: VA's prices for pharmaceuticals are in no way tied to the amounts of, or formulas for Medicaid rebates. Section 601 of the Veterans Health Care Act of 1992, Public Law 102-585, excluded all drug sales on the Federal Supply Schedule (FSS) to VA and the Department of Defense (among others) from Medicaid's "best price" reporting requirement. The Federal ceiling price (FCP) prescribed for VA and three other Federal agencies by Section 603 of the Public Law is calculated based on a covered drug manufacturer's commercial wholesale selling prices (Non-Federal Average Manufacturer's Price) and (in most years) on the previous year's FSS price. Beyond the FCP, FSS drug prices are also set through negotiations that seek to achieve a manufacturer's price to its most favored customer (MFC), buying in quantities and on terms and conditions similar to the Government's. The MFC price targeted by the VA contracting officer may be equivalent to the Medicaid best price on many occasions, but the two are not tied together. Furthermore, the Medicaid rebate rate and Medicare reimbursement level have no connection to VA's drug pricing.

Question 6: The Secretary of Veterans Affairs testified before this Committee on October 15, 2001 that VA needs $250 million to support new requirements for VA emergency preparedness for bio-terrorism. *The New York Times* of February 4, 2002 indicates the President's proposed budget will request $11 billion over 2 years for the government to improve preparedness for bio-terrorism. Would the VA be included in these funds? If the VA is not included, has the VA requested other funds to support preparedness, and from which accounts would such funds be drawn?

Answer: The Department will request a portion of the $11 billion contained in the President's budget to improve preparedness for bio-terrorism. The FY 2003 budget request includes $55 million for emergency preparedness. The Department is also exploring agreements with other departments to provide a range of medical, logistics, and other services dependent upon allocation of resources to VA.

Question 7: In September 1999, the Oversight and Investigations Subcommittee heard testimony about the management problems that the VA had with third-party payments in its Medical Care Collection Fund program.

Two years later on March 6, 2001, the Secretary of Veterans Affairs testified before this Committee on the Department's budget request for 2002. He stated:

"I also believe that we need to do a better job in medical care cost recovery. You've given us the right to retain those dollars in the VA medical care system, and every dollar we leave on the table, that we don't collect because of poor management or whatever the case might be, is a dollar that doesn't go to VA health care, and to me that's unacceptable. You know, we've been at this for over 10 years. I just believe that we haven't quite got it right. It's something that was never part of the culture, the institution of the VA, and we simply have not been aggressive enough in collecting the dollars. We need to look at a new model as to how we can improve our cost accounting systems that allow us to bill and collect those dollars from third party insurers."

Aside from implementation of a "reasonable charges" policy established over three years ago, please inform this Committee what progress has been made in addressing the third party collection problems?

Answer: VA's Revenue Improvement Plan identifies 24 items requiring some form of action, which would yield significant enhancements to revenue.

Our major initiatives, as follows, are dependent upon information technology and related requirements.

Consolidate VA's insurance billing and collection efforts to bring about uniform standards and best practices.

Acquire a commercial off-the-shelf (COTS) system for revenue-related functions.

Standardize Claims Analyzer and Encoder (software) products to facilitate bill generation.

Pursue insurance identification through (1) improvements to our electronic insurance capabilities (software programming will be completed so that the exchange of electronic information will fall within HIPAA standards); and (2) increased veteran and employee awareness and training campaigns.

Standardize use of electronic medical records documentation by mandating use of the Computerized Patient Record System and developing a national clinical education program.

Identify software enhancements or products to improve the management of accounts receivables.

Identify broad based educational needs to improve the overall skill level of our staff and managers.

Develop a Web-based performance metrics program to monitor and evaluate the critical steps in the Revenue cycle.

Update Reasonable Charges providing for new 2002 current procedural terminology codes and diagnosis-related groups (to be published in the Federal Register in spring 2002), which will increase revenue.

Update Reasonable Charges for additional enhancements scheduled for Fall 2002.

Question 8: The budget proposes a deductible of $1,500 for each priority 7 enrollee beginning in fiscal year 2003. The budget request states it "recognizes a new annual medical care deductible charged to higher-income non-disabled veterans." It is not clear how this deductible would affect insured veterans. For example, how would it affect a priority 7 veteran who is covered by a third-party insurance policy that is already subject to collections action through VA's Medical Care Cost Fund authority? Would an insured veteran be liable for amounts not reimbursed by the insurer?

Answer: There will be no change in the procedure currently being used to bill third parties and veteran co-payments at the present time. VA will consider other payment options by the veteran and the insurance company if the current policy does not have the anticipated impact. As currently planned, the health insurance carrier will be billed for the total reasonable charge for the service provided. The veteran will be billed a deductible for his/her health care at a percentage of the reasonable charges up to a $1,500 annual ceiling. This amount will be placed on hold until reimbursement is received from the insurance carrier. The reimbursement will be applied dollar for dollar toward the veteran's deductible amount. If no reimbursement is received, the veteran will be billed for the charge that is on hold. If the insurance reimbursement does not totally satisfy the veteran's deductible amount, the veteran will be billed for the unpaid portion of that deductible amount. As with current practice, the veteran is not billed for services not reimbursed by the insurance carrier. However, the veteran will be responsible for his/her share of the deductible amount for the associated service.

Question 9: It is puzzling that the budget this year is forcing agencies to contribute hundreds of millions of dollars to fund the full accruing cost of employee pensions when the CSRS trust fund owns investments in excess of $600 billion. What would the Administration's reaction be if, instead of transferring almost $900 million to CSRS trust funds to cover future retirement costs, we used this amount to repair some of the unsafe, dilapidated, or outdated medical treatment facilities.

Answer: The Administration's Managerial Flexibility Act of 2001 (transmitted to Congress on October 15, 2001) calls for full accrual funding implementation of all civilian retiree income and retiree health benefits in FY 2003. The President's Budget reflects this change across all agencies—not just VA—and all agencies were held harmless for the adjustment in the preparation of the budget. This is an accounting change to better reflect the true cost of operations. While each agency's budget authority and outlays were increased by these amounts, the transfer of these amounts to trust funds within the Federal Government produced equal and opposite transactions. The change reflects a transfer from mandatory to discretionary funds. Funds are available as part of the discretionary totals for this purpose only. If this legislation is not enacted, the discretionary totals will not increase.

Question: Using business-like accounting procedures, what is a reasonable amount that VA should spend each year to fund capital asset replacement?

Answer: VA wants to ensure that funding levels are adequate to maintain an inventory of capital assets that are in acceptable or above-average condition. VA has many tools at its disposal to make sure that the infrastructure is current and allows for provision of health care services to our Nation's veterans. For example, VA may use the enhanced-use lease arrangements to modify and modernize its facilitates and services.

Estimating VA's capital asset replacement costs is a function of numerous variables. These include an asset's age, condition, size, location, and function. The amount VA should spend on capital asset replacement is also dependent upon how and where VA can best meet the current and future needs of veterans and their families. VA is currently implementing the Capital Asset Realignment for Enhanced Services (CARES) initiative, which will identify where VA should provide services in the future to ensure that veterans can access care in the most appropriate setting. This will also result in a more efficient and effective medical care system.

Congressman Christopher Smith

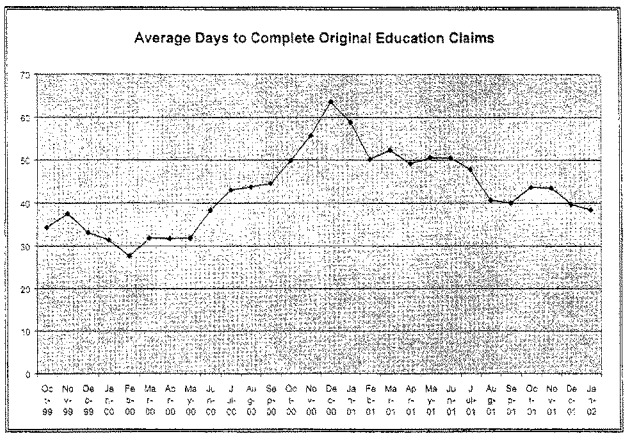
Question 1: Mr. Secretary: Despite last year's addition of 78 employees in the VA's education service, the average time to process an original education claim has risen from 36 days in 2000 to 50 days in 2001, a 38 percent increase in the time needed for a veteran to get his first education check. The blocked call rate soared to 45 percent in 2001, an unacceptable level when compared with the 3 percent blocked call rate in other VBA activities. Would you agree that this is a problem which requires intensive management oversight? Please furnish the Committee with a quarterly progress report on these two indicators, along with a summary of any steps taken to address this serious problem?

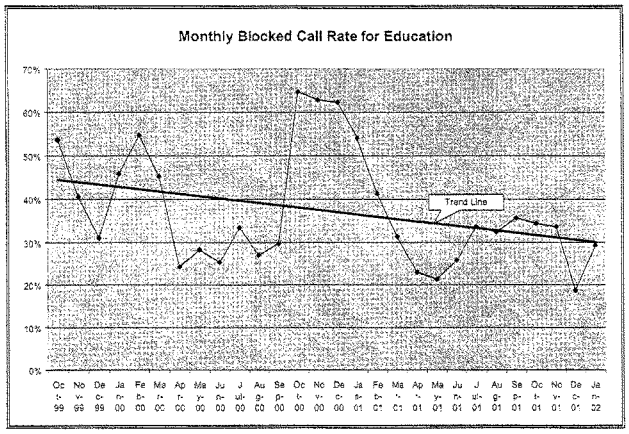
Answer: Intensive oversight from VBA management at all levels is focused on reducing the amount of time it takes to process both original claims and supplemental actions, while keeping the quality of all education actions high. We must also ensure that veterans and other claimants have access to VA when they need information concerning their claims.

Although in FY 2001 we missed our goal for processing original claims by 15 days, we were only short of our goal for processing supplemental actions by one day. We faced several challenges during the past year:

- Over 20,000 more claimants received education benefits during fiscal year 2001 than in fiscal year 2000. Moreover, almost 100,000 individuals began using the benefits for the first time during 2001.
- Telephone traffic volume during the first quarter of fiscal year 2001 was 30 percent higher than during the first quarter of fiscal year 2000.
- Hardware installation difficulties from fiscal year 2000 continued through the first quarter of fiscal year 2001. Although corrected by the end of the first quarter, recovery from the backlog took time.
- Many Education employees were promoted into Compensation & Pension positions. As a result, new hiring and training in Education were required. As of June 2001, forty-eight percent of the decision makers in the Education business line were trainees.
- Enhancements to the education benefits programs enacted in the 106th and 107th Congress required the development of processes to pay the new types of claims. These new processes are generally more labor intensive, as the automated systems could not accommodate the new provisions of law.

As shown in the following charts, the trends in both the timeliness of original claims and the blocked call rate show improvement during fiscal year 2001.





Recent and planned actions to improve timeliness of processing and phone service include:

- Enhancements to the Enrollment Certification Automated Processing (ECAP) prototype, allowing more cases to be processed without human intervention. ECAP is a proof-of-concept prototype that uses "expert" or rules-based systems to process claims in an automated environment. Currently only 3-4 percent of all incoming work is completely processed in this way. A more sophisticated rules-based application will allow many more claims to be completed without human intervention.

- Electronic Funds Transfer (direct deposit) was expanded to the MGIB-SR (chapter 1606) program, making funds available to these claimants 3 to 5 days earlier than if a check is mailed.

- One hundred new claims examiners were trained and, as they gain experience, improved timeliness of claims processing will result.

- Seasonal employees and Education Liaison Representatives answer calls during peak workload periods (August-October and January-February) to reduce the number of calls that are blocked.

- Web Automated Verification of Enrollment (WAVE) became available to claimants in late FY 2001. WAVE allows MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form. This improves communication with claimants, reduces paperwork in the regional processing offices, and speeds release of monthly payments.

- A system is being developed to enhance service delivery and manage veteran interactions by integrating people, processes, and technology through all means of communication. This will result in improved access to information over the Internet as well as improved phone service.

Question 2: Mr. Secretary: Your response to a letter which Mr. Evans and I wrote to you last April expresses a view on the consequences if the law were implemented, but what we requested was a plan to implement the law. Within 30 days, please provide us with a plan to implement the long-term care provisions of Public Law 106-117.

Answer: On March 20, 2002, VA provided the Committee with a plan explaining the implications of meeting the nursing home capacity requirement of Public Law 106-117.

Question 3. Mr. Secretary, most of us believe that VA can and should be funded to play a more prominent role in providing a medical response to acts of terrorism. Please inform us what the thinking is inside the Administration with regard to VA's role. Do you believe the Office of Homeland Security is properly apprised of VA's strength and capabilities? Has VA met with Mr. Tom Ridge, the Director of Homeland Security, regarding the VA's future role?

Answer: We recognize that the VA's primary mission is to provide quality services and timely benefits to our nation's veterans. However, it must also be recognized that since September 11, we face new threats and formidable challenges. We must continue to develop our capabilities and be prepared to meet our primary emergency response mission and our assigned homeland security support obligations. The Deputy Secretary recently met with Admiral Abbot, Deputy Director, Office of Homeland Security (OHS) and several other OHS staff to discuss how the Department's capabilities can be leveraged in the area of emergency preparedness. In addition, we plan on engaging FEMA and the Deputy Secretary of Health and Human Services in similar discussions, as done with OHS staff.

Question 4: Mr. Secretary: The statement for the record of the VFW says on page 3 that the American Lake Medical Center, which was damaged last year in an earthquake, has not received any funding for structural repairs to its main hospital and nursing home. Is that correct and what is the situation with American Lake?

Answer: Structural and cosmetic repairs to the American Lake VA Medical Center associated with damage that occurred during the earthquake have been funded and completed using minor and non-recurring maintenance (NRM) construction dollars. The American Lake facility, however, is located in a zone where it is at risk of being struck by future earthquakes, as are many other VA facilities along the west coast and other seismically high-risk areas of the country. VISN 20 has submitted a plan for seismic corrections at American Lake. VA continues to seek funding to provide seismic upgrades at "at-risk" facilities nationwide.

Question 5: Mr. Secretary: I remain concerned that the CARES process for planning VA's long-term construction needs has resulted in a de facto construction moratorium that could last several years. The VA construction budget proposed for fiscal year 2003 does not alleviate my concerns. Much more is needed than the seismic safety projects proposed, as necessary as they are. What are the VA's top five priorities for major construction?

Answer: Based on the VHA List of 20 Priority Major Medical Construction Projects reported to Congress, the top 5 listed projects are:

- Seismic Corrections for Building #2 at Palo Alto, CA
- Ambulatory Surgery and Clinical Consolidation at Cleveland, Ohio (Wade Park)
- Seismic Corrections for Building #203 at San Francisco, CA
- One-VA Healthcare System and Regional Office at Anchorage, Alaska
- Seismic Corrections for Building #501 at West Los Angeles, CA

The FY 2003 major construction budget request includes three (Palo Alto, San Francisco, and West LA) of the top five medical facility projects listed above. These projects are high priority life-safety projects.

In addition, I have instructed VHA to submit a project proposal for renovation of the Chicago Westside VAMC as part of the implementation plan for the VISN 12 CARES program. Implementation of the VISN 12 options is a top priority.

Question 6: What is your reaction to the Independent Budget suggestion that VBA program directors, including the director for Compensation and Pension, be given direct line authority over field offices as a way to help deal with the claims backlog?

Answer: We agree that clear lines of authority are important for both accountability and successful performance in the field offices. The VBA Claims Processing Task Force recommendations offered several methods to improve accountability and organizational communications. We will be implementing these recommended changes. Most notably, VBA regional offices will be held accountable to distinct and measurable performance standards and evaluated on their individual performance. In addition, the new organizational structure will include at least four field operations offices with line authority over the respective field offices. While VBA program directors will not have direct line authority, they will be intimately involved in the analysis and evaluation of individual regional office performance.

Question 7: Mr. Secretary: The written statement of the Vietnam Veterans of America on page two states that, "a supplemental appropriation of approximately $750 million is needed to stop the reductions in force now occurring at every VA medical facility in the nation." Are such reductions occurring, and how much of a supplemental is needed for the current fiscal year?

Answer: At this time, we are aware of only two Networks that are considering reductions-in-force (RIFs); however, all Networks are carefully managing employment levels to operate within available resources. VHA issued policy guidance to all facilities that requires the implementation of a variety of mandatory actions geared toward administrative actions to reduce costs, avoid costs, and increase revenues. These actions will allow for additional financial resources to be re-directed specifically for the care of veterans. Based on the continuation of full enrollment, VA determined there would be a shortage of $441 million in FY 2002. Approximately $300 million of this will be made up in management savings in FY 2002. The balance of the FY 2002 shortfall, $142 million associated with the continued enrollment of new Priority Group 7 veterans, is anticipated in supplemental funding.

Question 8: Mr. Secretary: Should VA medical research programs be limited to research projects that are directly relevant to specific health concerns or service-related exposures of veterans?

Answer: The purpose of VA research program is to discover knowledge and create innovations that advance the health and care of veterans and the Nation. Accordingly, VA aligns its research portfolio primarily, but not exclusively, to the high-priority health care needs of veterans. We believe that this best serves the needs of veterans.

Since 1998, approximately 99 percent of VA-funded research projects have addressed at least one of the nine Designated Research Areas (DRAs) that encompass veterans' high-priority health care needs. The DRAs include such categories as aging, mental health, military occupational and environmental exposures, and health services research.

VA research projects funded by other public and private agencies reflect the sponsors' priorities. Nevertheless, these projects may offer veterans access to treatments not otherwise available. In addition, the opportunities to conduct research in areas of their own choosing helps VA to recruit and retain the best clinicians to provide care for veterans, and to maintain a climate of inquiry conducive to the highest quality of health care.

Question 9: Mr. Secretary: You are proposing a new $1500 deductible in this budget. VA already collects from Priority 7 veterans' co-payments for medication, inpatient hospital, inpatient nursing home, and outpatient visits. Your budget estimates collections will near $1.1 billion in fiscal year 2003 without this new deductible feature. With it, collections presumably rise to $1.3 billion. This deductible is presumed to cause 121,000 veterans to leave VA care. Please inform the Committee why the Administration's position has changed from the decision the White House made in December 2001, to allow all veterans, including Priority 7 veterans, to continue to enroll in VA care.

Answer: The Administration's position has not changed. VA will continue to enroll in FY 2002 all veterans in all priority groups who choose to come to VA for their health care. However, in recent years VA has seen a tremendous increase in demand for health care services. The growth rate for Priority 7 veteran patients alone has averaged over 30 percent annually for the last 6 years. By 2010, we project that they will account for 42 percent of enrollees in the VA health care system. We do not want to exclude any group of veterans from the VA system; however, we must also maintain high-quality health care services for all veterans. Therefore, I have proposed that Priority 7 veterans pay for a greater portion of their health care in the form of a $1,500 deductible. Reimbursements from a veteran's insurance would be applied to reduce the veteran's out-of-pocket obligation. Without an alternative for offsetting rising costs, access for lower priority veterans would be curtailed.

Question 10: Mr. Secretary: For the current fiscal year, you estimated you needed $442 million to complete the year's requirements for funding the Priority 7 veterans' care. Since the President made the decision to keep them enrolled, how do you intend to make up the needed funding for this year?

Answer: We will make up $142 million in the form of a supplemental funding request, which was sent to Congress by the Administration on March 21, 2002. The remainder will be derived from an estimated $300 million in management efficiencies. The majority of management actions associated with this initiative is the result of best practices and is administrative in nature. For example, we propose to limit reimbursement to private sector vendors to the maximum Medicare rate for prosthetics devices, contract hospitalization, and fee basis. This is consistent with the practice of insurance carriers in fee-for-service, HMO, and PPO insurance plans. Clinical actions, such as utilizing Pharmacy Benefits Management to better manage pharmaceutical usage, are an effective cost-avoidance process. Consolidation of laundry production, reference laboratories and engineering supplies; implementation of the Revenue Cycle Improvement plan; and improved management of medical/surgical supplies are other best practices that have been shown to reduce costs, while maintaining the quality of care provided. Case management of high-cost patients not only reduces costs but also provides for better clinical review of patient care provided. Many VISNs, facilities, and VHA program offices have implemented hiring freezes. All of these actions will allow financial resources to be re-directed to the direct care of veterans.

Question 11: Mr. Secretary: Your budget estimates that Priority 7 veterans will constitute 42 percent of all patient enrollments in VA health care by the year 2010. Veteran population projections estimate that in 2010, this country will have only about

22 million veterans. What is the basis for VA's projection that about one-quarter of all Priority 7 veterans living in 2010 will be enrolled in VA health care?

Answer: VA has used an outside actuary to help us forecast workload. This estimate recognizes that VA has realized a tremendous increase in demand for health care services from veterans in recent years. The total number of patients treated increased by over 11 percent from 2000 to 2001. The growth rate for Priority 7 users has averaged over 30 percent annually for the last six years, and they currently comprise 33 percent of enrollees in the VA health care system. This percentage is expected to increase to 42 percent by 2010. This potential growth does not reflect the policy proposal of the $1,500 deductible.

Currently, VA health care is provided at essentially no cost to the veteran except for certain co-payments that the law currently authorizes for certain health care services. In view of the rising costs of private-sector health care generally, VA is an attractive option to veterans with relatively low incomes, particularly if they have no other type of health care coverage or only limited coverage. Medicare, of course, has no prescription coverage, and this makes the VA health care system particularly attractive to veterans over age 65 because VA provides medications and has a modest $7.00 co-payment. Moreover, there is an annual cap of $840.00 on this co-payment, which ensures that the total charges to veterans with high medication needs will be kept to a minimum. The recent restructuring of the outpatient co-payment, substantially lowering the co-payment for primary care visits, is an additional attraction. Section 202 of Public Law 107-135, which, in essence, reduces the inpatient co-payments of veterans whose income would qualify them as "a low income family" under the Housing Act of 1937, will serve as a further inducement to enroll in the VA health care system.

Question 12: Mr. Secretary: I appreciate your including some of the projects that would have been authorized had Congress enacted H.R. 811, my emergency construction bill from the First Session. Do you still support the purposes of this bill, and acknowledge that a number of VA hospitals are still in need of repairs and significant upgrading?

Answer: VA supports the purposes of H.R. 811 to the extent that it aligns with the President's budget.

Question 13: Mr. Secretary: The Medical Research budget requests $409 million, a very substantial increase over this year's account, and I commend you for the forward leadership on this key element in VA's academic responsibilities. Last fall, following the terrorist attacks, with original co-sponsorship by Ranking Member Evans, Health Subcommittee Chairman Moran and Ranking Member Filner, I introduced H.R. 3253. The bill would set up four centers of research excellence in VA to help the nation deal with bio-terrorism. Do you support our purposes in introducing this bill, and is part of the increase in your research request intended to address this proposed new function?

Answer: VA supports the underlying concept of H.R. 3253 that VA's resources should be enlisted to help the nation deal with bioterrorism. The Office of Research and Development (ORD) recently issued two solicitations for research relating to bioterrorism. Its Medical Research Service will fund and establish Research Enhancement Award Programs for scientifically meritorious program projects relating to the diagnosis, prevention, and treatment of potentially fatal airborne pathogens or toxins. The Health Services Research and Development Service will fund scientifically meritorious proposals whose focus is on improving VA's capacity to prepare for and respond to domestic terrorist attacks. In addition, ORD has issued a solicitation for proposals for security upgrades for research laboratories. Overall, in FY 2003 VA will commit up to $2 million for these initiatives.

Congressman Michael Bilirakis

Question 1: Please provide information, including yearly and aggregate figures, regarding the total amount of funds allocated for outpatient care through the VERA system in Fiscal Years 1999-2001.

Question 2: For each of the above fiscal years, please provide a breakdown of these allocations by VISN, ranked from largest allocation to the smallest. Please provide percentages as well as actual dollar amounts.

Question 3: Please provide information regarding the VERA allocation for VISN 8 for Fiscal Years 1999-2001. Include yearly and aggregate dollar amounts.

Answer (Questions 1 through 3): The VERA methodology is used to allocate funds to the Networks. VERA does not separately identify allocations for outpatient care. Funding for outpatient and inpatient care is included in both the Complex and Basic Care components of VERA. Attached is a table showing yearly allocations and yearly and aggregate percentage change for the FY 1996 to FY 2002 VERA by Network. The allocations are ranked from the largest allocation to the smallest allocation in FY 2002. VISN 8 has the second largest allocation in FY 2002 at $1.437 billion. VISN 8 also has the largest percentage cumulative increase of +49.8 percent for the FY 1996 to FY 2002 VERA. Please see attachment FY 1996 - FY 2002 VERA by Network (including VERA adjustments).

Question 4: Please provide a detailed description of the current status of VISN 8 funding in fiscal year 2001. Include the percentage of VISN 8 funding presently allocated to outpatient care.

Answer: The FY 2001 VISN 8 budget totaled approximately $1.3 billion. Of this, approximately 65 percent went toward employee salaries and benefits. It also included funding in support of research, maintenance and construction, equipment, leased costs, contract services, and other expenses.

In FY 2001, approximately $144 million was expended for operation of the large, satellite multi-specialty care clinics, and approximately $43 million was used to support the smaller satellite community-based outpatient clinics (CBOC). Altogether, the provision of outpatient care accounts for two-thirds of VISN 8's budget. The individual parent VA medical centers are responsible for the operation and funding of individual satellite clinics and CBOCs within their areas of operation.

The FY 2002 budget includes an additional $91.7 million that will be used to partially support the Federal pay raise and inflationary costs. Additionally, VISN 8 was just provided $14.1 million in additional funding as part of a total of $142 million provided to the VISNs. In FY 2001, VISN 8 did not request supplemental funds.

Question 5: I have been told that in recent months community based outpatient clinics (CBOCs) throughout the state of Florida have been required to institute caps on enrollment—i.e., clinics have been informed by officials in the Department of Veterans Affairs that they may not enroll additional patients at their clinic until a specific target number of veterans have disenrolled from the VA health care system. Please provide a detailed list of any enrollment caps, or similar limitations, of any kind currently in place in the VA system. Please provide a detailed explanation of the rationale for instituting these limitations on enrollment.

Answer: VHA has no national policy requiring caps on enrollment. All decisions related to clinic capacity and resultant "caps" on treatment of new enrollees are made at a local level. Many clinics across the country have reached capacity (contractual capacity in many cases), and therefore, in order to maintain quality of care for currently enrolled patients, they refer patients to their parent medical centers until there is room at the clinics. In VISN 8, for example, 12 of 43 clinics are currently at capacity (maximum number of patients assigned to clinical providers).

Question 6: Please provide a detailed list of current enrollment for CBOCs in VISN 8, both in the aggregate, as well as on a clinic-by-clinic basis.

Answer:

Ft. Myers OPC	15,846	Oakland Park OPC	21,010
Sarasota CBOC	4,569	Miami Sub. Abuse	1,331
South St. Peterburg	1,107	Key West CBOC	1,759
North Pinellas	2,195	Homestead	1,427
Manatee County	2,195	Pembroke Pines	1,971
Port Charlotte	3,220	Key Largo	983
Naples	2,792	Hallandale (New)	1,151
Avon Park (New)	812	Coral Springs (New)	1,319
Deerfield Beach (New)	365	Jacksonville OPC	13,311
Daytona Beach	12,362	Mayaguez, PR OPC	10,999
Tallahassee	9,725	Ponce	10,991
Valdosta CBOC	3,178	Arecibo	2,386
Ocala	3,488	St. Croix, VI CBOC	926
Inverness	2,077	St. Thomas	805
St. Augustine (New)	1,193	Leesburg (New)	2,578
Orlando OPC	34,553	Port Richey	12,438
Ft. Pierce CBOC	5,621	Viera (Brevard)	12,256
Delray Beach	12,149	Lakeland CBOC	1,897
Stuart	5,508	Brooksville	2,474
Boca Raton	2,420	Sanford	2,353
Vero Beach (New)	960	Zephyrhills	3,729
Okeechobee (New)	864	Kissimmee	2,172

The current patient enrollment for VISN 8 multi-specialty outpatient clinics and primary care CBOCs, in the aggregate, is 239,409. This aggregate may include duplicate enrollees seen at more than one clinic. It excludes VAMC patient enrollees.

Question 7: Please provide the expected opening dates of any new CBOCs in VISN 8 or the status of any contracts to build or operate additional clinics.

Answer: At this time, no additional CBOCs are planned in VISN 8 through FY 2004.

FY 1996 - FY 2002 VERA by Network (including VERA adjustments)

	Network VERA Allocations (Dollars in millions)							Percent Change						
Network	FY96	FY97	FY98	FY99	FY00	FY01	FY02	FY 96 - FY97	FY97- FY98	FY98- FY99	FY99- FY00	FY00 - FY01	FY01- FY02	Net FY 96 - FY02
16 Jackson	$1,074	$1,135	$1,194	$1,238	$1,384	$1,431	$1,467	5.7	5.1	3.7	11.7	3.4	2.5	36.6
8 Bay Pines	**$960**	**$1,018**	**$1,071**	**$1,118**	**$1,290**	**$1,354**	**$1,437**	**6.1**	**5.2**	**4.5**	**15.4**	**5.0**	**6.1**	**49.8**
22 Long Beach	$900	$918	$943	$936	$977	$1,042	$1,062	2.0	2.7	(0.8)	4.4	6.7	1.9	18.0
7 Atlanta	$778	$815	$856	$884	$946	$1,011	$1,050	4.7	5.1	3.3	6.9	6.9	3.9	34.9
3 Bronx	$1,022	$1,017	$974	$952	$974	$995	$1,037	(0.5)	(4.2)	(2.3)	2.3	2.1	4.3	1.5
4 Pittsburgh	$775	$779	$779	$790	$862	$940	$936	0.5	(0.0)	1.5	9.1	9.0	(0.4)	20.8
21 San Francisco	$688	$720	$733	$749	$821	$893	$932	4.7	1.7	2.2	9.6	8.8	4.3	35.3
1 Boston	$854	$845	$809	$785	$821	$895	$910	(1.0)	(4.2)	(3.0)	4.6	9.1	1.6	6.6
12 Chicago	$834	$828	$795	$781	$831	$878	$883	(0.8)	(4.0)	(1.8)	6.3	5.7	0.6	5.9
6 Durham	$682	$707	$704	$716	$788	$843	$861	3.7	(0.4)	1.8	10.1	7.0	2.2	26.4
17 Dallas	$587	$623	$652	$654	$744	$792	$832	6.2	4.7	0.3	13.6	6.4	5.1	41.8
9 Nashville	$688	$700	$704	$710	$772	$805	$832	1.7	0.6	0.8	8.8	4.3	3.3	20.8
20 Portland	$584	$622	$652	$677	$760	$798	$825	6.4	4.9	3.8	12.3	4.9	3.4	41.2
11 Ann Arbor	$655	$657	$632	$656	$695	$753	$750	0.4	(3.8)	3.8	6.0	8.3	(0.4)	14.6
18 Phoenix	$485	$518	$545	$567	$683	$713	$715	6.8	5.1	4.0	20.4	4.5	0.3	47.3
15 Kansas City	$585	$616	$616	$608	$640	$676	$703	5.3	0.1	(1.4)	5.4	5.5	4.1	20.2
10 Cincinnati	$511	$530	$535	$555	$621	$657	$683	3.8	0.9	3.7	11.9	5.9	3.9	33.7
5 Baltimore	$424	$442	$460	$471	$514	$557	$565	4.2	4.1	2.3	9.1	8.5	1.4	33.2
13 Minneapolis	$417	$426	$415	$427	$448	$498	$509	2.0	(2.6)	3.0	4.9	11.0	2.2	21.9
2 Albany	$437	$434	$416	$411	$460	$495	$497	(0.7)	(4.1)	(1.1)	11.9	7.5	0.5	13.9
19 Denver	$367	$385	$394	$388	$426	$458	$474	4.8	2.4	(1.5)	9.9	7.5	3.5	29.1
14 Lincoln	$291	$288	$277	$285	$306	$351	$348	(1.1)	(3.8)	2.9	7.2	14.9	(0.9)	19.6
VHA Totals	**$14,598**	**$15,022**	**$15,157**	**$15,359**	**$16,762**	**$17,835**	**$18,309**	**2.9**	**0.9**	**1.3**	**9.1**	**6.4**	**2.7**	**25.4**

These figures do include adjusted funding provided to networks.

FY 1997 - FY 1999 includes caps and adjustments.

FY00 reduced by the prosthethics funds recentralized in FY01 ($156M)

FY01 reduced for the recission ($43M) and VERA adjustments.

FY02 includes approved patient classification policy changes: 2x acute, Dom, CMI, DSS Adjusted Costs, Geographic Price Adjustment expanded, and VERA adjustments.

FY99, FY00, FY01 and FY02 include supplemental grants, loans and VERA Adjustments.

Congressman Steve Buyer

Question 1: On page 3B-21 of Volume 5 of the VA's 2003 Congressional Budget Submission, there is a section that praises the VA's revenue collection outsourcing pilot projects that have been implemented in four VISNs. However, only one of these pilot programs is engaged in an outsourcing initiative. Two of these VISNs have implemented VISN level consolidation efforts and the fourth VISN was unable to attract any serious proposals from the private sector. With only one VISN actively carrying out an outsourcing pilot program, how can the VA make the claim that it "has made considerable progress in terms of executing a new outsourcing business plan?"

Answer: The purpose of the VISN 2 pilot project was twofold: 1) to determine if the business plan presented effective revenue collection models; and 2) to determine how best to implement these models while mitigating the negative impact on revenue and minimizing the impact on our employees during the transition period.

Based on information gathered from the pilot, generic transition plans and standard operating procedures will be developed to help other VISNs consolidate their revenue collection activities. In the pilot test, we developed a phased acquisition plan that provided for multiple solicitations, aggressively performed market analysis, and convened pre-proposal conferences to make our requirements clear and enhance vendor interest in these procurements. We found that many vendors are interested in working for VA. As a result of the acquisition efforts, pre-registration and insurance verification was outsourced in VISN 2. We awarded a performance-based contract. Initial success of the contract was marginal because data could not be transferred electronically between VA and the vendor. To fix this problem, VA engaged DAOU Systems to develop an interface. The result was a dramatic increase in productivity.

As a result of this pilot test, we identified the inability of VHA to efficiently exchange data with revenue collection vendors as a major barrier to contracting for revenue collection services. The lack of an information technology interface is a major roadblock to contracting for revenue collection services. Many VISNs and medical centers would readily contract for insurance verification or collection of aged receivables if an interface were in place. We are working on a solution to this problem.

To encourage additional VISNs to outsource core revenue collection activities, VA is considering revenue models that would consolidate and/or contract for all accounts receivable activities (collection and follow-up), while permitting VISNs to realign affected employees to "upstream" MCCF activities – e.g., coding, billing, etc. Under this concept, VA pays for re-training, paid for from increased collections.

While outsource pilot tests were not as extensive as envisioned, they did test our business plan and provide very important lessons learned. We believe this to be progress.

Question 2: VISN 15 was one of two VISNs designated to serve as a pilot program for the outsourcing of third party payment collections, with the main focus being upon the contracting out at the VA Medical Center, Kansas City, MO of its coding, billing, and collection efforts. However, this contract would only last for three months, making it economically infeasible for the private sector to seriously entertain entering into such a contract. Is the VA truly committed to exploring the feasibility and effects of outsourcing its revenue collections? If it is serious, please explain how setting up a scenario in which the private sector cannot enter into a viable contract helps the VA measure the potential benefits or consequences of Medical Care Collection Fund (MCCF) outsourcing?

Answer: You are correct, the three-month "scenario" at the Kansas City VA Medical Center (VAMC) proved impractical. However, this was not our initial plan.

The original scope of the Phase II acquisition at the other pilot test, VISN 15, was to process coding, billing, and collections for the backlog at all facilities in the VISN.

However, in 2001, the VISN implemented a database consolidation project that integrated the VAMC databases. Once the databases were integrated, it was no longer possible to accurately identify which bills the vendor would have generated; therefore, the VISN would have had to manually track vendor workload in order to compensate them correctly.

Because we had already prepared the performance work statement and performance requirements for the backlog effort, we strived to continue this pilot test. To fulfill their commitment to participate in a contracting pilot test, VISN 15 agreed to contract current coding, billing and collections workload for one installation, the Kansas City VAMC. The vendor was to process all episodes of care that occurred between October 1, 2001 and December 31, 2001 (the first three months of fiscal year 2002). The vendor would then have 60 days after the 31st of December to finish collecting on any outstanding claims. By changing the scope in this manner, it enabled the VISN to track the work performed by the vendor based on the bill number, and compensate the vendor according to the percentage of collections obtained. Nine proposals were received but none were deemed responsive to the complete requirement. The solicitation was subsequently cancelled due to a lack of responsiveness.

It was our intention to set up a scenario that was viable for the private sector vendor and to test how a vendor could provide the full scope of revenue collection services—coding, billing, collections. That would have proved most useful, not only in assessing the effectiveness of revenue collection, but also in examining the alternative protocols for data transfer. Unfortunately the downsizing of the requirement to one medical center and constraining it to three months was just not a requirement that vendors could respond to.

Question 3: Why is it that VA is not included in funding dedicated to homeland defense? What can VA do to secure a portion of the funding?

Answer: Of the $37.7 billion in the President's 2003 budget for homeland defense, $34 million was identified for VA. This cost estimate reflects on-going critical infrastructure protection initiatives and continuity of operations expenses of $29 million and recurring cost of $6 million to replace pharmaceutical caches to support local emergencies in the event of a chemical, biological, or radiological event. The costs submitted in the President's budget were based on the annual report to Congress regarding total Federal spending on programs designed to combat terrorism and counter unconventional threats. In future reports, additional resources that VA can apply in the area of homeland security will be included.

The Deputy Secretary recently met with Admiral Abbot, Deputy Director, Office of Homeland Security (OHS) and several other OHS staff to discuss how the Department's capabilities can be leveraged in the area of emergency preparedness. In addition, we plan on engaging FEMA and the Deputy Secretary of Health and Human Services in similar discussions, as done with OHS staff.

Question 4: Please explain the process that was used to settle on the $1,500 figure as an annual deductible for Priority level 7 veterans?

Answer: The reasons behind the $1,500 figure are the following:

- The deductible amount is below the average cost for priority 7 veterans ($1,900).
- It would encourage veterans to identify insurance.
- The $1,500 cap still allows for catastrophic coverage for those with large annual medical costs.
- This amount is not likely to devastate those without insurance who need health care, because the cost of most Priority 7's care is low, a greater share of their total cost is for pharmacy, and a small percentage have large medical costs.

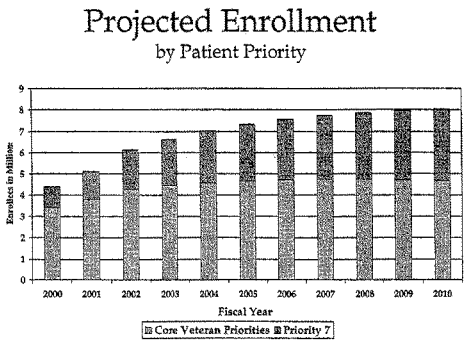
The following "Background on VA's $1,500 Deductible Proposal for Priority 7 Veterans" provides additional information on this proposal.

Background on VA's $1,500 Deductible Proposal for Priority 7 Patients

VA's estimate of the financial and programmatic impact of the $1,500 deductible upon Priority 7 veterans was based upon the Milliman USA, Inc. actuarial estimates for projections of enrollees and resources that were used as the foundation of the FY 2002 enrollment decision. The actuarial estimates were based upon FY 2000 actual experience and did not reflect increased utilization by Priority 7 veterans seen in FY 2001. The actuarial estimates were first available in late summer of 2001.

Future Year Projections

This deductible policy would not have been proposed if the growth in Priority 7 veterans was estimated to be a one or two year anomaly. As the chart below shows, the Priority 7 workload is estimated to continue to rise through 2010.



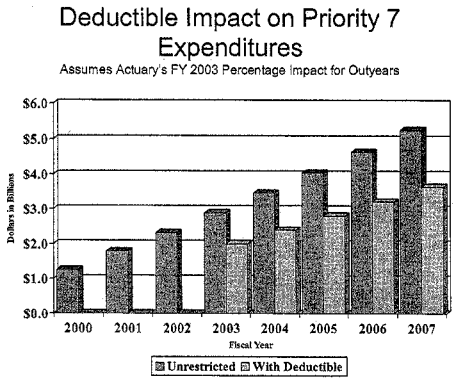
VA's primary reason for proposing a significant policy change is to assure that quality of care is maintained.

The Deductible Proposal

The table below shows the forecast of key workload factors including associated workload expenditures. Estimates are shown with and without the deductible in place for 2003. Priorities 1-6 veterans are VA's core veterans—service connected and low income—Priority 7 veterans—(higher income veterans, about $25,000 for a single veteran and $28,000 for a married veteran). As the table indicates, Priority 7 users are projected to rise by 43 percent from 2001 to 2003 and resource requirements by 61 percent without the $1,500 deductible. With the $1,500 deductible, the growth is held to 29 percent and 12 percent respectively

	2001 Estimate	2002 Estimate	2003 Without Deductible	2003 With Deductible
Priority 7 Enrollees (Average) in millions	1.4	1.9	2.2	2.1
Patients (unique)	841,153	1,060,482	1,206,860	1,085,074
Workload Expenditures in millions	$1,790	$2,320	$2,885	$2,000
Deductible Revenue in millions				$ 260

Application of the deductible proposal reduces Priority 7 veterans by 10 percent and their related workload expenditures by 31 percent in 2003. Their expenditures decline by a greater amount because a large portion of the veterans will seek fewer medical services from VA and will shift some of their care to other providers. The following graphic displays the Priority 7 expenditures projected for 2000–2007 with and without the proposed deductible starting in 2003.



The actuarial estimate concentrates on medical procedures workload (outpatient visits--CPT codes and inpatient episodes of care—DRG) of Priority 7 patients, as this factor is more directly related to expenditures than the number of patients or enrollees. The actuarial expectation is that, with the application of the $1,500 deductible, VA will experience a 10 percent reduction in unique medical users (122,000), a 50 percent decline in outpatient procedures, a 40 percent decline in inpatient episodes of care, and a 10 percent decline in pharmacy utilization. The overall effect on resources is expected to be a 31 percent decline in cost.

Because this type of policy change has not been seen in any large health care system before, or in a system with similar characteristics to the VA—a system where the patient pays only a small fraction of their health care costs, the change in Priority 7 veterans behavior due to the introduction of a $1,500 deductible could be different than that forecasted. The ramification of expenditure savings and the impact on budgets in the future is very significant.

Revenue Estimate

The actuary estimates that this proposal will bring in an additional $260 million in revenue in addition to the $885 million in cost reduction for an overall reduction to the appropriation request of $1.145 billion.

Why This Proposal Was Chosen?

Continued growth in the demand for VA health care services will require significant increases in budget resources. Without significant increases in resources or the implementation of an alternative policy/policies (limit enrollment, change uniform benefits package, cost share proposal), VA would face critical issues impacting quality, such as, increasing waiting times, increasing system congestion impacting all patients, inability to meet demand. VA considered these policies and determined that the deductible (cost sharing) proposal seemed to be the preferable option that addresses the following most overarching concerns:

- Maintain quality of care for all those that VA serves
- Continue VA open enrollment for all veterans
- Maintain, not reduce, the basic benefit package of medical services for core veterans
- Provide veterans appropriate access to outpatient, inpatient, and non-institutional long-term care services
- Require veterans that have higher incomes to contribute more to their cost of care than other veterans
- Assess a charge for use of healthcare services as opposed to assessing an upfront charge or enrollment fee
- Allow veterans to benefit from private insurance coverage and encourage veterans to identify their insurance coverage and improve third party collections
- Continue VA long-term services, especially non-institutional care
- Provide catastrophic coverage for those with high annual medical costs

How does the Deductible Work?

Who pays the deductible?

- All Priority 7s for non-preventive, non-service connected care
- Insurance will help offset deductible charge to veterans
    - Dollar for dollar
    - Veteran will not be billed until insurance payment is made

How much is the deductible?

- Pay only for care received (no upfront charge)
- Once annual deductible ($1,500) is met, no more deductible for that year
- Excludes pharmacy (only $7 copay applies)

How do co-payments work with the deductible?

- Inpatient and outpatient copays start after deductible cap is reached
- Pharmacy copays will be in effect the entire year

How was the $1,500 cap determined?

- The deductible amount is below the average overall cost for priority 7 veterans ($1,900)
- Would encourage veterans to identify insurance

- The cap provides catastrophic coverage for those with huge annual medical costs
- Not likely to devastate those without insurance who need health care as the cost of most Priority 7's care is low, a greater share of their total cost is for pharmacy and a small percentage have large medical costs

Question 5: VISN 11 received a 0.4 percent ($2.8 million) decrease in allocated funds in FY 02. Will VISN 11 receive a plus up in FY 2003?

Answer: Preliminary FY 2003 financial planning estimates based on the President's budget request level were provided to all VISNs on February 26, 2002. That data shows an increase of $24.6 million or 3.2 percent for FY 2003 compared to FY 2002, but this is preliminary and is subject to change for updates related to workload validation and any new VERA policy changes.

Question 6: The MCCF program only allows VA to bill third-party payers for treatment for nonservice-connected disabilities. This policy was further expressed in 38 CFR Part 17. Please provide the Subcommittee on Oversight and Investigations a timeline of when and how VA has enacted this policy. Please explain the process that VA has developed to differentiate between service connected and non-service treatment and care with regards to bill preparation.

Answer: Last year, VA submitted a proposed regulation regarding the SC/NSC issue to the Office of Management and Budget (OMB). VA is studying the response by OMB to VA's proposal and plans to resubmit the regulation to OMB after appropriate modifications have been made.

The Under Secretary for Health is proposing the creation of a Business Office within the Veterans Health Administration (VHA). This proposed office would combine the Revenue Office, Health Administration Service, the Health Eligibility Center, and other program responsibilities into one centralized office. This office would be responsible for the development of centralized program direction and management for enrollment, eligibility, insurance identification and verification, and all activities associated with the billing and collection of veteran co-payments and health insurance reimbursements. This proposed Business Office would be the main focal point for all inquiries and contacts regarding the revenue program, as well as the other program responsibilities, and should demonstrate the importance of the revenue program to all levels of field staff.

A directive was released to all medical centers in 1991, which provided guidance for implementing the new billing authority. Medical centers were advised that the outpatient routing sheet had been modified to list the veteran's SC conditions. The routing sheet also contained a check-off question regarding NSC treatment that the health care provider needed to complete. Similar procedures were put in place for inpatient services. Medical center staffs were advised that any treatment provided for a condition formally rated as SC is not billable to an insurance carrier for reimbursement. Treatment of conditions not formally rated as SC is considered to be NSC care and is billable to an insurance carrier.

VA recognizes the importance of meeting and exceeding its collection goals. As an example of the commitment to revenue initiatives, I am pleased to state that VHA has exceeded $80 million in monthly collections on several occasions. Most recently VHA closed the month of March 2002 with $90 million in medical care collections, and an additional $16 million in Health Services Improvement Fund (HSIF) collections, for a total of $106 million. VA has steadily improved its collections each fiscal year and, at the current collection rate, we expect to exceed our collection goal for this fiscal year.

Congressman Rob Simmons

Question 1: The large population of retirees and veterans in my district has created increased needs that require innovative public policy decisions. Will the Veterans' Administration examine the benefits of co-locating the Hartford Regional Veterans Benefit Administrative Office and the Newington Campus of VA CT Healthcare System at the Newington facility? It is my understanding that such a move will benefit both VA employees at the two facilities and veterans in the region by providing a one-stop service location, improving services at an equal or lesser cost to the VA.

Answer: The Department of Veterans Affairs examined the potential for the co-location of the Hartford Regional Office with the Newington Campus of the VA Connecticut Healthcare System. The Veterans Benefits Administration developed a Capital Investment Application for this major construction initiative for FY 2003. The application did not rank high enough for inclusion in the President's FY 2003 Budget Submission.

Question 2: I understand that this project is expected to save an estimated $7 million dollars over a 30-year period, which could be reinvested into the veterans' healthcare system. As we examine the fiscal year 2003 budget, can you indicate your evaluation of this co-location proposal, and other examples of efforts at resource sharing within the VISN 1 region including the savings that would be accrued?

Answer: VA has evaluated the opportunity to co-locate the Hartford Regional Office in vacant space at the VA Connecticut Healthcare System, Newington campus. Such a co-location would facilitate the speedy processing of eligibility determinations, compensation and pension claims, and other benefit functions requiring close communication between VHA and VBA. It would certainly provide "one-stop shopping" and One VA service to Connecticut veterans. The co-location would also expand the mission of VA's property from a VHA facility to a Federal Services Center, since Newington is already the home of the Connecticut National Guard.

The current VBA construction estimate is $7 million and reflects a requirement to convert a "racetrack" hospital room configuration into a more useable regional office configuration. The request for construction dollars has been submitted by VBA through the VA Capital Asset Board process. The estimate was prepared several years ago and is currently associated with the construction project as it progresses through the steps of VA's Capital Investment Board process. As the VA Connecticut Healthcare System adjusts to meet changing healthcare needs, more and different space becomes available at the Newington campus. Within the last 12 months, the regional office was offered first floor space at the Newington campus, which should significantly change the amount of re-construction needed. The VBA construction staff has not yet evaluated this alternate space to determine the potential construction savings. If the co-location were to actually occur, VA could expect to save in excess of $21 million over 30 years from rent currently paid to GSA. VA will consider the proposal for the collocation of Hartford within the context of the CARES review for VISN 1.

Network 1 has numerous space sharing arrangements with other private, public and non-profit organizations that generate revenue, which reinvested into health care services for veterans. Several examples of leased space revenue include: National Guard offices; telecommunication companies' rooftop antennas; day care centers; non-profit organizations; and local, state and federal agency offices. Annual revenue to Network 1 from space sharing is in excess of $700,000.

Congressman Henry E. Brown, Jr.

Question 1: It is my understanding that the VA announced an increase in medication co-payment for veterans which will increase costs from $2 to $7 per prescription. With many veterans living on fixed incomes, this increase more than triples their monthly budget for prescription drugs. Clearly, the VA Health Care Budget has not kept pace with the double-digit increases in prescription drug spending over the last decade. If money is not budgeted in this area, what can be done to lessen the impact of this drastic increase on our veterans?

Answer: We believe that the $7 co-payment is a moderate amount, well below the medication co-payments charged by most private-sector health insurance plans. Moreover, an annual cap has been established for veterans in Priority Groups 2 through 6. For calendar year 2002, the cap is $840. When a veteran reaches the annual cap, he or she will continue to receive medications without making a co-payment. The following table shows pharmaceutical expenditures and revenues derived from medication co-payments for FY 2001 through FY 2003.

	FY 2001	FY 2002 (estimate)	FY 2003 (Budget)
Expenditures	$2,546,653,000	$2,934,727,000	$3,300,981,000
Co-payment Revenue	$138,800,000	$315,000,000	$509,000,000

VA expenditures for pharmaceuticals continue to increase as a percentage of VA's health care dollar. The primary drivers of increased pharmaceutical outlays are (1) increased new unique patient demand, (2) increases in the intensity of therapy in the aging veteran population, (3) increased utilization of pharmaceuticals and a change in the mix or intensity of pharmaceuticals used, and (4) new high-cost agents that have no alternatives.

National contracting, blanket purchase agreements, and ongoing standardization are proven successes in managing outlays for, and the clinical use of, drug products across the VA health care system. The slow rate of growth in the average cost per prescription dispensed over the past 3 years is partly attributable to the clinical strategies and resulting contracting actions taken by VHA.

To encourage the appropriate use of pharmaceuticals, VA continues to aggressively pursue the development of disease management guidance, standardization contracting, and utilization management initiatives at both the national and VISN levels. Most recently, VA implemented sophisticated and timely data management capabilities that enable local clinical staff to analyze VISN-, facility-, and provider-specific drug use patterns. This information will enhance the ability of VA staff to identify opportunities for quality improvement and cost avoidance. VA's aggressive strategies have helped contain the overall increases in pharmaceutical expenditures due to medical inflation to between 3 and 4 percent. Additionally, the Under Secretary for Health has tasked VISN directors to formally implement pharmacy benefits management initiatives in fiscal year 2002. To date, VISN officials have identified over $100 million in cost avoidance actions to be addressed in the remainder of FY 2002.

Question 2: Concurrent receipt of military retirement pay and disability compensation continues to be one of the top issues for all military and veterans' groups when I speak to them. With estimated costs for the proposal as high as $3 billion per year according to some CBO estimates, has the VA looked in great detail at the impact that full concurrent receipt would have upon the VA budget? What if partial concurrent receipt was provided to certain categories of veterans, for example, those most severely disability, with combat disability or at the lowest income levels?

Answer: If legislation were passed to allow concurrent receipt of military retired pay and VA compensation, we currently estimate receiving 700,000 new claims from retirees who have not previously filed for compensation benefits and 118,000 reopened claims from military retirees currently on VA compensation rolls over the next 5 years. Our

cost estimates assume 50 percent of these claims would be received in the first year following enactment of the legislation.

First-year VA costs would approach $766 million in benefits, and GOE costs would exceed $135 million (2,514 FTE). Five-year combined costs would exceed $6.5 billion. Ten-year costs are estimated at $16 billion.

VA workload and performance (i.e., timeliness) would be affected. Recruiting and training the staff needed to handle this new work would have compounding impacts. Existing staff would be diverted to accommodate their training and mentoring needs while newly trained technicians would not be fully productive for 2 years.

VA's cost would be lower if partial concurrent receipt were to be enacted. The Department of Defense characterizes severe disability as being 60 percent or greater. Currently, approximately 118,000 retirees on VA compensation rolls are severely disabled according to this definition.

Question 3: Although the overall veteran population is declining, the increase in older age groups is increasing the demand on more intensive health care needs. The Floyd D. Spence National Defense Authorization Act established TRICARE For Life with TRICARE being a secondary payer to Medicare for military retirees age 65 and over. Is it too early to determine whether the VA has realized any cost savings as a result of older veterans using the TRICARE for Life system?

Answer: The TRICARE for Life (TFL) benefit became effective on October 1, 2001. It is still too early to determine the full impact on VA. We will be happy to share this information with Congress when we have analyzed it.

Question 4: The proposed budget includes estimated management savings of over $316 million that should partially offset the overall cost of health care with specific actions. These include improved standardization policies that are expected to facilitate best-value product pricing through volume purchasing. How will this facilitate the delivery of high quality health care, pharmaceuticals, equipment and other capital purchases?

Answer: Standardization is expected to facilitate best-value product pricing through volume purchasing. It is VHA policy to standardize, to the maximum extent possible, the types and kinds of supplies and equipment it purchases, consistent with clinical and practitioner needs. The types of items considered for national standardization are only those that are not limited by geographic differences in availability, and for which technology is mature enough that they are unlikely to change dramatically within a 1 year period. Standardized items establish an equal standard for veterans across the system. Deviations are allowed only with a specific clinical justification. In pharmacy, standardization will be the result of the combined efforts of using the equivalent generic product in place of more costly pharmaceuticals, reviewing variations in the system nationwide, and by having additional contracting initiatives. All of these actions will allow for additional financial resources to be re-directed to the direct care of veterans, which should facilitate the delivery of high-quality health care.

Question 5: The proposed budget includes $193.7 billion for the major construction program and $210.7 billion for the minor construction program. Is there enough funding to cover all of the maintenance and repair work on the infrastructure that needs to be addressed? It is my understanding that some networks, including one that includes my district in Charleston, South Carolina, have faced deficits to fund capital projects. Will they be faced with the prospect of transferring a portion of their operating budget to cover maintenance and facility repair work in fiscal year 2003 and beyond?

Answer: The facilities in VISN 7, including Charleston, have received their budgets for normal maintenance construction projects. Earlier in the fiscal year, VISN 7 had temporarily put on hold these types of construction projects until clarification was received on VA's supplemental budget request for FY 2002. In February 2002, these construction funds were released and VISN 7 is proceeding with its construction plans.

Since we do not know the budgets for 2003 and beyond, we are unable at this time to predict what actions the VISN will need to undertake in response to those future budgets.

Question 6: Recently, a hearing was held by the Health Subcommittee to address some of the lessons learned from the Persian Gulf War. That hearing made clear that to date there are still many unresolved issues for our veterans of that conflict. How does this budget address the need to continue research efforts and medical treatment for Persian Gulf War veterans afflicted with ALS as well as those with undiagnosed symptoms?

Answer: Since 1994, VA, DOD, and the Department Health and Human Services have sponsored 224 Gulf War research projects at a total cost of $213 million. During 2001, VA funded 6 new projects that will cost $4.9 million.

These 224 projects focus on both diagnosed illnesses and undiagnosed illnesses. Ninety-two projects focus on the function of the brain and nervous system. VHA's Office of Research and Development also recently developed and released a request for proposals and a solicitation to fund a research program (the ALS Research Enhancement Award Program) to address questions on ALS.

Approximately 55 percent of the 224 projects have been completed. Significantly, the results of 32 of the completed studies were published in the medical literature during 2001. Eleven of these studies focused on the health effects of specific exposures that occurred during the Gulf War, including depleted uranium, pyridostigmine bromide, pesticides, and multiple vaccinations.

Gulf War veterans continue to have special eligibility for care at VA medical centers and clinics. Every veteran patient has access to a primary care physician, and if necessary, that physician can make referrals to appropriate medical specialists. Veterans with ALS or with undiagnosed illnesses will be well served by this approach, and the current budget adequately addresses those needs.

The VA Gulf War Registry offers a complete medical examination to any veterans with health concerns. Since the Registry's inception in 1992, more than 83,000 Gulf War veterans have completed medical evaluations. In addition, VA recently funded two Centers for the Study of War-Related Illnesses located at the East Orange (NJ) and Washington (DC) VA Medical Centers (VAMC). The Centers' primary mission is to provide in-depth clinical care and evaluation for combat veterans with debilitating symptoms that remain unexplained after thorough medical examinations by local VAMCs. In addition to its primary mission, each center incorporates four major areas including clinical care, research, risk communication and education of clinicians.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 13, 2002

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

Enclosed are the Department of Veterans Affairs' responses to the post-hearing questions submitted in your letter of February 20, 2002, on the FY 2003 budget. I apologize for the delay in responding.

I look forward to continuing our work together.

Sincerely yours,

Anthony J. Principi

Enclosure

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN REYES TO DEPARTMENT OF VETERANS AFFAIRS

Congressman Silvestre Reyes

Question 1: Although a number of steps have been taken to reduce the backlog, it continues to grow. Please provide an analysis of the reasons for the increased backlog.

Answer: A significant increase in the volume of incoming work has affected our ability to reduce the pending inventory of rating-related claims. The increased volume of claims is attributed to the following factors:

- The review of more than 98,000 cases under the Veterans Claims Assistance Act (VCAA).
- VA's expanded outreach efforts to separating service members (Benefits Delivery at Discharge initiative).
- Receipt of 66,000 Type 2 diabetes claims based on exposure to Agent Orange.
- The requirement to review 13,000 previously adjudicated diabetes claims under the Nehmer stipulation. (In the case of Nehmer v. VA, plaintiffs' attorneys and VA agreed, in a 1991 Stipulation and Order, on a process for applying an earlier than usual effective date for certain claims for benefits based on Agent Orange exposure. As a result of court decisions in the Nehmer case, VA is required to re-adjudicate over 13,000 diabetes claims.)

All of the 98,000 VCAA claims have now been added to the inventory. Following the initial surge of Type 2 diabetes claims, the incoming volume of diabetes claims is expected to taper off. We have also completed a significant portion of the Nehmer reviews.

At the same time, the aggressive steps we have taken to increase rating production have had a positive result. In the latter months of FY 2001 and into this year, production of rating decisions significantly increased—which is the key to reducing the claims backlog. From October 2001 through February 2002, VBA decided over 294,000 cases for a 5-month average of 58,800. This represents a 47 percent increase over FY 2001 production levels. We expect our production to continue to increase as many of our recently hired employees gain additional experience and we begin to implement the recommendations of the Claims Processing Task Force.

We believe our increased production levels and the Task Force initiatives will now enable us to make major inroads into the pending inventory. Our goal is to reduce the pending rating inventory to 315,000 claims by the end of this year.

Question 2: Please provide information for the first quarter of fiscal year 2002 concerning the characteristics of original and reopened claims filed at each regional office.
Answer: The following excel spreadsheet contains first quarter FY 2002 data on original and reopened claims is attached. The data on numbers of compensation claims filed for gulf war illness at each regional office is not available. We do know that nationally 68 claims for undiagnosed illness were processed in the first quarter.

Completed First Quarter FY 2002

	Original Compensation Claims	Initial Death Comp/DIC	Initial Disability Pension	Initial Death Pension	Reopened Comp.	Reopened Pension
USA	34,181	6,122	9,496	9,624	96,110	15,600
Boston Regional Office	359	70	85	105	1,793	111
Providence Regional Office	157	36	35	44	535	47
New York Regional Office	612	113	235	304	2,446	372
Buffalo Regional Office	470	67	124	177	1,269	195
Hartford Regional Office	251	22	59	62	583	79
Manchester Regional Office	135	22	36	8	435	43
Togus VAMROC	200	41	79	65	843	92
White River Junction VAMROC	68	13	26	18	255	26
Newark Regional Office	332	66	36	124	1,433	41
Philadelphia Regional Office	575	144	238	217	2,096	350
Pittsburgh Regional Office	352	40	265	310	1,281	334
Cleveland Regional Office	674	122	377	425	1,935	457
Indianapolis Regional Office	391	82	142	224	1,402	222
Detroit Regional Office	482	177	280	155	1,788	339
Wilmington VAMROC	109	6	14	23	178	13
Baltimore Regional Office	564	73	94	100	1,072	161
Roanoke Regional Office	1,207	150	153	199	2,256	250
Huntington Regional Office	301	81	158	106	1,267	242
Louisville Regional Office	475	75	124	125	1,239	180
Washington Regional Office	304	67	24	49	785	55
Atlanta Regional Office	1,175	208	302	406	3,097	500
Winston-Salem Regional Office	2,048	293	386	394	4,026	628
Columbia Regional Office	869	119	225	218	2,709	346
Nashville Regional Office	795	192	221	250	2,418	509
St. Petersburg Regional Office	2,511	592	794	582	7,073	1,095
Montgomery Regional Office	704	179	391	443	2,147	672
Jackson Regional Office	424	101	196	210	1,465	410
San Juan Regional Office	145	50	140	219	828	715
Chicago Regional Office	871	110	287	395	2,150	540
Milwaukee Regional Office	319	33	164	129	1,595	346
St. Louis Regional Office	787	90	167	288	2,206	251
Des Moines Regional Office	180	40	143	121	926	233
Lincoln Regional Office	406	35	96	41	1,124	91
St. Paul Regional Office	441	83	188	264	1,910	361
Fargo VAMROC	158	19	51	50	470	68
Sioux Falls VAMROC	96	15	34	43	475	82
Wichita VAMROC	293	46	108	53	731	200
New Orleans Regional Office	625	113	282	331	2,119	609
Waco Regional Office	2,145	374	325	385	5,211	692
Little Rock Regional Office	443	113	170	111	1,758	317
Muskogee Regional Office	732	221	205	292	2,615	451
Houston Regional Office	1,439	217	323	308	3,540	557
Denver Regional Office	895	142	140	96	1,363	163
Albuquerque Regional Office	309	56	47	75	1,135	96
Salt Lake City Regional Office	225	14	44	51	643	62
Seattle Regional Office	1,378	153	156	163	2,337	177
Boise Regional Office	286	38	77	63	736	105
Portland Regional Office	384	30	219	81	1,278	302
Fort Harrison VAMROC	161	17	43	35	492	96
Anchorage VAMROC	264	10	10	3	498	8
Oakland Regional Office	912	146	186	83	3,376	277
Los Angeles Regional Office	885	186	295	198	3,233	448
Phoenix Regional Office	549	132	202	193	2,308	202
Reno Regional Office	336	25	126	51	864	167
Manila Regional Office	224	324	85	93	938	112
San Diego Regional Office	1,421	101	70	57	1,109	81
Honolulu VAMROC	328	38	14	9	516	22

Question 3: Please provide a detailed description, including the cost and FTE of all Veterans Benefits Administration personnel, if any, who are providing services at alternative locations, such as pre-discharge locations, the National Personnel Records Center, the US Armed Services Center for Research of Unit Records and any other similar locations. Please provide a brief description of the expected improvement in processing claims as a result of these activities.

Answer: VBA has employees outbased at the National Personnel Records Center (NPRC) and at military separation sites throughout the United States and overseas under our Benefits Delivery at Discharge (BDD) Program. There are no VBA employees located at the US Armed Services Center for Unit Records Research.

VBA's Records Management Center operates an outbased Veterans Affairs Liaison Office (VALO) at the NPRC. This office processes requests for military service and personnel records needed by field stations to adjudicate disability claims. Currently 67.5 FTE are assigned to the VALO. Since its inception in October 1999, the VALO has reduced pending records requests from 62,000 to 46,000 and decreased average processing time from over 180 days to 63 days. Over the next 12 months, we expect to reduce the pending requests to less than 12,000 and improve average response time by two thirds – to less than 21 days. This will in turn improve overall claims processing time in VBA.

There are 128 VBA Benefits Delivery at Discharge sites located throughout the United States. Outbased claims processing teams are assigned to 38 of these sites and are currently staffed with 149 VBA employees. The medical examination protocols used at these sites allow VBA to evaluate the disabilities claimed without requiring additional examinations after separation. As a result of the services provided by the VBA staff at the separation sites, a complete "ready-to-rate" claim is forwarded to the regional offices or processed to completion at the separation site. Most of these claims are processed within 30 days of the service members' separation from the service. In FY 2001, there were 23,451 examinations conducted and 22,524 claims finalized at BDD locations. In addition to processing claims, BDD staff conduct transition assistance briefings and provide benefits counseling to separating service members.

Two overseas BDD sites have been established in Germany and Korea. The office in Germany is currently staffed with an Officer in Charge (OIC), three Rating Veterans Service Representatives (RVSRs), and one Senior Veterans Service Representative (VSR). The office in Korea is staffed with an OIC, one RVSR, and two VSRs. Employees at these sites conduct outreach activities, provide benefits counseling and process original compensation claims.

Separate budgets are not prepared for these outbased locations. The costs are incorporated into the overall operating budgets of the responsible regional office. Specific information on the costs to operate these sites is therefore not readily available.

Question 4: As various laws and regulations are promulgated, changes in adjudication of claims for compensation and pension need to be quickly implemented in a consistent manner. Please indicate the status of efforts to make Training and Performance Support Systems (TPSS) available on line, so that changes can be made in a timely manner?

Answer: All TPSS modules currently in production are designed for Web-based delivery. All future modules of TPSS will also be designed in this manner. TPSS modules released in 2001 for Veterans Service Representatives are available online on the Veterans Benefits Administration Intranet site.

We are working to convert all previously released Basic Rating TPSS modules to web-based delivery. This conversion is expected to be complete by the end of this calendar year.

Question 5: Please describe actions taken during FY 2001 to provide information concerning changes in law, regulations and precedential case law to adjudication staff in a timely and consistent manner?

Answer: The Compensation & Pension (C&P) Service initially disseminates changes in law, regulations, and precedential case law to field stations by "Fast Letter." These Fast Letters are issued in advance of formal changes to our regulations and procedural manuals to ensure that new information is relayed as quickly as possible. The Fast Letters are initially sent via e-mail to regional office directors and Veterans Service Center managers for appropriate distribution throughout the facility. Significant changes are also discussed on nationwide conference calls with all field facilities. Subsequently, the C&P Service issues regulation changes and procedural manual changes in the same manner. All of this information is indexed and maintained on C&P's Intranet Web site.

The Secretary has established a cross-organizational process to analyze and disseminate Court decisions. It involves the Office of General Counsel (OGC), the Board of Veterans' Appeals (BVA), and the Compensation and Pension (C&P) Service. The Appellate Litigation Group of the OGC distributes the Court's Orders and decisions to the BVA, OGC, and the Judicial Review Staff of the C&P Service on a daily basis. The principals of those activities regularly discuss the decisions and their impact on operations throughout VBA. This group leads the effort to interpret the Court's rulings, disseminate information and monitor compliance with the Court's rulings. In addition, BVA and the C&P Service produce timely written assessments of the Court's case law and disseminate these assessments to all VBA decision-makers.

C&P Service currently updates its Intranet site to reflect all changes in law, regulations and precedential case law as soon as they receive final approval. In June 2001, an Intranet user's guide was released to field stations, to include adjudication staff. This guide detailed all references available on the Intranet site and provided guidance on how to find and search them. All Compensation and Pension regulations, manuals, circulars, court-related materials, training materials and letters are now available from this site. Searches can be made of the entire site or only a small portion of it. The curriculum for new Veterans Service Representatives and Rating Veteran Service Representatives includes training on how to use this Intranet site to access changes in law, regulations and case law.

Question 6: VBA currently determines quality by using information from the STAR quality review program. In some offices there appears to be a significant difference between the STAR data and reversal and reasons for remand data from the Board of Veterans' Appeals. Recognizing the lag time between regional office decisions and decision by the Board of Veterans' Appeals (BVA), how does the Veterans Benefits Administration utilize Board data concerning reversals and reasons for remand to evaluate regional office performance? Is Board data considered in evaluating the quality of work produced at the regional offices?

Answer: Appeals are filed on only 6 percent of rating-related claims. Therefore, BVA remand and allowance rates are not necessarily good indicators of regional office performance or the quality of decisions made at the regional office level. Appellants can submit new evidence after the appeal has been certified to BVA that could result in BVA overturning a regional office decision or remanding a case back to the regional office. Changes in the laws or regulations (e.g., enactment of the Veterans Claims Assistance Act) or a Court decision, during the appeal period, can have the same effect. Additionally, BVA has de novo review authority, which allows them to overturn regional office decisions based on judgment variance.

VBA tracks quality nationally by using the STAR review process to evaluate decisions made at each regional office and to determine national training needs. STAR assures a thorough evaluation of all aspects of the decision process, whereas BVA remand and reversal data provide more limited information. The STAR case selection process also assures a statistically valid sampling of all claims, whereas appellate cases are not representative of entire universe of claims decisions.

While not considered a direct quality measure, data captured through the Veterans Appeals Control and Locator System (VACOLS) on claims remanded and granted by BVA is used to identify trends at both the national and regional office levels. The Office of Field Operations and the Compensation and Pension Service analyze and discuss these trends with the regional offices to identify areas where additional guidance and/or training may be needed. The ratio of appeals received (Notices of Disagreement) to claims completed is measured as a performance indicator on VBA's Balanced Scorecard.

Question 7: How many ratings is a rating specialist required to produce in a day? What factors are taken into consideration in determining these amounts?

Answer: A national performance plan for journey-level Rating Veterans Service Representatives (RVSRs) was implemented in January 2002. A journey-level RVSR is defined as a GS-12 with 24 or more months of experience in the position. The minimum acceptable level of production for a journey-level RVSR is three weighted cases per day.

Case weight is calculated according to the complexity of the claim. For example, an original disability compensation claim with seven or fewer issues is assigned one case weight, while original disability compensation claims with eight or more issues receive multiple case weights. Those claims that are generally less complex, such as review examinations, receive a half-case weight.

In determining the appropriate standard, the following assumptions were used:

- Seventy percent of an RVSR's time is spent producing rating decisions. It is expected that journey-level RVSRs will produce three weighted cases during this portion of their day.
- Seventeen percent of an RVSR's time is spent requesting medical examinations and directing claims development.
- Thirteen percent of an RVSR's time is spent consulting other RVSRs and Decision Review Officers and performing miscellaneous administrative duties.

Question 8: Given the continuing increase in the backlog of claims, what steps have been taken to assure that seriously ill, homeless and financially destitute veterans are not irreparably harmed by a delay in adjudicating claims? How is this monitored?

Answer: Veterans who are terminally ill, homeless, or have been identified as being financially destitute are among those most in need of personalized services from VBA. Regional offices are required to identify these claims for priority handling, which includes frequent and personal contacts with the claimants and case management of their claims throughout the adjudicative process. Individuals, teams and managers monitor these special cases throughout the duration of the claim to ensure the claims receive expedited processing at each step of the claims process.

The Claims Processing Task Force recommended a new model for processing claims that involves specialized teams. This new model requires each regional office to establish a "Triage Team," responsible for analyzing all incoming claims as they are received. Through the triage process, we will ensure that claims for veterans who are seriously ill, homeless, and/or financially destitute are immediately identified. Those claims that require no further development will be completed within one to two workdays. Those that require development for additional evidence will be conspicuously flagged for special handling (both on the physical claims file and in our claims tracking systems). The new specialized team processing model is currently being tested in four regional offices. Nationwide implementation will begin immediately following completion of the test later in this fiscal year.

Question 9: Please provide an update on the status of the A-76 study for property management in the VA Home Loan Program.

Answer: VA's Property Management A-76 Cost Comparison Study is in the solicitation phase. The deadline for receipt of the proposals was October 3, 2001. The evaluation of the private proposals was completed in late January 2002. Currently we are projecting a tentative decision on the winner of the competition in April or May of 2002. Meeting this milestone will revolve around completing the final evaluation, making any necessary modifications to the Government's bid and having an independent review conducted.

Congressman Lane Evans

Question 1: During testimony, the Secretary identified, as a class, future improvements in the procurement and acquisition practice of VA and noted the efforts of the VA Task Force on this issue. Please send us the final report of the Task Force and provide an executive summary for the record.

Answer: The Procurement Reform Task Force Report is still under Department review. Once the review is completed and the Secretary has evaluated and made his final determinations regarding the report's findings and recommendations, we would be pleased to furnish copies of both the report and the Secretary's determinations.

Question 2: Please provide information concerning the end product quotas which have been assigned to regional offices for the months of October 2001 and February 2002, including:

Question 2(a): The quota for each regional office.

Answer: The attached excel spreadsheet provides the monthly quotas for October 2001 and February 2002 by regional office.

Question 2(b): The manner in which the quotas were determined.

Answer: Rating output quotas were established through a systematic process. The steps involved in developing targets at the station level are outlined below.

Step 1—Projections for the number of rating-related end products to be completed at the national level each month were developed based on several factors. These factors include the targeted end-of-year inventory of 315,000 pending ratings; the number of available work hours per Rating Veterans Service Representative (RVSR); and the number of RVSRs at each regional office and their experience levels. A production factor was applied for each RVSR based on experience level, with factors for 0 to 6 months, 6 months to 1 year, 1 year to 3 years, and more than 3 years experience.

Step 2—Each station's share of the monthly rating production requirement was calculated based on its share of the national productive capacity for rating-related end products during calendar year 2001. This percentage was applied against each month's projection for ratings completed in order to arrive at monthly targets for rating-related end products.

Question 2(c): The number and category of full-time employees at each regional office responsible for training, supervision and adjudication of claims;

Answer: The attached data sheet provides the number of employees assigned to the Veterans Service Center in each regional office as of February 2002. Regional office directors are responsible for effectively allocating their Veterans Service Center resources within the guidelines prescribed by VBA headquarters. The specific breakdown of supervisors and trainers is dependent upon the size of the station and varies based on local training and supervisory requirements.

Question 2(d): The number and category of FTE at each regional office who are in training status.

Answer: The attached spreadsheet provides a breakdown of the number of RVSRs at each regional office and experience levels as of February 2002. This data was used in determining each regional office's rating production target.

Question 2(e): The number of claims and/or the amount of time that trainers, coaches or other supervisors and Decision Review Officers (DRO) are expected to produce in order to meet the regional offices' quota of end products.

Attachment - Congressman Evans - Question 2(a)

VBA Monthly Production Targets
Rating Related Claims

	Oct-01	Feb-02
USA	56,684	57,555
Boston Regional Office	685	762
Providence Regional Office	286	268
New York Regional Office	1,038	1,451
Buffalo Regional Office	794	895
Hartford Regional Office	327	364
Manchester Regional Office	223	299
Togus VAMROC	462	455
White River Junction VAMROC	128	158
Newark Regional Office	876	666
Philadelphia Regional Office	1,080	1,026
Pittsburgh Regional Office	690	986
Cleveland Regional Office	1,475	1,147
Indianapolis Regional Office	769	850
Detroit Regional Office	1,005	1,082
Wilmington VAMROC	80	111
Baltimore Regional Office	800	668
Roanoke Regional Office	1,860	1,699
Huntington Regional Office	531	581
Louisville Regional Office	1,200	810
Washington Regional Office	608	406
Atlanta Regional Office	2,000	2,152
Winston-Salem Regional Office	2,159	2,274
Columbia Regional Office	920	1,256
Nashville Regional Office	1,493	1,545
St. Petersburg Regional Office	3,821	4,473
Montgomery Regional Office	1,500	1,333
Jackson Regional Office	925	975
San Juan Regional Office	648	760
Chicago Regional Office	1,312	1,674
Milwaukee Regional Office	900	987
St. Louis Regional Office	1,330	1,071
Des Moines Regional Office	408	480
Lincoln Regional Office	520	506
St. Paul Regional Office	1,120	786
Fargo VAMROC	244	232
Sioux Falls VAMROC	265	248
Wichita VAMROC	490	524
New Orleans Regional Office	1,320	1,258
Waco Regional Office	3,450	2,888
Little Rock Regional Office	849	883
Muskogee Regional Office	1,500	1,508
Houston Regional Office	1,907	2,036
Denver Regional Office	1,150	1,278
Albuquerque Regional Office	629	545
Salt Lake City Regional Office	306	304
Seattle Regional Office	1,700	1,418
Boise Regional Office	370	381
Portland Regional Office	1,100	829
Fort Harrison VAMROC	251	333
Anchorage VAMROC	300	191
Oakland Regional Office	1,734	1,861
Los Angeles Regional Office	1,309	1,855
Phoenix Regional Office	1,026	1,423
Reno Regional Office	529	489
Manila Regional Office	807	668
San Diego Regional Office	1,139	1,065
Honolulu VAMROC	336	383

Prepared by OFO
~dm3151

Fiscal Year 2002

ACTUAL STAFFING LEVELS BY PROGRAM CODE

Pay period 02

Station	VBA TOTAL	Veterans Serv Centers	Resource Centers	Education	Loan Guaranty	VR&E	Insurance	Executive Direction	Field ADP	Support Services	Human Resources	Social Security
All Field Stations .	11925.7	6905.7	379.8	709.1	1054.5	848.2	401.8	242.4	249	934.3	171.9	29
SDN 1	964.9	571	15	153	37.8	67.6	0	27.4	23.2	63.9	6	0
Boston MA	120.8	91.7	0	...	0	15.1	...	3	2	8	1	...
Buffalo NY	304.4	108.6	0	153	3.8	7.4	...	6	5	18.6	2	...
Hartford CT	68.4	51.4	0	...	0	7	...	3	2	4	1	...
Manchester NH ...	82.5	33	0	...	33	5.5	...	4.4	2	4.6	0	...
New York NY	238.3	178.4	0	...	1	19	...	6	7.2	24.7	2	...
Providence RI ...	55.6	41	0	...	0	5.6	...	3	2	4	0	...
Togus ME	73.9	49.9	15	...	0	5	...	2	2	...	0	...
White River Jct. VT	21	17	0	...	0	3	...	0	1	...	0	...
	1806.9	871.1	110	0	136.4	85	401.8	33	30.6	124	15	0
Cleveland OH	428.4	234.9	42	...	84.6	20.5	...	6	9	27.4	4	...
Detroit MI	189.5	140	0	...	10	12.5	...	5	4	16	2	...
Indianapolis IN ..	161	102.2	0	...	22.8	15	...	5	3	12	1	...
Newark NJ	126.7	92.7	0	...	8	9	...	5	2	9	1	...
Philadelphia PA ..	736.8	170.4	68	...	7	18	401.8	8	9	48.6	6	...
Pittsburgh PA ...	138.2	108.6	0	...	4	6	...	4	3.6	11	1	...
Wilmington DE ...	26.3	22.3	0	...	0	4	...	0	0	...	0	...
	916.4	567.1	25	0	137.1	80.5	0	21	20	58.7	7	0
Baltimore MD	127.8	92.8	0	...	8	12	...	4	4	6	1	...
Huntington WV ...	123.1	76.6	25	...	1	7.5	...	3	2	7	1	...
Louisville KY ...	141.6	108.6	0	...	4	14	...	3	4	6	2	...
Roanoke VA	366.1	193.2	0	...	107.9	26	...	6	7	25	1	...
Washington DC ...	157.8	95.9	0	...	16.2	21	...	5	3	14.7	2	...
	1293.3	773.5	18	176.6	137.2	83	0	22	23	52	8	0
Atlanta GA	526.1	194.2	0	176.6	89.6	22	...	7	10	22.7	4	...
Columbia SC	190.8	123	18	...	3.8	20	...	6	4	15	1	...
Nashville TN	231.2	188.2	0	...	6	23	...	5	4	3	2	...
Winston Salem NC ..	345.2	268.1	0	...	37.8	18	...	4	5	11.3	1	...
	1249.1	860.0	19	0	110.7	101.9	0	22	15	111.7	8	0
Jackson MS	148.6	106.2	0	...	6.4	7	...	4	5	19	1	...
Montgomery AL ...	244.8	171.3	0	...	5	40	...	6	5	15.5	2	...
San Juan PR	158.1	118.7	0	...	7.4	11	...	4	3	12	2	...
St. Petersburg FL .	697.6	464.6	19	...	91.9	43.9	...	8	2	65.2	3	...
	1359.5	732.4	126.8	162.1	94.7	89.5	0	30	21.3	92.7	10	0

Fiscal Year 2002

ACTUAL STAFFING LEVELS BY PROGRAM CODE

Pay period 02

Station	VBA TOTAL	Veterans Serv Centers	Resource Centers	Education	Loan Guaranty	VR&E	Insurance	Executive Direction	Field ADP	Support Services	Human Resources	Social Security
Chicago IL	226.7	172.7	0	...	7	21	...	5	4	15	2	...
Des Moines IA ...	80.3	53.1	0	...	3	9.9	...	4	2	7.3	1	...
Fargo ND	35	30	0	...	0	5	...	0	0	...	0	...
Lincoln NE	79.8	61.4	0	...	2.4	6	...	2	2	5	1	...
Milwaukee WI	195.8	108.1	49.8	...	3.9	15.6	...	4	4	8.4	2	...
Sioux Falls SD ...	34	31	0	...	0	3	...	0	0	...	0	...
St. Louis MO	367.3	126.9	19	162.1	8	14	...	8	7.3	21	2	...
St. Paul MN	268	91	58	...	67	9	...	5	0	36	2	...
Wichita KS	72.6	59.2	0	...	3.4	6	...	2	2	...	0	...
	1719.9	1019.5	25	217.4	127.9	117.6	0	26	30	142.5	14	0
Houston TX	432.6	242.1	0	...	100.9	43.6	...	5	7	30	4	...
Little Rock AR ...	154.2	120	0	...	3.2	10	...	4	2	13	2	...
Muskogee OK	482.7	156.8	25	217.4	5	16	...	6	7	46.5	3	...
New Orleans LA ...	194.2	146.2	0	...	6	14	...	5	4	17	2	...
Waco TX	456.2	354.4	0	...	12.8	34	...	6	10	36	3	...
	980	931.1	18	0	95	120	0	25	21	60.9	9	0
Albuquerque NM ...	86.6	65	0	...	3.6	9	...	2	2	4	1	...
Anchorage AK	36.8	26.8	0	...	2	7	...	1	0	...	0	...
Boise ID	52	37	0	...	5	0	...	1	2	6	1	...
Denver CO	260.8	139	0	...	65.8	25	...	6	6	16	3	...
Ft. Harrison MT ..	46.7	37.7	0	...	0	9	...	0	0	...	0	...
Portland OR	161.9	114	0	...	3	23	...	5	3	12.9	1	...
Salt Lake City UT .	63	36.6	0	...	3.4	11	...	3	2	6	1	...
Seattle WA	272.2	176	18	...	12.2	36	...	7	6	16	2	...
	1391.5	670.2	23	0	177.7	103.1	0	36	20	110.5	13	29
Honolulu HI	71	48	0	...	6	15	...	2	0	...	0	...
Los Angeles CA ...	309.6	207	0	...	39.8	17	...	8	7	27.8	3	...
Manila RP	141	86	...	...	0	2	...	5	0	18	1	29
Oakland CA	285.9	205.5	0	...	16.9	20.8	...	7	8	26.7	1	...
Phoenix AZ	296.7	133.1	0	...	107.6	25	...	6	4	17	4	...
Reno NV	74.4	56.4	0	...	0	7	...	3	1	6	1	...
San Diego CA	212.9	143.2	23	...	7.4	16.3	...	5	0	15	3	...

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Attachment - Congressman Evans - Question 2(d)

PP Number 02	Total RVSRs	Number RVSRs < 6 Mos	Number RVSRs 6-12 Mos.	Number RVSRs 1-2 Yrs.	Number RVSRs > 2 Yrs.	Number DROs
National	**1,752.5**	**145.0**	**477.9**	**265.0**	**864.6**	**222.0**
Regional Offices	**1,607.5**	**141.0**	**420.9**	**225.0**	**820.6**	**220.0**
Boston	21.0	0.0	8.0	0.0	13.0	4.0
Providence	10.0	1.0	2.0	0.0	7.0	2.0
New York	42.7	11.0	1.0	3.0	27.7	6.0
Buffalo	25.0	0.0	4.0	3.0	18.0	4.0
Hartford	11.0	0.0	1.0	5.0	5.0	3.0
Manchester	9.0	0.0	2.0	1.0	6.0	1.0
Togus	11.0	0.0	2.0	4.0	5.0	2.0
White River Jct.	4.0	0.0	0.0	2.0	2.0	1.0
Newark	20.0	3.0	6.0	1.0	10.0	2.0
Philadelphia	30.9	7.0	6.0	8.0	9.9	8.0
Pittsburgh	21.9	2.0	4.9	0.0	15.0	5.0
Cleveland	47.5	23.0	8.0	7.0	9.5	7.0
Indianapolis	22.8	3.0	4.0	5.0	10.8	3.0
Detroit	23.8	6.0	1.0	2.0	14.8	4.0
Wilmington	3.0	0.0	2.0	0.0	1.0	1.0
Baltimore	19.0	2.0	3.0	5.0	9.0	3.0
Roanoke	37.0	2.0	2.0	8.0	25.0	6.0
Huntington	18.0	0.0	11.0	0.0	7.0	3.0
Louisville	25.0	0.0	2.0	6.0	17.0	3.0
Washington	21.0	0.0	2.0	5.0	14.0	4.0
SRA Huntington	5.0	0.0	0.0	0.0	5.0	0.0
Atlanta	57.0	0.0	17.0	2.0	38.0	5.0
Winston-Salem	71.7	5.0	34.0	2.0	30.7	4.0
Columbia	24.0	0.0	10.0	2.0	12.0	2.0
Nashville	47.5	9.0	9.0	9.0	20.5	6.0
St. Petersburg	110.0	3.0	26.0	17.0	64.0	11.0
Montgomery	34.0	7.0	2.0	6.0	19.0	4.0
Jackson	24.0	0.0	6.0	5.0	13.0	3.0
San Juan	30.0	0.0	11.0	6.0	13.0	5.0
Milwaukee	22.0	2.0	7.0	0.0	13.0	2.0
St. Louis	29.6	0.0	6.0	5.0	18.6	5.0
Des Moines	13.0	1.0	3.0	4.0	5.0	2.0
Lincoln	15.2	3.0	6.0	0.0	6.2	2.0
St. Paul	17.0	1.0	4.0	2.0	10.0	1.0
Fargo	8.0	2.0	4.0	1.0	1.0	1.0
Sioux Falls	9.0	3.0	3.0	1.0	2.0	1.0
Wichita	12.0	0.0	6.0	0.0	6.0	2.0

PP Number 02	Total RVSRs	Number RVSRs < 6 Mos	Number RVSRs 6-12 Mos.	Number RVSRs 1-2 Yrs.	Number RVSRs > 2 Yrs.	Number DROs
New Orleans	21.0	1.0	0.0	6.0	14.0	4.0
Waco	80.5	13.0	14.0	15.0	38.5	13.0
Little Rock	26.0	0.0	12.0	3.0	11.0	3.0
Muskogee	45.0	0.0	2.0	21.0	22.0	3.0
Houston	45.0	0.0	7.0	6.0	32.0	10.0
SRA St.Louis RMC	1.0	0.0	0.0	0.0	1.0	
Denver	36.0	1.0	11.0	3.0	21.0	4.0
Albuquerque	17.0	0.0	6.0	7.0	4.0	3.0
Salt Lake City	6.0	0.0	2.0	2.0	2.0	2.0
Seattle	43.0	2.0	17.0	3.0	21.0	6.0
Boise	9.0	0.0	3.0	0.0	6.0	2.0
Portland	24.0	0.0	6.0	1.0	17.0	3.0
Ft.Harrison	9.0	1.0	1.0	2.0	5.0	2.0
Anchorage	3.0	2.0	0.0	0.0	1.0	1.0
Oakland	71.0	22.0	21.0	1.0	27.0	5.0
Los Angeles	62.0	0.0	25.0	16.0	21.0	9.0
Phoenix	38.6	0.0	17.0	7.0	14.6	4.0
Reno	12.0	2.0	2.0	2.0	6.0	2.0
Manila	13.0	0.0	8.0	0.0	5.0	2.0
San Diego	37.0	0.0	23.0	1.0	13.0	8.0
Honolulu	10.0	0.0	5.0	2.0	3.0	2.0

Tiger Team/SRCs	145.0	4.0	57.0	40.0	44.0	2.0
Togus	9.0	0.0	8.0	0.0	1.0	0.0
Phila.	16.0	3.0	11.0	2.0	0.0	0.0
Huntington	10.0	0.0	9.0	0.0	1.0	0.0
Columbia	13.0	0.0	11.0	0.0	2.0	0.0
St.Pete	12.0	0.0	0.0	12.0	0.0	2.0
St.Louis	14.0	0.0	7.0	0.0	7.0	0.0
Muskogee	19.0	0.0	1.0	16.0	2.0	0.0
Seattle	13.0	0.0	3.0	0.0	10.0	0.0
San Diego	18.0	0.0	6.0	8.0	4.0	0.0
TT Cleveland	21.0	1.0	1.0	2.0	17.0	0.0

Answer: Neither supervisors nor DROs were considered in establishing rating output targets for regional offices. Output targets are based on the numbers of RVSRs in each regional office and their experience levels.

Question 3: How is proper supervision and training being provided to the large number of trainees currently employed while supervisors and trainers are being required to spend a significant amount of time performing work associated with adjudicating claims?

Answer: Please see the response to question 2 above, along with the spreadsheet on trainees and FTE.

Attachment - Congressman Evans - Question 3

Challenge 2001: Centralized Training
VSR Trainees by Regional Office

	Class April 2, 2001	Class July 30, 2001	Total
USA	**241**	**541**	**782**
Boston Regional Office	0	4	**4**
Providence Regional Office	3	1	**4**
New York Regional Office	0	18	**18**
Buffalo Regional Office	0	12	**12**
Hartford Regional Office	0	0	**0**
Manchester Regional Office	0	1	**1**
Togus VAMROC	10	0	**10**
White River Junction VAMROC	0	3	**3**
Newark Regional Office	4	8	**12**
Philadelphia Regional Office	29	30	**59**
Pittsburgh Regional Office	0	14	**14**
Cleveland Regional Office	10	30	**40**
Indianapolis Regional Office	2	11	**13**
Detroit Regional Office	0	13	**13**
Wilmington VAMROC	0	5	**5**
Baltimore Regional Office	3	19	**22**
Roanoke Regional Office	0	13	**13**
Huntington Regional Office	5	10	**15**
Louisville Regional Office	3	3	**6**
Washington Regional Office	1	3	**4**
Atlanta Regional Office	5	4	**9**
Winston-Salem Regional Office	0	13	**13**
Columbia Regional Office	0	11	**11**
Nashville Regional Office	4	14	**18**
St. Petersburg Regional Office	25	13	**38**
Montgomery Regional Office	3	14	**17**
Jackson Regional Office	14	2	**16**
San Juan Regional Office	0	0	**0**
Chicago Regional Office	8	15	**23**
Milwaukee Regional Office	2	8	**10**
St. Louis Regional Office	15	5	**20**
Des Moines Regional Office	6	6	**12**
Lincoln Regional Office	1	7	**8**
St. Paul Regional Office	0	18	**18**
Fargo VAMROC	0	5	**5**
Sioux Falls VAMROC	0	3	**3**
Wichita VAMROC	0	10	**10**
New Orleans Regional Office	2	23	**25**
Waco Regional Office	8	14	**22**
Little Rock Regional Office	0	13	**13**
Muskogee Regional Office	27	12	**39**
Houston Regional Office	8	26	**34**
Denver	1	12	**13**
Albuquerque Regional Office	0	4	**4**
Salt Lake City Regional Office	1	5	**6**
Seattle Regional Office	11	26	**37**
Boise Regional Office	0	7	**7**
Portland Regional Office	7	4	**11**
Fort Harrison VAMROC	0	5	**5**
Anchorage VAMROC	0	6	**6**
Oakland Regional Office	14	9	**23**
Los Angeles Regional Office	0	9	**9**
Phoenix Regional Office	0	10	**10**
Reno Regional Office	0	3	**3**
Manila Regional Office	0	0	**0**
San Diego Regional Office	9	2	**11**
Honolulu VAMROC	0	5	**5**

Question 4: Some offices report a significant lack of employees with the subject matter expertise to provide a second signature on ratings. Has any analysis been done of the subject matter expertise of personnel in regional offices? If so, please provide a copy of the analysis.

Answer: At least 2 full years of experience in the RVSR position is required to become proficient in most aspects of disability claims evaluations. At present, only one-half of VBA's rating staff meets this experience level. An additional 265 RVSRs (15 percent) have between 1 and 2 years experience in the RVSR position, and 623 RVSRs (35 percent) have less than 1 year on the job. (See response to question 2 above, along with the spreadsheet on FTE and experience levels.)

There are no specific, standardized criteria, such as years of experience or hours of training that determines whether an employee is granted or denied second signature authority on ratings. While such factors are considered, the assessment of the employee's personal qualifications by station management is the basis for the decision.

Question 5: A large number of employees have been hired over the past two years. Please provide information concerning the number of persons who have been added to each regional office and the number of those who have left VA employment.

Answer: Information on the gains and losses at each regional office is provided in the following spreadsheet. Not included in the data are those employees hired after the beginning of the fiscal year whose employment terminated before the end of the same fiscal year. Our actual attrition rate is therefore somewhat higher than the numbers reflected in the spreadsheet.

VBA's attrition rate was approximately 8 percent of the average employment level in FY 2001 and we project a similar rate in FY 2002. To combat this reduction in the workforce, VBA increased the number of decision-makers across the board by 10 percent. VBA expects to lose about 450 FTE over the next 7 months of this fiscal year. We are currently recruiting approximately 350 FTE who should be hired in the second quarter. VBA plans to recruit an additional 50 FTE in the third quarter. The recruitment in the third quarter will be adjusted based on the actual attrition rate.

STATION	STATION LOCATION	LOSSES 2000	2000 Gains	Net Gains / Losses (-)	LOSSES 2001	2001 Gains	Net Gains / Losses (-)
101	Washington, DC	50	58	8	49	73	24
201	Hines, IL	1	0	-1	1	0	-1
282	Hines, IL	8	1	-7	11	3	-8
283	Hines, IL	4	1	-3	9	3	-6
284	Philadelphia, PA	3	0	-3	7	2	-5
301	Boston, MA	7	15	8	6	15	9
304	Providence, RI	7	2	-5	1	9	8
306	New York, NY	25	21	-4	18	34	16
307	Buffalo, NY	15	42	27	20	65	45
308	Hartford, CT	4	6	2	4	11	7
309	Newark, NJ	23	10	-13	13	20	7
310	Philadelphia, PA	61	39	-22	24	109	85
311	Pittsburgh, PA	4	8	4	8	18	10
313	Baltimore, MD	24	16	-8	12	35	23
314	Roanoke, VA	24	37	13	16	47	31
315	Huntington, WV	3	13	10	8	26	18
316	Atlanta, GA	61	81	20	43	98	55
317	St. Petersburg, FL	58	96	38	30	162	132
318	Winston-Salem, NC	28	55	27	21	70	49
319	Columbia, SC	18	26	8	20	44	24
320	Nashville, TN	38	34	-4	14	43	29
321	New Orleans, LA	20	40	20	16	36	20
322	Montgomery, AL	18	28	10	7	46	39
323	Jackson, MS	12	10	-2	4	30	26
325	Cleveland, OH	42	28	-14	39	108	69
326	Indianapolis, IN	25	16	-9	7	27	20
327	Louisville, KY	14	17	3	13	20	7
328	Chicago, IL	20	20	0	10	41	31
329	Detroit, MI	23	8	-15	12	16	4
330	Milwaukee, WI	11	5	-6	9	36	27
331	St. Louis, MO	28	20	-8	18	51	33
333	Des Moines, IA	13	6	-7	8	18	10
334	Lincoln, NE	8	10	2	3	15	12
335	St. Paul, MN	51	19	-32	16	27	11
339	Denver, CO	37	46	9	20	44	24
340	Albuquerque, NM	9	23	14	4	19	15
341	Salt Lake City, UT	9	9	0	6	11	5
343	Oakland, CA	38	20	-18	29	42	13
344	Los Angeles, CA	58	5	-53	26	55	29
345	Phoenix, AZ	24	48	24	15	59	44
346	Seattle, WA	20	27	7	18	73	55
347	Boise, ID	3	6	3	3	10	7

STATION	STATION LOCATION	LOSSES 2000	2000 Gains	Net Gains / Losses (-)	LOSSES 2001	2001 Gains	Net Gains / Losses (+)
348	Portland, OR	14	33	19	8	41	33
349	WACO, TX	28	33	5	23	69	46
350	Little Rock, AR	15	20	5	6	25	19
351	Muskogee, OK	35	48	13	35	127	92
354	Reno, NV	9	18	9	5	14	9
355	San Juan, PR	13	26	13	5	16	11
358	Manila, Philippines	1	1	0	2	1	-1
362	Houston, TX	51	51	0	19	62	43
372	Washington, DC	17	10	-7	21	28	7
373	Manchester, NH	6	4	-2	6	4	-2
376	St. Louis, MO	21	23	2	12	53	41
377	San Diego, CA	13	29	16	15	52	37
392	Baltimore, MD (HR Center)	3	2	-1	1	4	3
393	Jackson, MS (HR Center)	6	1	-5	3	11	8
394	Detroit, MI (HR Center)	3	0	-3	3	9	6
395	Western HR Center	1	1	0	1	6	5
402	Togus, ME	3	3	0	0	11	11
405	White River Ju, VT	1	0	-1	0	1	1
436	Fort Harrison, MT	4	9	5	4	9	5
437	Fargo, ND	0	1	1	3	2	-1
438	Sioux Falls, SD	3	2	-1	2	4	2
452	Wichita, KS	5	6	1	10	12	2
459	Honolulu, HI	1	2	1	5	6	1
460	Wilmington, DE	2	4	2	2	4	2
463	Anchorage, AK	2	5	3	2	3	1
	Total	**1,206**	**1,304**	**98**	**811**	**2,245**	**1434**

Question 6: Is there any plan to reduce staffing at regional offices below current levels?

Answer: The VA Claims Processing Task Force recommended that VBA allocate new staffing resources to high-performing and high-quality regional offices. This recommendation was made in the context of the apparent random hiring that occurred during FY 2000 – 2001. The Task Force report specifically identified the need to have an integrated and well-understood hiring strategy based on workload, efficiency, and demonstrated need.

As recommended by the Task Force, VBA revised its resource allocation model. The focus is to have a cohesive strategy for getting resources to the stations that can most effectively address VA's national workload challenges. The FY 2002 resource distribution model developed by VBA added a factor to address productivity as recommended by the Task Force. The productivity factor takes into account how effectively stations utilize their resources. The FY 2002 model also changed the weighting factor, consistent with the Task Force recommendations, and allocated resources toward the Secretary's priorities. These include VBA's Tiger Team and Pension Maintenance consolidation initiatives.

FY 2001		FY 2002	
Factor	Weight %	Factor	Weight %
Received Workload	45	Received Workload	43
Accuracy*	20	Production/Accuracy	30
Pending Workload	10	Pending Workload	5
Appeals Workload	10	Appeals Workload	5
Training	10	Training	10
Outreach	5	Special Missions**	7

* Stations were provided resources based on poor quality, in an effort to improve that quality. FY 2002 amended to provide resources based on high quality.

**Tiger Team, Pension Maintenance Centers, and other.

While FY 2002 resource allocation provided for any new staffing resources to high-performing stations, no station was required to terminate any employee in support of resource re-distribution.

The FY 2002 model also allocated resources to support the accomplishment of the Secretary's priorities, which resulted in staffing allocations for VBA's Tiger Team, the Resource Centers, and the Pension Maintenance Centers. All of these initiatives provide additional support to offices experiencing workload difficulties.

Question 7: The budget provides for increased sample size for reviewing regional office accuracy at the six poorest performing offices and the four largest offices. How will poor performance be determined? Will reversal rates from the Board of Veterans Appeals be considered in determining accuracy?

Answer: Performance for accuracy purposes is determined based on prior year Systematic Technical Accuracy Review (STAR) data. Performance ranking is specific to the review category. For example, a station may rank among the six poorest performing stations for rating-related end product reviews, but not for authorization end product reviews. Therefore, the six poorest performing stations for rating reviews may be entirely different than the six for authorization reviews.

Reversal rates from BVA (BVA allowance rates) will not be used in determining accuracy. Instead, accuracy will be determined based on the results of national STAR reviews that randomly sample adjudication claims. BVA allowance rates reflect significant variables including submission of additional evidence, de novo review authority of the Board of Veterans' Appeals, and the filter of regional office appeal processing.

Question 8: In determining the timeliness of claims processing, what consideration is given to such factors as claims filed at separation versus claims originally filed many years after service, the need for extensive development, such as verification of combat

experiences at the Center for Unit Records Research or the total number of issues claimed? What controls are in place to assure that appeals are not categorized as requests for increase and that multiple decisions are not being made on the same issue several times a year?

Answer: The measures for timeliness of claims processing are derived based on the average for all claims filed within certain categories, such as original or reopened compensation or pension claims. We recognize that some variance in regional office processing times can result from differences in the composition of the workload, including factors such as the volume of predischarge claims, total number of issues claimed, volume of PTSD claims requiring stressor verification, etc. Limitations of our current Benefits Delivery and Work Measurement Systems do not allow us to consider all of these factors in our timeliness measures. However, we continue to analyze all of the factors that affect our ability to provide timely decisions and look for ways to minimize the cycle times at each regional office.

All veterans' appeals are entered and tracked through the Veterans Appeals Control and Locator System (VACOLS). This system is jointly used and shared by all VA regional offices and the Board of Veterans' Appeals. Using this system, appellate cases are clearly distinguished from claims for increased benefits or reopened claims that were previously denied.

Question 9: Please describe in detail how VBA has implemented the quality assurance provisions in section 801 of Public Law 106-117. In particular, please provide information concerning any changes made since October 1, 2000, to the Statistical Technical Accuracy Review (STAR) program, including the criteria for determining errors, the number of claims reviewed and any trends identified in errors.

Answer: VBA revised the STAR quality assurance review to assess regional office accuracy based on the results of national reviews conducted by independent staff in the C&P Service. This staff does not process claims and is not organizationally responsible for claims processing in the regional offices. GAO conducted a follow-up review and confirmed that this procedure does indeed comply with required standards of segregation of duties and organizational independence.

The cited public law also stipulated a provision that requires sufficient staffing to accomplish the required quality review function. With the expansion of the national review to assess regional office accuracy, authorized staffing for the review process was increased from 9 to 18 full-time reviewers.

As required by this public law, an annual report to Congress has been prepared.

The STAR review process was revised effective in FY 2002 to provide regional office accuracy results based on national reviews and to redefine claims processing errors based on benefit entitlement determinations. To independently assess regional office accuracy, the sample size for national review was increased by over 11,000 cases for rating and authorization reviews (from 6,300 to 17,640). This revised sample provides adequate sample size to assess regional office accuracy as well as new processing organizations including the Tiger Team, Pension Maintenance Centers, and Resource Centers.

The VA Claims Processing Task Force, in its October 2001 Report to the Secretary of Veterans Affairs, recommended the redefinition of claims processing errors to errors that affect entitlement, amount of benefit, and effective date. Those changes have been implemented in the STAR review process for FY 2002. Beginning with reviews of work completed in FY 2002, accuracy rate will be based on "benefit entitlement" processing elements including: addressing all issues; VCAA compliant claims development; correct decisions; and correct payment dates. This core accuracy measurement will be recorded on VBA's balanced scorecard and will be the official accuracy rate for compensation and pension claims processing.

During FY 2001, we achieved significant improvement in accuracy. We consider this improvement a significant and very positive result reflecting our quality-related initiatives. While improvement was documented in all processing areas, notification accuracy was the single most significant factor, with an overall improvement from 81 percent to 93 percent. We addressed notification problems via training bulletins, broadcast information, and individual office reminders. We also developed improved notification letter support software and modified our policy, adopting a notification package approach that includes enclosure of the rating decision to provide the required summary of evidence considered and explanation of the decision.

Question 10: Please provide a copy of the regional office and veterans service center managers' performance plan for fiscal year 2002.

Answer: The following is a copy of the regional office directors' performance standards for FY 2002. The directors are responsible for developing local standards for their Veterans Service Center managers, in line with and supporting the directors' standards. VBA reviews the appropriateness of the Service Center Managers' standards as part of the on-site surveys of regional office operations.

Regional Office Directors
Performance Appraisal Plan for FY 2002

I. Service Delivery (Critical Element):

The executive leads his or her station in the pursuit of optimum performance in all applicable program areas. Appropriate emphasis is placed on the Secretary for Veterans Affairs and Under Secretary for Benefits priorities assuring that those priorities are reflected in station performance. In addition, through efficient and effective management, ensures that benefits/services are provided in a timely, objective manner with respect to speed, accuracy, customer satisfaction, and employee development. Evidence of this leadership will be observable in terms of performance against scorecard targets and goals. The executive assures that national policy and procedural changes are expeditiously distributed, accurately communicated and effectively implemented. Directs and documents actions taken to sustain sound quality assurance programs, workload management processes, and internal control systems to effectively oversee work accomplishments and minimize risks in all program areas.

The Director is also responsible for ensuring that programs and policies are implemented, assessed through an effective internal control process, and adjusted as necessary to achieve appropriate results.

A failure to meet any of the following sub-elements means that the Director will be required to submit compelling mitigating reasons why the sub-element was not met and to identify those actions that are being taken to achieve the standard set in the sub-element. The Rater will have the discretion to determine if the Director meets that sub-element based on management actions taken rather than on actual performance achieved.

A. Achieve Monthly Rating Production Goals

The station will meet monthly Ratings Production goals in either:

Nine out of the 12 months.

Overall average monthly production meets or exceeds goal.

B. Improve the Timeliness of Rating End Products Completed

1. The station will meet the following targets for average days to completion for the EPs 010, 110, 020, 180, and 140. The target is cumulative FYTD. Each station will improve a specified percentage based on their performance relative to national performance as reflected in the following table.

Relationship to FY 01 performance	Percent to improve
Station performance is more than 120% of FY 01 national performance	15% from FY 01 performance
Station performance is equal to or up to 120% of FY 01 national performance	10% from FY 01 performance
Station performance is 85% of or equal to FY 01 national performance	5% from FY 01 performance
Station performance is better than 85% of FY 01 national performance	Maintain FY 01 performance

Example:

End Product	FY 01 National Performance	FY 01 RO Performance	Target
010	244.0	381.8	324.5
110	242.1	249.7	224.8
020	202.1	171.0	171.0
180	142.1	140.4	133.4
140	152.3	177.8	160.1

2. In order to achieve processing timeliness improvements in these and other types of claims, each station must improve the cycle times of claims processing. To achieve this, stations must adhere to Inventory Management System practices and policy. This includes establishing current, accurate, and complete CAPS records. Specific improvement must be demonstrated in reducing cycle times in the following areas: development time, rating time, and authorization time.

3. In addition to reducing the cycle times identified in sub-element I.B.2, a specific standard is established for the time it takes to establish (CEST) a claim. This is commonly referred to as the control time or delay time. 70% of claims established after December 1, 2001, must be established within 7 days. A weighted average of the claims establishment times for pending end products 010, 110, 020, 180, and 140 will be used to determine if this sub-element is met.

C. Reduce Total C&P Cases Pending Over Six Months

In order to reduce the percentage of cases pending over 6 months (as reflected in the Monday Morning Workload Report), stations will achieve the improvements reflected in the following table:

End of FY 01 Percent pending over 6 Months	Target
Over 50%	5 Point improvement
40% to 50%	4 Point improvement
30% to 40%	3 Point improvement
20% to 30%	2 Point improvement
Below 20%	1 Point improvement

D. Reduce the Pending Inventory of C&P Claims

The station will reduce the number of Ratings and Authorization cases pending at the station (from the beginning of FY 2002 as reflected in the Monday Morning Workload Report). Specific station targets are set that will bring the inventory of rating related cases down to at least 315,586 by the end of the rating period. Additionally, authorization cases will be reduced by at least 20%. Specific station targets for both Rating and Authorization cases are attached.

E. Reduce Inventory of Appeals and Achieve Improvement in Remand Timeliness

The station will reduced the total number of pending appeals as measured on the Monday Morning Workload Report (total appeals pending adjudicative action) by 10%.

The station will achieve a 10% improvement in the average number of days a remand is pending.

F. Achieve established Balanced Scorecard Targets

METHOD. At the beginning of each fiscal year, targets or goals are established for balanced scorecard performance at the national and station levels. Station targets will be individual and will take into account current performance levels, strengths, and liabilities.

The executive's performance on this element will be determined by comparing the results of the station's scorecard with the station's corresponding goal, as well as the station's contribution to VBA's national scorecard. The following are the relative weights of the scorecards.

VBA	20%	(Targeted Number of the Scorecard's
Regional Office	80%	Weighted Score)

The executive must achieve a minimum level of 90% of the composite target.

G. SRC and RPO Functions

SRC Directors are required to meet the following monthly production targets either in nine of 12 months or the overall average of monthly production meets or exceeds the goal.

Monthly SRC Production Targets

	First Six Months [Cases]	Second Six Months [Cases]	Full Goal [Cases]
Togus	149.4	224.1	298.8
Philadelphia	249.0	373.5	498.0
Huntington	182.6	273.9	365.2
Columbia	249.0	373.5	498.0
St. Petersburg	282.2	423.3	564.4
St. Louis	232.4	348.6	464.8
Muskogee	282.2	423.3	564.4
Seattle	215.8	323.7	431.6
San Diego	315.4	473.1	630.8

RPO Directors will have an additional standard provided in January 2002.

H. Additional priorities as may be established by the Secretary for Veterans Affairs will also be used to evaluate performance in this element.

II. Organizational support/teamwork (critical element)

Content: the executive regularly participates in activities and projects intended to further the goals of VBA. These activities typically require the contribution of local resources. Examples include, but are not limited to:

- *Projects at the National Level*
- *Special Ad Hoc Efforts*

Method: The executive will be assigned projects during the course of the performance year. The executive and rater will agree on clear expectations for successful

completion of the project at the time of assignment. The size and quantity of these projects will be considered in light of the size of the executive's regional office.

Met Level. Performance is acceptable if the rater determines that completion of projects and innovations is substantially equal (or equivalent) to agreed upon expectations.

III. PROGRAM INTEGRITY (CRITICAL ELEMENT)

Content: The executive will lead his or her station to ensure compliance with VBA's program integrity directives.

The Director is responsible to ensure that program integrity initiatives and policies are implemented, assessed through an effective internal control process, and adjusted as necessary to achieve appropriate results.

Method: Adherence to IG Recommendations applicable to VAROs as outlined in VBA Letter 20-99-68

Adherence to VBA program integrity directives.

Met level—Performance will be satisfactory if all required program integrity safeguards are implemented, monitored and on-site reviews do not reveal critical flaws in oversight of program integrity issues.

IV. Workplace Responsibilities (Critical Element)

Content: The director assures a high quality of work life for all employees of the regional office. He or she:

- *Promotes and maintains an effective labor-management relations program.*
- *Creates and maintains a working environment that is free of discrimination and one that assures diversity in the workplace.*
- *Ensures that plans exist and are adequately implemented to recruit, train, retain, motivate, empower, and advance employees; and promotes the needs and goals of the individual and the organization.*
- *Provides a safe, healthy work environment*

Method: Indicators of performance in this element include performance management and recognition, employee development and training, EEO policy statement, EEO/Affirmative employment statistics, performance standards, physical plant enhancements, climate and employee satisfaction surveys.

Met Level: Performance is satisfactory if all required plans, programs, statement, and goals are established and maintained and if no more than two failures to meet a recognized VA or VBA standard are found

V. External Relations (non-critical element)

Content: The director builds effective, productive relationships with organizations external to VBA in order to further VA's goals and interests. Activities might include, but are not limited to:

- *Work on a Federal Executive Board project.*
- *Participation in VISN meetings.*
- *Relations with the media, congressional offices and service organizations.*

Met Level: Performance is acceptable if the rater finds substantial and meaningful evidence of active engagement with external organizations described in this element.

VI. Information Security (Non-critical)

Directors must exercise due diligence in their efforts to plan, develop, coordinate, and implement effective information security procedures as identified by the Office of Management and Budget (OMB), the National Institute of Standards and Technology, VA policies, and VBA policy and guidance documents.

Directors will have met their standard by:

- *Ensuring that Information System (IS) security plans that safeguard systems within their authority exist and are implemented in accordance with NIST and OMB guidelines.*
- *Ensuring that annual risk assessments are conducted for each identified IS (applications, hardware, software, etc.) within their jurisdiction to ensure that the identified risks, vulnerabilities, and threats are adequately addressed by appropriate security controls.*
- *Ensuring that all employees comply with departmental training requirements and are trained to understand their information security responsibilities.*

Attachment 1

How scores for Element I will be calculated

I. Service Delivery

A. Achieve Monthly Rating Production Goal

1. Data obtained from OFO intranet page (Rating Output Plans—Monthly Production Rating

B. Improve Timeliness of Rating End Products Completed

1. Average days to completion for EPs 010, 110, 120, 180, and 140. To ascertain FY 2001 performance for nation and individual stations, obtain data from DMO intranet page (DOOR Reports 1017, September 2001) or from the DMO intranet page (Ops Center, Scorecard Performance Reports, September 2001)

2. Data obtained from DMO intranet page Inventory Management Reports, IMS Summary Reports

C. Reduce Total C&P Cases Pending Over Six Months

To ascertain FY 2001 performance and current status, obtain data from DMO intranet page (Monday Morning Workload Report). FY 2001 report is October 2001 weekly report.

D. Reduce the Pending Inventory of C&P Claims

To ascertain FY 2001 performance and current status, obtain data from DMO intranet page (Monday Morning Workload Report). Data should be compared with Rating and Authorization inventory targets as contained in the attached spreadsheet.

E. Reduce the Number of Pending Remands and Improve the Timeliness of Pending Remands

Obtain data from C&P intranet page, Data and Reports, Appeals Reports, Appeals Pending. FY 2001 performance will be measured from September 2001 report.

F. Achieve Established Balance Scorecard Targets—Use DMO Intranet Page (Balanced Scorecard)

Use DMO Intranet Page (Balanced Scorecard)

As noted in the performance element itself, the composite percentage of goals reached is the "bottom-line" number on which this portion of the appraisal is based. It will be computed in the following way:

A percentage of goals reached is computed in the two segments, i.e., national and local. This is possible because each scorecard yields a "bottom line," a sum total of points earned. This is the Sum of the Weighted Scores. For each segment, the total points represented by the station or national goal are divided into the total earned points to yield the percentage of goal reached.

Each of the two percentages is multiplied by the appropriate weighting factor as follows:

Station	80%
National	20%

The resulting fractions are then added together. Their sum is the composite percentage of goals reached.

Please note that the goals themselves already represent achievement short of the individual program strategic objectives. Setting a standard for the composite percentage of goals reached of 90% allows for significant shortfalls over and above those already "built in" with the goals. On the other hand, if the station itself actually exceeded its goal, this overage would be credited toward the composite percentage of goals reached.

Question 11: Mr. Secretary, the increase proposed by the Administration for VA medical care has been touted as "historic". Would you say that's a fair description?

Answer: Yes, the increase in the direct appropriation when adjusted for the proposed transfer of the retirement liability is $1.414 billion, which is the largest Presidential increase ever proposed for the medical care program.

Question 12: Will these additional funds be enough to ensure that you are able to keep pace with inflation, maintain a system of open enrollment and ensure reasonably timely access to high-quality services to veterans?

Answer: The FY 2003 budget takes into consideration the following:

- A projected Medical CPIU inflation rate of 3.9 percent.
- Continued open enrollment based on the assumption that all projections, funding levels, and the new $1,500 cost-sharing deductible for Priority 7 veterans is realized.
- Continued efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics in medical centers nationwide.

The proposed $1,500 annual deductible for Priority 7 veterans, the recent increase in pharmacy co-payments, and the decrease in outpatient co-payments will allow VA's health care system to continue to deliver high-quality health care and remain financially sound and sustainable.

Question 13: I understand that in justifying its preliminary decision to restrict enrollment of Priority 7 veterans to those already enrolled in VA's health care system, VA identified for the Office of Management and Budget (OMB) a $600-800 million shortfall in funding for current services. First, I would like to request, Mr. Chairman, that any information that was provided to OMB be provided to the Committee and inserted in our hearing record. Second, presuming Congress provides a supplement of $142 million to cover the costs of continuing to keep Priority 7 veterans won't VA have to identify "management efficiencies" in the range of $500-600 million instead of the $300 million that it has previously discussed with Congress and the veterans' service organizations? How can VA hope to find these savings without seriously affecting clinical services?

Answer: Based on the continuation of full enrollment, VHA determined there would be a shortage of about $441 million in FY 2002. Approximately $300 million in management savings is anticipated in FY 2002. We expect that these savings will be generated from a multi-year effort to improve standardization and compliance in the procurement of equipment, pharmacy, and medical supplies. Other savings are expected from program efficiencies related to new criteria to assess community-based outpatient clinics and centrally managed programs. The balance of the FY 2002 shortfall, $142 million, associated with the continued enrollment of new priority 7 veterans, is anticipated as an FY 2002 supplemental.

Question 14: In FY 2003, VA also plans to identify an additional $316 million in "management efficiencies". After 6-7 years of serious reforms in its health care system, is there really still so much "fat" in the system that VA managers will be able to readily identify $600 million to $1 billion in "efficiencies" in the next two years? What is VA's plan for identifying and implementing such efficiencies?

Answer: Based on the continuation of full enrollment, VHA determined there would be a shortage of about $441 million in FY 2002. Approximately $300 million in management savings is anticipated in FY 2002. We expect that these savings will be generated from a multi-year effort to improve standardization and compliance in the procurement of equipment, pharmacy, and medical supplies. Other savings are expected from program efficiencies related to new criteria to assess community based outpatient clinics and centrally managed programs. The balance of the FY 2002 shortfall, $142 million,

associated with the continued enrollment of new priority 7 veterans, is anticipated as an FY 2002 supplemental.

Question 15: There is a government-wide proposal in this year's budget request to transfer some of the previously "mandatory" spending from the Office of Personnel Management to VA and the other federal agencies to finance the full cost of future benefits under the Civil Service Retirement System and their retirees' participation in the Federal Employee Health Benefits program. The Washington Post reported on Feb. 6 that, "Currently, agency and employee contributions do not fully cover the cost of CSRS benefits. As a result, unfunded liabilities have built up over the years."

Question 15(a). How is this likely to affect the availability of funding available for discretionary programs?

Answer: The Administration's Managerial Flexibility Act of 2001 (transmitted to Congress on October 15, 2001) calls for full accrual funding implementation of all civilian retiree income and retiree health benefits in FY 2003. The President's Budget reflects this change across all agencies—not just VA—and all agencies were held harmless for the adjustment in the preparation of the budget. This is an accounting change to better reflect the true cost of operations.

The proposal does not increase or lower total budget outlays or alter the surplus/deficit since the higher payments will be offset by receipts in the pension and health funds. The shift will reduce reported costs from central mandatory accounts and increase reported costs in the affected discretionary accounts. Consequently, these costs will be properly reported in the budget for the first time and considered as an annual cost of managing these programs, as they should be.

The Administration will oppose any attempt to divert the additional funding from the intended purpose and instead use it to fund programmatic increases. Therefore, the Administration proposes that the additional funding be fenced or held in a reserve and only be made available to the committees of jurisdiction for the specific purpose of adjusting for the understatement of costs.

Question 15(b): Is there a possibility that these underfunded accounts will be an unrecognized liability to VA medical programs and other discretionary programs?

Answer: The President's 2003 Budget corrects a long-standing understatement of the true cost of literally thousands of government programs. For some time, the accruing charge of the Federal Employee retirement system (FERS) and military retirement system (MRS) costs and a portion of the old Civil Service retirement system (CSRS) costs have been allocated to the affected salary and expense accounts, and the remainder (a portion of CSRS, other small retirement systems, and all civilian and military retiree health benefits) has been charged to central accounts. The full cost of accruing benefits should be allocated to the affected salary and expense accounts, so that budget choices for program managers and budget decision-makers are not distorted by inaccurate cost information.

For the retirement accrual, agencies will pay their full share of accruing benefits. There will still be a mandatory general fund payment to amortize the unfunded liability accruing prior to this change. The benefit payments continue to be mandatory.

For the health benefits, agencies pay the full cost of accruing benefits. The accrual payments are discretionary or mandatory, depending on the account. The general fund will make mandatory payments to amortize the unfunded liability accruing prior to this change. The benefit payments continue to be mandatory.

Question 16: VA estimates that it would "avoid" $885 million and 8,853 full-time employees in the costs of treating priority 7 veterans, but it appears that you only estimate losing about 121,740 of these veterans if the deductible is implemented. If the annual treatment cost for these veterans is less than $2,000, how do you estimate such large savings?

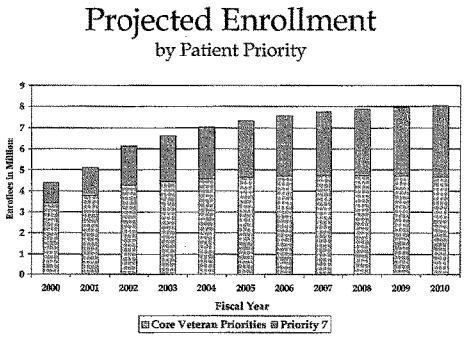
Answer: The "avoidance" of $885 million and 8,853 FTE is the direct result of a 31 percent workload reduction anticipated in implementing the $1,500 deductible. Although we project that approximately 10 percent fewer Priority 7 patients will use VA health care services, we anticipate a 31 percent reduction in workload expenditures overall, since many patients who remain will use fewer VA services when faced with the $1,500 deductible. The attached paper "Background on VA's $1,500 Deductible Proposal for Priority 7 Veterans" provides the assumptions and details of this proposal.

Background on VA's $1,500 Deductible Proposal for Priority 7 Patients

VA's estimate of the financial and programmatic impact of the $1,500 deductible upon Priority 7 veterans was based upon the Milliman USA, Inc. actuarial estimates for projections of enrollees and resources that were used as the foundation of the FY 2002 enrollment decision. The actuarial estimates were based upon FY 2000 actual experience and did not reflect increased utilization by Priority 7 veterans seen in FY 2001. The actuarial estimates were first available in late summer of 2001.

Future Year Projections

This deductible policy would not have been proposed if the growth in Priority 7 veterans was estimated to be a one or two year anomaly. As the chart below shows, the Priority 7 workload is estimated to continue to rise through 2010.



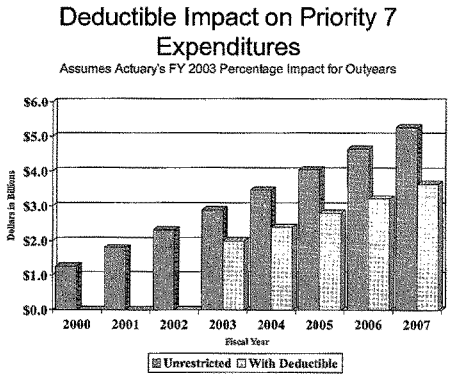
VA's primary reason for proposing a significant policy change is to assure that quality of care is maintained.

The Deductible Proposal

The table below shows the forecast of key workload factors including associated workload expenditures. Estimates are shown with and without the deductible in place for 2003. Priorities 1-6 veterans are VA's core veterans—service connected and low income—Priority 7 veterans—(higher income veterans, about $25,000 for a single veteran and $28,000 for a married veteran). As the table indicates, Priority 7 users are projected to rise by 43 percent from 2001 to 2003 and resource requirements by 61 percent without the $1,500 deductible. With the $1,500 deductible, the growth is held to 29 percent and 12 percent respectively

	2001 Estimate	2002 Estimate	2003 Without Deductible	2003 With Deductible
Priority 7 Enrollees (Average) in millions	1.4	1.9	2.2	2.1
Patients (unique)	841,153	1,060,482	1,206,860	1,085,074
Workload Expenditures in millions	$1,790	$2,320	$2,885	$2,000
Deductible Revenue in millions				$ 260

Application of the deductible proposal reduces Priority 7 veterans by 10 percent and their related workload expenditures by 31 percent in 2003. Their expenditures decline by a greater amount because a large portion of the veterans will seek fewer medical services from VA and will shift some of their care to other providers. The following graphic displays the Priority 7 expenditures projected for 2000–2007 with and without the proposed deductible starting in 2003.



The actuarial estimate concentrates on medical procedures workload (outpatient visits--CPT codes and inpatient episodes of care—DRG) of Priority 7 patients, as this factor is more directly related to expenditures than the number of patients or enrollees. The actuarial expectation is that, with the application of the $1,500 deductible, VA will experience a 10 percent reduction in unique medical users (122,000), a 50 percent decline in outpatient procedures, a 40 percent decline in inpatient episodes of care, and a 10 percent decline in pharmacy utilization. The overall effect on resources is expected to be a 31 percent decline in cost.

Because this type of policy change has not been seen in any large health care system before, or in a system with similar characteristics to the VA—a system where the patient pays only a small fraction of their health care costs, the change in Priority 7 veterans behavior due to the introduction of a $1,500 deductible could be different than that forecasted. The ramification of expenditure savings and the impact on budgets in the future is very significant.

Revenue Estimate

The actuary estimates that this proposal will bring in an additional $260 million in revenue in addition to the $885 million in cost reduction for an overall reduction to the appropriation request of $1.145 billion.

Why This Proposal Was Chosen?

Continued growth in the demand for VA health care services will require significant increases in budget resources. Without significant increases in resources or the implementation of an alternative policy/policies (limit enrollment, change uniform benefits package, cost share proposal), VA would face critical issues impacting quality, such as, increasing waiting times, increasing system congestion impacting all patients, inability to meet demand. VA considered these policies and determined that the deductible (cost sharing) proposal seemed to be the preferable option that addresses the following most overarching concerns:

- Maintain quality of care for all those that VA serves
- Continue VA open enrollment for all veterans
- Maintain, not reduce, the basic benefit package of medical services for core veterans
- Provide veterans appropriate access to outpatient, inpatient, and non-institutional long-term care services
- Require veterans that have higher incomes to contribute more to their cost of care than other veterans
- Assess a charge for use of healthcare services as opposed to assessing an upfront charge or enrollment fee
- Allow veterans to benefit from private insurance coverage and encourage veterans to identify their insurance coverage and improve third party collections
- Continue VA long-term services, especially non-institutional care
- Provide catastrophic coverage for those with high annual medical costs

How does the Deductible Work?

Who pays the deductible?

- All Priority 7s for non-preventive, non-service connected care
- Insurance will help offset deductible charge to veterans
    - Dollar for dollar
    - Veteran will not be billed until insurance payment is made

How much is the deductible?

- Pay only for care received (no upfront charge)
- Once annual deductible ($1,500) is met, no more deductible for that year
- Excludes pharmacy (only $7 copay applies)

How do co-payments work with the deductible?

- Inpatient and outpatient copays start after deductible cap is reached
- Pharmacy copays will be in effect the entire year

How was the $1,500 cap determined?

- The deductible amount is below the average overall cost for priority 7 veterans ($1,900)
- Would encourage veterans to identify insurance
- The cap provides catastrophic coverage for those with huge annual medical costs
- Not likely to devastate those without insurance who need health care as the cost of most Priority 7's care is low, a greater share of their total cost is for pharmacy and a

small percentage have large medical costs

Question 17: Secretary Prinicipi, we received a letter that indicates VA has no plans to increase the capacity of its inpatient long-term care programs. As you recall, in Public Law 106-117 Congress required VA to "ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department" be maintained at the level the Department provided in fiscal year 1998. Your response to the Chairman and me indicates that VA does not intend to restore inpatient capacity to the FY 1998 level. If the reason that VA cannot comply with this requirement is funding, why was it that VA requested no additional funding to ensure that it was able to comply?

Answer: Although the average daily census in VA nursing homes has declined, veterans who are required under Public Law 106-117 to receive such care are being served in both VA and contract community nursing homes, as well as in state veterans nursing homes, the expansion of which has been encouraged through large increases in the State Home Construction Grant appropriations. VA has also been expanding care for veterans in home and community-based extended care, and patient preferences strongly support the use of community nursing homes and home-based care alternatives, which enable veterans to be close to their families and loved ones.

On March 20, 2002, VA provided the Committee with a plan that will allow VA to meet the nursing home capacity requirement of Public Law 106-117 by the end of FY 2004 by increasing the census to the 1998 level (13,391 ADC). However, as discussed in the letter, reaching the FY 1998 level strictly through increasing VA NHCU census will have substantial implications. VA has forwarded a proposal to the Committee to include VA Contract Nursing Home and State Home Census in the determination of this capacity requirement. This will allow VA to use an estimated $161.2 million on other veteran health needs including expanding non-institutional long-term care services.

In formulating the budget, VA was faced with difficult decisions, and a number of alternatives were considered. However, we felt that placing a funding priority on increasing non-institutional long-term care would result in the best use of resources and create capacity for modes of care that veterans prefer.

VA wants to work with the Senate and House Committees on how best to meet both the nursing home care and home and community-based care needs of veterans.

Question 18: There is a reason Congress wants to maintain capacity within VA nursing homes—namely Members believe VA provides high-quality, specialized care to veterans that are often not available in the private sector or state homes. Would you like to explain to this Committee why your budget request does not allow this to occur?

Answer: Since 1998, the level of extended care services, measured as average daily census (ADC), has declined in VA nursing homes and in contract community nursing homes. During the same time period, however, the level of services has increased in State home nursing homes. In addition, there has been significant expansion of home and community-based extended care provided or contracted for by VA.

Projected obligations in the President's FY 2003 Budget total $2.3 billion in 2003, which represents an increase of $204 million. This amount will support growth in nursing home care for veterans, with a 3.8 percent increase in workload in FY 2003. However, for FY 2003, growth in nursing home care is limited to community nursing homes (increase of 17 percent) and state veterans homes (4.2 percent).

Public Law 106-117, requires that the staffing and level of extended care services provided by VA nationally in VA facilities during any fiscal year must not be less than the staffing and level of such services provided nationally in VA facilities during fiscal year 1998. For meeting this capacity requirement, only VA nursing home staffing and level of service is currently considered. On March 20, 2002, VA provided the Committee with a plan explaining the implications of meeting the nursing home capacity requirement of Public Law 106-117.

Question 19: What steps would this budget request allow you to take to address access problems, such as waiting times particularly in community based outpatient clinics, experienced by some veterans? How would you propose to allocate the $159 million and 748 FTE this budget allows for this purpose? Will there be any effort to link to sites with greatest timeliness problems?

Answer: Initiatives addressed in this budget request are for improved timeliness by enhancing existing CBOCs, improved work processes, infrastructure modifications, better telephone access, increased use of telemedicine, and technology enhancements. More specifically, space renovations, space enhancements and additional space (for CBOCs), and hiring of contract providers to provide immediate access to care are all actions that can be taken, but the exact need will be different for each VISN.

VHA also has a number of initiatives in place to address waiting times. VHA is collaborating with the Institute for Healthcare Improvement (IHI) to continue work already started on improving our waits and delays. The Advanced Clinic Access (ACA) Initiative is a 20-month project that will end in December 2002. The goal of the project is to build an advanced clinic access system that can achieve and sustain access levels and patient flow times that meet or exceed the current VHA performance standards. The initiative focuses on the six clinics highlighted in the Network directors' performance contract: primary care, audiology, cardiology, eye care, orthopedics, and urology. In addition to our work with IHI, we have also made a concerted effort to improve waiting times by:

- Enhancing the measurement system to measure the waiting times of nearly every patient treated.
- Developing a National Waiting Times Web site that provides information on ACA.
- Coordinating two Access Experts meetings held in Dallas in April 2001 and October 2001.
- Monitoring implementation of the key principles of ACA.
- Developing a monitor to identify the percent of active patients assigned to a primary care provider and the percent of primary care provider capacity utilized by active patients.
- Developing guidance for panel management.
- Developing a communications/marketing plan for the ACA initiative.
- Developing a guide on the proper use of the scheduling package.
- Preparing a managers guide to analyzing waiting times data.

The additional funds and FTE requested in the budget will be distributed through the VERA process, which will be based on actual workloads. Generally speaking, those facilities with the largest increase in workload also experience longer patient waiting times.

Question 20: We recently became aware of VA efforts to largely implement the chiropractic provision signed into law this January without input from the statutorily required oversight advisory board. What is the justification for constituting this group as one of the final steps in this process?

Answer: To date, our only action to implement the chiropractic provisions of Public Law 107-135 has been to initiate the process for establishing the advisory committee. A charter has been drafted and is under departmental review. Chiropractic organizations and other interested professional organizations and individuals have been contacted to nominate candidates for membership on the advisory committee. We are moving to appoint members and schedule the first committee meeting as soon as possible. In addition, we have started preparing orientation and briefing materials for the committee

in order to facilitate their work. We do not intend to issue any new policy until we have benefit of the committee's guidance.

Question 21: One of your principles in executing the Capital Assets Realignment for Enhanced Services (CARES) process is not to reduce health care services. How does VA intend to monitor this to ensure there is no reduction in services?

Answer: Enhancement of health care services is fundamental in the CARES process. The most highly rated criterion is access to care. No CARES option will be accepted that reduces or impedes quality of services provided to veterans. Within the CARES evaluation process, each option will be reviewed with a critical focus on the continued or enhanced services resulting from that option, were it to be implemented. Not only will such a review take place at the VISN and VACO levels, each option will also be reviewed by an outside CARES commission. During the public comment period, as was the case in Phase I, stakeholders will provide feedback on a variety of issues, including those perceived to impact delivery of quality veterans' health care services. Outside the CARES process, there is a performance measurement system that measures the ability of a VAMC and VISN to deliver services in a variety of clinical programs. That system will also track the implementation impact of CARES on services.

Question 22: Major construction program funding is essentially frozen at the FY 2002 level, but $5 million is added for CARES. Is VA waiting for the CARES process to roll out to propose additional funds for construction? Given the time it took to complete the CARES process in VISN 12 (plus the long history of analysis and assessments done there prior to CARES) is it feasible to complete this process in the remaining 20 networks in 2 years?

Answer: For the past two budget cycles, VA has identified projected funding needs in support of CARES. Each budget included significant major and minor construction funding requests. The needed resources were initially estimated based on the earlier completed Boston Integration and VISN 12 Options studies. Each of these previous studies identified capital investment requirements in support of a CARES-like approach to capital adjustments. The past budget cycle included more detailed estimates based on the completed Phase I, VISN 12 CARES study. When the schedule known at the time of Phase II studies was considered, it was likely that a variety of significant construction needs would be identified for design, and a somewhat lesser number for construction support. A new schedule is under development, and a more aggressive timeline is anticipated. This will allow all studies to be completed during the next 2 years. Through the use of an objective CARES commission, VA believes the studies will be reviewed, vetted with stakeholders, and approved in less time than required for previous similar studies.

Question 23: It is clear that this budget request does not include funds to fully implement the Millennium Health Care and Benefits Act (Public Law 106-117). Does this budget request include adequate funds to implement the recently enacted Public Law 107-95 (the Homeless Bill) and Public Law 107-135?

Answer: The FY 2003 budget includes an estimate of $138 million for emergency care and a request of $121 million towards satisfying the long-term care requirements under Public Law 106-117. The resource requirements associated with Public Law 107-95 and Public Law 107-135 were not considered in this request. VA will implement the provisions of these laws as resources allow.

Question 24: Mr. Secretary, you were promised a supplemental at least to cover the costs of caring for additional priority 7 veterans. Is $142 million enough to get VA through the current fiscal year? What supplemental request have you made of the Administration and when do you suspect you will see some action from the White House?

Answer: The Administration sent a supplemental funding request of $142 million to Congress on March 21, 2002. VA can provide health care to an estimated 143,039 new priority 7 enrollees during fiscal year 2002 with $142 million in supplemental funding.

This will ensure VA has health care funding consistent with the President's decision to keep VA veterans' enrollment open for all veteran health care, preserving VA's long history of providing timely, high-quality health care to all eligible veterans.

Question 25: "The number of individual veterans who received care in VA increased from more than 3 million in 1998 to more than 4 million veterans in 2001, due primarily to VA's efforts to expand access to primary care," according to a statement you recently made.

Question 25(a): Is VA continuing its effort to expand access to primary care? If so, please describe the goals of further expansion.

Answer: To the extent that new veteran users continue to come to VA for care, workload continues to increase. However, we do not believe that this is due to VHA outreach efforts, such as marketing or aggressively opening new CBOCs. In fact, new CBOCs are now being subjected to more stringent criteria prior to approval. Additional expansion of access will take into account veterans' needs in the area served in light of health care services already provided.

Question 25(b): Is access expansion coming at the expense of veterans being provided timely and quality medical care—(30-day appointments)?

Answer: Access expansion is being done on a limited basis. Although VA is currently struggling to provide its users with timely access to care, we have many initiatives to address the multitude of issues involved, ranging from re-engineering the scheduling package to institutionalizing office practice efficiencies. Despite the timeliness issue, VHA continues to provide high-quality care as evidenced in the prevention index and clinical practice guideline performance results. As a matter of fact, VHA serves as the benchmark for both federal and private sectors in many of the areas in these indices.

Question 25(c): Does VA have the capacity today to provide timely and quality medical care to every veteran enrolled in VA?

Answer: VA does not want to exclude any group of veterans from the VA system; at the same time, we must maintain high-quality health care services for all veterans. However, based on the Administration's decision to continue full enrollment, VA determined there would be a shortage of about $441 million in FY 2002. Approximately $300 million in management savings is anticipated in FY 2002. The balance of the FY 2002 shortfall, $142 million associated with the continued enrollment of new Priority 7 veterans, is anticipated as an FY 2002 supplemental.

For FY 2003, VA has proposed that Priority 7 veterans pay for a greater portion of their health care in the form of a $1,500 deductible. Reimbursements from a veteran's insurance would be applied to reduce the veteran's out-of-pocket obligation. With the deductible, we anticipate an additional $260 million in collections and $885 million in savings in workload expenditures. Without the deductible or another alternative for offsetting rising costs, access for lower priority veterans would be curtailed. Further information about the impact of this deductible is provided in the attached background paper to question 16.

Question 26: According to your testimony, 24 actions have been identified that will yield significant enhancements to VA's ability to collect revenue.

Question 26(a): How much is requested in the2003 budget to implement these 24 actions and what is the total investment needed to fully implement all 24 actions?

Answer: At this time, we have not identified the total dollar impact of the 24 actions.

Question 26(b): When will these 24 actions be fully implemented?

Answer: The latest projected completion date for an action item is November 2003. However, some items will require extensive and sustained efforts beyond that date to

bring about full implementation. We have already completed many tasks. Guidance has been issued or is in the final review on such actions as pre-registration, insurance identification, required use of electronic medical records (CPRS), and use of claims analyzers. We have accomplished systems testing for our Electronic Data Interchange (EDI) initiatives, conducted training, developed electronic encounter forms and templates, and are aggressively pursuing related automation initiatives. We have also actively sought out potential private-sector solutions, conducting market research and identifying potential vendor solutions that may be adapted to the VHA business model.

Question 26(c): What is the cost: benefit ratio of fully implementing these 24 actions?

Answer: We are currently in the design phase of a cost-benefit analysis. The anticipated completion date for this analysis is late summer 2002.

Question 27: The budget requests $159 million to improve timely delivery of VA medical care.

Question 27(a): What is the total investment VA needs to make to achieve the goal of veterans receiving appointments for primary and specialty care in 30 days or less and being seen within 20 minutes of their scheduled appointment?

Answer: At this time, we cannot estimate the total resources necessary to reach these goals. Two reasons account for this. First, we are continuing to refine the performance measure itself. Originally the measures were expressed in average days or minutes, which meant that the goals could be met when half the clinics exceeded the goal and half were deficient. Subsequently, the measures were expressed as percentage compliance towards reaching appointment/clinic time goals, with 90 percent as the target. The measures will highlight the waiting times for first appointments of new enrollees, which is the area in which performance has been lowest. The second reason for difficulty in estimating needed resources is related to veterans' increased use of VA health care services. Factors contributing to this include VA's excellent health care quality, improved health care benefits, outstanding patient safety program, generous pharmacy program, and the availability of and quality of health care alternatives, to name a few. We anticipate that the continued use of actuary estimates in predicting veteran demand for VA health care and the application of better performance measures will allow us to improve our performance budgeting in reaching these goals.

Question 27(b): When will VA achieve these goals?

Answer: VA is currently developing new clinic wait time measures to quantify the wait times of new enrollees. A target date for completion of the goals has not been set.

Question 27(c): What results will VA achieve with $159 million requested?

Answer: Initiatives addressed in this request include: improved timeliness by enhancing existing community-based outpatient clinics, improved work processes, infrastructure modifications, better telephone access, increased telemedicine utilization, and technology enhancements. Under the performance measures for FY 2003:

- Eighty-nine percent of primary care veterans' appointments will be scheduled within 30 days of desired date (excludes new enrollees who are pending scheduling of their first appointment).
- Eighty-seven percent of specialist appointments will be scheduled within 30 days of desired date (excluded new enrollees who are pending scheduling of their first appointment).
- Seventy-two percent of patients will report being seen within 20 minutes of their scheduled appointments at VA health care facilities.

Question 28: The budget requests $817 million to address this rising demand for more health care services required by a rapidly aging veteran population. Specifically, how will this $817 million address this rising demand for more health care services required

by a rapidly aging veteran population? How much is needed to completely address the rising demand for more health care services required by a rapidly aging veteran population?

Answer: The identified estimated expenditures of $816,552,000 will cover the utilization of services for the benefits package available to all projected enrollees in 2003 (Priorities 1-7). The $816,552,000 requested in the FY 2003 is based on actuarial projections of the demand for FY 2003.

The Base Health Care Demand Adjustment is a subsection of the $1.8 billion specifically necessary for the care and treatment of veterans including infrastructure improvements such as long-term care, access and service delivery, pharmacy and prosthetics, as well as additional funds needed to treat veterans' dependents eligible under CHAMPVA for Life. Included in the $1.8 billion is an increase of $121.3 million for long-term care to expand some services required by the Veterans Millennium Health Care and Benefits Act to continue addressing the needs of the aging population.

Question 29: The budget has so-called "management savings" of over $316 million to partially offset resources needed to meet the rising demand for more health care services required by a rapidly aging veteran population. Identify these management savings and how they contribute to meeting the rising demand for more health care services required by a rapidly aging veteran population need.

Answer: Based on the continuation of full enrollment, VHA determined there would be a shortage of about $441 million in FY 2002. Approximately $300 million in management savings is anticipated in FY 2002. We expect that these savings will be generated from a multi-year effort to improve standardization and compliance in the procurement of equipment, pharmacy, and medical supplies. Other savings are expected from program efficiencies related to new criteria to assess community-based outpatient clinics and centrally managed programs. The balance of the FY 2002 shortfall, $142 million associated with the continued enrollment of new priority 7 veterans, is anticipated as an FY 2002 supplemental.

Question 30: According to your statement, "Over the past year, we have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a reinvigorated VA and DoD Executive Council." Yet the Administration budget reports sharing accounts for only 1/10 of one percent the $40 billion total annual VA and DoD medical care spending.

Question 30(a): Who should be held responsible for this lackluster record?

Answer: There are many reasons why VA and DoD do not indicate more dollars for sharing. These include:

- Before significantly increased sharing of clinical services can occur, a key issue has to be resolved—what is VA's role with DoD, i.e., partner or a subcontractor under the TRICARE contracts. VA has found that DoD contracts with managed care support contractors under TRICARE are an obstacle to direct VA/DoD sharing. Many DoD facilities will not enter into direct sharing agreements for clinical services if there is a TRICARE contract in place. VA may only provide health care service to DoD beneficiaries (including active duty members) under VA/DoD sharing authority, when such services are not included within the TRICARE contract. The TRICARE contracts are very comprehensive and include a myriad of inpatient, outpatient, and ancillary health care services. As a network provider, VHA facilities have no guarantee or reliable estimate or potential TRICARE workload, and are therefore unable to allocate additional staff or services to meet the demand.
- The numbers reported for sharing typically do not account for many activities, such as joint purchases of pharmaceuticals, medical/surgical supplies, etc.
- Many sharing activities involve bartering, which is not reflected in the accounting system used to collect this information.

- With the increase in veterans seeking care at VA, there is less capacity to provide health care to DoD beneficiaries.

However, over the past year, VA and DoD leadership have aggressively pursued many new sharing opportunities. For example, VA is studying how to use DoD's enrollment system, DEERS/RAPID, as VA's enrollment system. In addition, VA and DoD are working together to develop an electronic patient medical record. We are optimistic that implementing the recommendations made by the VA/DoD Executive Council and the President's Task Force to Improve Health Care Delivery of Our Nation's Veterans will result in increased activity and improved reporting of joint VA-DoD activities.

Question 30(b): Why are the goals for VA/DoD sharing in each of the next four years less than the amount of sharing currently reported by the Administration?

Answer: The dollar goals over the next 4 years represent an increase of approximately 5 percent per year over the FY 2002 estimate. The number of sharing agreements reflects a decrease due to the current shift from direct sharing to TRICARE agreements. Separate sharing agreements were normally developed for each service between an individual VA medical center and a military treatment facility. TRICARE agreements are usually for a wide range of services and are often negotiated at the VISN level for all of the medical facilities within the VISN.

Question 31: VA reportedly spent $4 million for the VISN 12 CARES study. How much will VA spend to complete the CARES process in all other VISNs?

Answer: The cost of the VISN 12 CARES study is not representative of all remaining studies. The VISN 12 study was a developmental pilot, with algorithms, models, and process development required of the contractor. Future studies will benefit from the work accomplished in the VISN 12 study. VA is closely reviewing the VISN 12 study, and believes more VA staff involvement is desirable and possible. The greater involvement of VA staff in CARES would have the added benefit of reducing the contractor costs for CARES. The review of VA staff involvement is still underway, with no decision about an approach, and no associated cost estimates at this time. However, from what we can currently anticipate as developmental work continues, scopes of work become finalized, and final costs are negotiated, we estimate that specific costs may be available in July 2002. We will provide you with the information at that time.

Question 32: What are the tangible results of the claims processing task force established last year? How many recommendations have been accepted and of those accepted, how many have been fully implemented? What are the results attributable to the implementation of the recommendations? When will all accepted recommendations be fully implemented? What are the expected results of fully implementing all accepted recommendations? Does the budget contain all funds needed to implement these recommendations?

Answer: The Claims Processing Task Force (CPTF) produced 34 short- and mid-term recommendations. VBA generally accepted all of the recommendations.

In developing an implementation plan, VBA divided the recommendations into specific actionable tasks. Project managers have been assigned to each task to ensure all actions are carefully planned and integrated. The implementation approach, progress and performance measures are being tracked and monitored in VBA's Project Tracking System to ensure they receive priority attention at all levels of the organization, the proposed courses of action are appropriate, and the results achieve the intended objective.

VBA has implemented the following actions:

- Establish Tiger Team
- Expedite Favorable Decisions

- Extend Timeframe for Routine Compensation Reexaminations
- Improve Records Recovery
    1. Memorandum of Agreement with the National Personnel Records Center (NPRC)
        a. Implementation of Non-Findable Statement
        b. Priority processing of Tiger Team requests
- Establish and Enforce Accountability
    1. Establish performance plans that hold RO directors accountable to meaningful and measurable standards
    2. Allocate resources to the most effective regional offices
- Establish Uniform Procedures for Off-Site Storage of Claims Folders

Of the remaining tasks, the majority will be completed within the next 12 months. Nine tasks will require more than 12 months to complete.

The implementation of the CPTF recommendations, taken in total, will have a very positive impact on claims processing timeliness in FY 2003 and beyond, and will reduce the volume of pending claims. However, it is too early in the implementation phase to specifically quantify the impact of the recommended actions.

Some of the CPTF recommendations align closely with planned VBA initiatives and can be accomplished with current and requested budget funds.

Question 33: Please identify all services currently being evaluated for closure, e.g. cardio-thoracic at Milwaukee, because of budgetary constraints.

Answer: Proposals concerning program consolidation, program closure, or inpatient bed change require formal submission to VA Central Office for review and concurrence and approval by the Under Secretary for Health, prior to implementation. A proposal to consolidate cardiac surgery programs at the Milwaukee and Madison VHA facilities to the Madison VA Medical Center was sent to VA Central Office for approval. Following review, the proposal was returned to the VISN for reconsideration and reassessment.

Question 34: To how many unique patients did VA expect to provide medical care in fiscal year 2001 and to how many unique patients did VA actually provide medical care in fiscal year 2001?

Answer: The FY 2001 estimate used for the FY 2001 budget was 3,894,864 unique patients; the actual was 4,247,204 unique patients.

Question 35: Does every enrolled veteran have equitable access to VA provided non-institutional long-term care? Describe the actions being taken by VA and the resources needed for every enrolled veteran to have equitable access to VA provided non-institutional long-term care. When will every enrolled veteran have equitable access to VA provided non-institutional long-term care?

Answer: VA strives to provide equitable access for all health care programs including non-institutional care. We, however, are continually being challenged due to the large increase in volume of patients being treated and due to unyielding demand for resources for other medical services.

The FY 2003 President's Budget supports improved access to home and community-based care (H&CBC) services for enrolled veterans. These services comprise the following programs: Home-Based Primary Care, Contract Home Health Care, Adult Day Health Care (VA and Contract), and Homemaker/Home Health Aide services. The increase is part of a 6-year plan that targets a 144 percent increase in workload between the year 2000 and 2006. The workload is projected to increase from an

average daily census (ADC) of 16,150 in 2001 to 34,500 in 2006. The projected need is based on VA's Long-Term Care Planning Model and incorporates the analysis and recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care. Based upon projected need and demographics, the Committee recommended that VA triple its investment in home and community-based long-term care.

The majority of the workload increase is found in Home-Based Primary Care (HBPC). VA plans to accommodate the increase by establishing 30 new HBPC programs, expanding the existing 75 HBPC programs, and adding 274 FTE to HBPC. The 30 new HBPC programs would collectively require 150 FTE and provide care for an additional ADC of 1,500 veterans. The 75 existing HBPC programs would expand capacity by 16 percent. This expansion would require an additional 124 FTE and would provide care for an additional ADC of 1,235 veterans.

Question 36: Does VA establish individual accountability for adjudication errors or mistakes?

Answer: Quality of work is a critical element in the performance standards of all VBA claims processing decision-makers. During the past year, VBA established national performance floors to help ensure quality and production consistency in the claims adjudication process. The minimum acceptable accuracy (quality) rate is currently 85 percent. If a decision-maker's accuracy falls below that level, the first line supervisor discusses the deficiencies with the individual and an improvement plan is developed. Adverse action is taken if performance does not improve.

Question 37: How is the enrollment system today used to manage the delivery of services?

Answer: VHA's current actuarial enrollment model projected enrollees, utilization and expenditures, and patients for FY 2002 based upon the accrual of actual health care enrollment as of April 30, 2001. Enrollment-related projections were made through the end of FY 2001 and for each succeeding year through FY 2010. The actuary applies the private sector's current experience of providing the services included in the VA medical benefits package (MBP) to the projected enrollee population. Private sector utilization norms are adjusted to the VA enrollee population by age, gender, morbidity, and reliance upon VA. The utilization norms are also adjusted by the degree of management within the VA system compared to the private sector's degree of management. Projected enrollee expenditures are calculated by multiplying VA unit costs by the matched adjusted private sector utilization norms for VA enrollees. Unique patients are also projected based upon the enrollee and utilization projections. The analysis includes an estimate of the expenditures needed to make the MBP available to all projected enrollees. VA compares the projected MBP expenditures to the resources available to cover these services for all projected enrollees by priority, and determines the priority level at which VA can continue to enroll. This analysis forms the basis of VHA's recommendation to the Secretary concerning VA's annual decision on enrollment.

Question 38: On a per claim basis, provide the total resources provided for claims worked by the Tiger Team. Compare the total resources provided for claims worked by the Tiger Team to claims not worked by the Tiger Team. If the amount of resources provided for claims worked by the Tiger Team were provided for every claim, how much additional resources (funding and FTE) would be needed?

Answer: The Tiger Team, located in the Cleveland VARO, began full operation in November 2001. Through January 2002, the team completed 3,765 rating claims, for an average of 3.3 ratings per Rating Veterans Service Representative (RVSR) per workday. During this same 3-month time period, the regional offices completed 161,292 rating claims, for a daily average of 1.6 ratings per RVSR.

However, a simple comparison between the Tiger Team and the regional offices—whether discussing resources or production—is not appropriate.

The Cleveland Tiger Team is dedicated to a specific mission: processing rating-related claims of veterans 70 years or older, and claims pending more than 1 year. The Team currently consists of 16 Veterans Services Representatives (VSRs) and 21 RVSRs. Slightly more than 80 percent of the RVSRs (17) are highly experienced, most having a great deal more than 2 years of rating experience. The Tiger Team VSRs are also highly experienced in both authorization activities and evidentiary development procedures. In addition, the Tiger Team has specific Memoranda of Understanding with the Veterans Health Administration, National Personnel Records Center, National Archives, and US Armed Services Center for Unit Records Research, which places a priority on their requests.

By contrast, only slightly more than half of the RVSRs in the regional offices have 2 or more years of rating experience; 14 percent of the RVSRs have between 1 and 2 years of experience; and the remaining 35 percent have less than 1 year of experience. Considering only the RVSRs with 1 or more years of experience, the daily average production rate for regional offices would equal 2.6 ratings. In addition, although the new, inexperienced RVSRs participate in an intensive 12-week centralized training program, much of their training is completed on-the-job, requiring a considerable amount of mentoring by our more experienced regional office employees.

The responsibilities of the regional offices are also broader than the responsibilities of the Tiger Team. Veterans Service Center employees answer veteran phone inquires (7.7 million in FY 2001), conduct personal interviews (1.1 million), respond to written inquires (219,000), participate in outreach efforts (e.g. homeless veterans), and process a host of authorization and ancillary benefit claims (such as dependency award adjustments, income determinations, death pension, etc.).

The responsibilities of the Cleveland Tiger Team and its structure are not the same as those of our regional offices. Replication of the Tiger Team concept in each regional office would result in competing priorities.

Question 39: In the budget proposal last year and again this year, the Administration has not recommended the creation of one new national cemetery not already authorized by Congress. Veterans are dying at the rate of 1,600 per day. Half of all national cemeteries are closed to new burials. The new cemeteries being planned today will not meet the need of the entire nation. Should new national cemeteries be developed?

Answer: The Veterans Millennium Health Care and Benefits Act of 1999 requires VA to contract for an independent demographic study. This study will identify those areas in the United States with the greatest number of veterans who will not have reasonable access to a burial option in a national or state veterans cemetery from 2005 through 2020. The results of this study will be evaluated and used to assist VA in determining where new national cemeteries may be established as well as to assist states in selecting locations for new state veterans cemeteries.

Many of our national cemeteries date from the Civil War. Most of these cemeteries are smaller historic sites, often under 10 acres, and located near Civil War battlefields and not near today's veteran population. About 96 percent of the total acreage within the National Cemetery Administration is in national cemeteries where gravesites are available for new burials. Currently, nearly 74 percent of veterans reside within 75 miles of a burial option in a national or state veterans cemetery. This percentage is expected to increase to 85 percent by 2007, resulting from the planned opening of new national and state veterans cemeteries.

VA is continuously working to provide service to a greater number of veterans. The Department is currently using demographic data from the 1987 and 1994 Reports to Congress to locate new cemeteries. These reports identified areas of greatest need based on large concentrations of veteran population. Six new national cemeteries are under development in Ft. Sill, Oklahoma; Atlanta, Georgia; south Florida; Pittsburgh, Pennsylvania; Detroit, Michigan; and Sacramento, California. VA dedicated a "fast track" section at Ft. Sill National Cemetery in November 2001, enabling that cemetery to provide a burial option for veterans in the Oklahoma City area prior to full completion of

all construction activities. VA plans to open similar "fast track" sections where feasible at each of the remaining new cemetery locations.

In addition, VA partners with states through the State Cemetery Grants Program to fund construction of state veterans cemeteries as a complement to national cemeteries. This program has proven to be very effective in providing service to an increasing number of veterans.

Question 40: What percent of patients receiving medical care from VA this fiscal year will be tested for Hepatitis C?

Answer: Over the past three years, more than 1.7 million VA medical care users have been screened for hepatitis C risk factors. Since there is a significant risk of false positive blood tests in patients who have little or no risk for infection, screening for risk factors before testing is more efficient and medically more appropriate than simple universal testing. Offering blood tests to every patient with identified risk factors is a network performance measure for FY 2002. The target for FY 2003 is 65 percent with an ultimate goal of 82 percent. During FY 2001, VA performed over 480,000 blood tests for diagnosis of hepatitis C. The actual number of patients tested will depend on the number of veterans who are identified as having risk factors. It is anticipated that as VA continues to screen in lower risk populations, the number of patients tested may actually decrease (i.e., the number of at-risk or infected patients not yet identified will decrease).

Question 41: Please provide a list of all remands issued before October 1, 2000 from the United States Court of Appeals for Veterans Claims and the Board of Appeals which are still pending at VA regional offices. Kindly provide these as a separate document and attachment in order to assure compliance with the Privacy Act.

Answer: An Excel spreadsheet containing the list of pending remands issued before October 1, 2000 is attached.

Question 42: Please provide your views on VA participation with the state of Colorado in the collaborative development of a new medical center to serve veterans in Denver.

Answer: For many years, an affiliation with the University of Colorado Health Sciences Center (UCHSC) has served to enhance the provision of health care to veterans. UCHSC is now moving to the former Fitzsimons army base in Aurora, which is in the eastern part of the Denver metropolitan area. University of Colorado Hospital (UCH), which is located adjacent to the Denver VAMC, will soon be part of this move. The move presents both challenges and opportunities for VA. The future of the VAMC at the present location is problematic. Renovations may not yield an optimal result and the recruitment of physicians and other medical staff will be much more difficult without the university adjacent to the Denver VAMC. These concerns have led VA management to examine the possibility of moving VA health care to Fitzsimons through enhanced partnership with UCH. Three options are under study by the VA:

- Option A—Build a free-standing VA hospital adjacent to UCH.
- Option B—Build a VA bed tower/VA clinic attached to UCH.
- Option C—Merge a VA outpatient clinic and hospital.

VISN 19 has contracted with a consultant to help further evaluate the pros and cons and the costs of relocation of the Denver VAMC to the Fitzsimons campus. They are also assisting in preparing a capital investment application for this project, which will include a financial analysis of several scenarios for relocation. The analysis will include demand projections and service needs through the year 2020. It will also consider the residual value of the existing land and facility as well as the cost associated with each scenario. After the contractor's option study is finalized, the Secretary will make a decision about the VA's potential relocation to the Fitzsimons campus. Until that work is completed, VA is not able to make a decision about whether to give the project serious consideration or to commit additional planning resources to it. This timetable did not permit the project to be included in the President's budget for FY 2003.

Congressman Bob Filner

Question 1. I have been concerned that VA has been hesitant to use new authorities established under P.L. 106-419 to provide specialty pay for dentists. Unfortunately, I understand that there are still many vacancies in the VA dental service. Do you have any sense of how often these enhanced authorities are being used to ensure adequate recruitment and retention of VA dentists? Please provide, for the record, all of the instances since its enactment in November 2000, in which these enhanced authorities have been used.

Answer: The Department has consistently supported and encouraged the use by local managers of the enhanced pay flexibilities in P.L. 106-419, the "Veterans Benefits and Health Care Improvement Act of 2000." Evidence of the degree to which VA has used these flexibilities is the overall increase in special pay expenditures from FY 2000 to FY 2001. The Department's total authorized special pay for dentists as of the end of FY 2001 was $20.5 million, vs. the FY 2000 total authorized dentist special pay of $6.9 million. This represents an increase in total dentist special pay of $13.6 million, or 195.6 percent.

In August 2001, the Office of Dentistry reported seven full-time vacancies for general dentists and approximately 3.5 FTEE vacancies for various dental specialists, or roughly 10.5 vacancies. In April 2002, the Office's informal records showed six vacancies currently being actively recruited, with two additional positions vacant but not yet announced. A review of the VA healthcare Internet recruitment site revealed that there are two full-time general dentist vacancies currently posted. While the number of active vacancies represents a small portion of the dentist workforce, some of these vacancies have persisted for some time. The Office of Dentistry continues to monitor these problematic vacancies and to offer its assistance in announcing vacancies and publicizing them to the military and other sources.

Anecdotally, the enhanced pay flexibilities have contributed to improved retention of dentists, who state that they have changed their career plans as a result of the increased amounts of special pay.

We provide information on the use of the enhanced special pay flexibilities based on the available detailed salary data in the PAID System. Of the 670 dentists employed by VA as of March 2002, payroll information on the individual special pay components authorized is available for only 570 dentists -- only the total special pay amounts are available for the other 100 dentists, individual components amounts are not coded in the system. Based on this partial report on dentist special pay amounts and data available from prior time periods, the records show the increased use of the enhanced dentist special pay flexibilities.

Time Period ⇒	**12/31/1995 [1]**		**3/31/1999 [2]**		**3/31/2002 [3]**		
Component ⇓	**# Paid**	**Avg $**	**# Paid**	**Avg $**	**# Paid**	**Avg $**	**# @ Max.**
Geographic Location Pay	191 21.9%	$4,383	200 26.1%	$4,175	189 33.2%	$5,923	24 @ $12K
Scarce Specialty Pay	71 8.1%	$14,373	67 8.8%	$13,662	146 25.6%	$16,535	27 @ $30K
Responsibility Pay	247 28.3%	Unknown	182 23.8%	Unknown	111 19.5%	$10,180	27 @ $15K

[1] Based on non-resident dentist employment of 873 as of 9/30/1995.
[2] Based on non-resident dentist employment of 765 as of 9/30/1999.
[3] Based on component data for 570 dentists, of 670 employed as of 3/31/2002.

The current data show that one-third of VA dentists (based on available data) are authorized to receive this component. Of the 189 recipients of geographic location pay, 62 are receiving amounts above $5,000, the maximum rate payable before P.L. 106-419. Thus, fully one-third of dentists receiving geographic location pay are benefiting from the enhanced flexibilities enacted in November 2000.

The scarce specialty pay data show that significantly more dentists are receiving scarce specialty pay since November 2000: the reported number more than doubled in the three-year period from March 1999 to March 2002 even as the total number of dentists employed by VA declined. The enhanced flexibilities are being used to pay 43 dentists amounts of scarce specialty pay above $20,000, the previous maximum payable amount for this component.

The data on responsibility pay reflects the overall trend in VA and the rest of the Federal Government to streamline and reduce management layers. The number of supervisory dentists declined over the period examined, as VA consolidated or integrated facilities and restructured to product lines, thereby reducing the number of positions receiving this component. As of March 2002, 111 of the 570 dentists on which detailed pay data are available are receiving this component. Of the 111 dentists receiving the responsibility pay component, 87, or 78.4 percent, are receiving responsibility pay above $5,000, the previous maximum payable amount.

The other special pay increases in P.L. 106-419 were for the full-time and length of service (tenure) components. The full-time component increased from $3,500 to $9,000, a 157 percent increase. However, the amount authorized in the PAID System showed an increase of 172 percent from FY 2000 to FY 2001. This larger increase is due to the increased number of full-time dentists employed by VA in FY 2001. The number of full-time dentists employed by VA increased from 640 to 656 from FY 2000 to FY 2001, it appears as a result of the enhanced pay flexibilities in P.L. 106-419.

The largest portion of the overall increase in dentist special pay authorizations was attributable to the length of service (tenure) component of special pay. The maximum payable amount increased as a result of P.L. 106-419 from $4,000 to $18,000. The total annual amount authorized for VA dentists, for this component, increased by 337 percent from FY 2000 to FY 2001.

Question 2. As you probably know, I am very concerned with obligation I believe this country has reneged upon for providing veterans' benefits to certain Filipino veterans. I have introduced legislation with Congressman Gilman and others that would deem the service of many of these veterans in World War II to be U.S. service for the purposes of administering VA benefits. At one time, VA stated that it would take about $30 million to provide health care services to Filipino veterans newly deemed "U.S." veterans. Is that still a fair estimate?

Answer: VA estimates that there are approximately 11,000 nonservice-connected Filipino veterans residing in the United States and extending eligibility to new Philippine Scouts would result in approximately 2,300 new users of the health care system. VA estimates the cost of this use would be approximately $11.6 million in the first year and $52.6 million over five years.

Question 3. I see that a major construction project to redress seismic hazards at the San Diego VA Medical Center identified as one of VA's highest priorities in the FY 2002 budget request, is no longer considered a high funding priority. Would you explain to me why this important project appears to be bumped?

Answer: The San Diego Seismic Corrections project continues to be a high priority project for the Department. It was ranked 13th in VA's Priority Major Medical Facility Project Report that was provided to the Congress in February 2002. This report provides the top twenty major medical facility projects as scored by the Department. The Department's scoring methodology addresses multiple attributes within the eight scoring categories. The eight categories used for FY 2003 are Customer Service; Return on Taxpayer Investment; High Performing Workforce; Risk; Seismic; Special Emphasis Programs; Strategic Alignment; and Secretarial Priorities. Unfortunately, budget restraints cause VA to request funding for our highest priority needs. The FY 2003 budget request includes the top four other seismic projects (all located in the State of California) that ranked higher than San Diego. This project will again be considered for funding in FY 2004.

Responses from the Honorable Frederico Juarbe, Jr.
Assistant Secretary for Veterans' Employment and Training
U. S. Department of Labor
Questions submitted by the Honorable Silvestre Reyes
Ranking Democratic Member
Subcommittee on Benefits
House Committee on Veterans Affairs
Full Committee Hearing, February 13, 2002

Mr. Reyes: Under the Administration's proposed employment grants program, what will happen to the National Veterans' Training Institute? Please explain your plan for assuring that the functions currently provided by this organization will continue. One of the reasons the position of Assistant Secretary of Labor for Veterans' employment and Training exists is to ensure that our veterans get a seat at the table when national employment policy is concerned. I would also note that the Department of Labor has been criticized in past Administrations- both Republican and Democrat-for a lack of internal communications and an apparent reluctance to organizationally embrace the Veterans' Employment and Training Service.

Mr. Juarbe: The Administration's FY2003 budget request did not include funding for NVTI during this transition year. We recognize the need to provide training to our staff and grantees, and we will address these needs with the Department of Veterans Affairs as the details of the transfer proposal are developed.

Mr. Reyes: Now we are presented with a new employment grants program that would completely eliminate an Assistant Secretary level position from the Department of Labor's organizational structure. Keeping in mind the insensitivity to veterans that has existed within the Department of Labor previously: How will removing your Assistant Secretary position improve employment services to veterans who seek them from the Department of Labor?

Mr. Juarbe: Transferring the Assistant Secretary for Veterans Employment and Training Services to the VA will not diminish the responsiveness of the Department of Labor to provide maximum employment and training opportunities to all eligible workers, including veterans.

Mr. Reyes: What impact do you think the elimination of your position and offices will have on veterans' issues within the Department of Labor?

Mr. Juarbe: The Secretary is committed to serving all workers, including veterans. This is an absolute commitment from the highest level of the Department.

Mr. Reyes: You have testified that 199 FTE will be transferred to VA for its new employment grants program while only 51 FTE will remain in the Department of Labor to maintain responsibilities associated with employment rights and other vital programs. I am deeply concerned by this news. Does the Administration consider the 199:51 ratio to be accurately reflective of the importance of the respective programs they are associated with? Please explain your rationale.

Mr. Juarbe: We believe that 199 employees are needed to administer the programs that would be transferred to the VA under the Administration's proposal. We believe that 51 employees are needed to effectively carry out the duties that would remain at the Department of Labor. The ratio was determined by a thorough analysis of current and projected requirements for these programs to be successful.

Mr. Reyes: How will the Department of Labor adequately protect veterans' employment and reemployment rights nationwide, especially the rights of states employees, with only 51 FTE? How would this benefit veterans, especially those veterans who are state employees?

Mr. Juarbe: These programs will continue to function effectively because qualified and competent staff will remain assigned in the Department of Labor to carry out these functions. The same staff that has been dedicated to compliance activities will continue to perform these duties.

Congressman Evans to The Independent Budget

Questions for the Record
Ranking Democratic Member Lane Evans
Committee on Veterans' Affairs
House of Representatives
February 13, 2002

Hearing on the Department of Veterans Affairs Fiscal Year 2003 Budget

The following are answers to questions submitted to *The Independent Budget*:

1. **The IB group clearly did not anticipate the legislative proposal to shift certain OPM retirement accrual accounts to the individual agencies. What is the IB's position on shifting these accounts?**

Answer: *The Independent Budget* opposes this legislative proposal and believes that all such amounts included in the individual agency accounts, as part of the Administration's budget request, should be disregarded. The inclusion of these amounts, attributable to a legislative proposal that may never get farther in the process than a proposal, creates a confusing picture of the actual amounts being recommended by the Administration.

2. **Are waiting times and access still an issues for veterans as we have heard? If so, do you believe $159 million (perhaps funded in part by the $316 million in "management efficiencies") is enough to address this problem?**

Answer: We believe that a $500 million supplemental is required to solve this and other access issues, as well as an adequate and realistic FY 2003 health care appropriation. We frankly doubt that there are "management efficiencies" left after many years of relying upon this catch-all to mask inadequate budgets. Already unconscionable waiting times have been growing worse, and veterans are facing de facto health care rationing. We have heard reports that medical center directors are actively attempting to persuade certain veterans from utilizing the VA health care system, while others are planning on no longer providing such basic items as mouthwash, tissues, lotion, or soap for veteran patients. This is a direct effect of previous inadequate health care budgets. It is essential that the shortfalls already identified in FY 2002 be remedied, and the true resources necessary for FY 2003 be provided.

3. **At first blush, your recommendation for VA medical care funding actually appears lower than the VA's request. Will you comment on some of the difference in the VA's proposal and your proposal that may explain this discrepancy?**

Answer: Essential to *The Independent Budget*'s requested "current services" budget recommendation is the acknowledgement that spending deficiencies created by past budgets must be remedied. For this reason, *The Independent Budget* has requested an appropriation of $24.5 billion, a $3.1 billion increase.

The Administration's FY 2003 budget request for VA health care calls for only a $1.4 billion increase in appropriated dollars for VA health care. To provide the actual resources necessary to provide health care to sick and disabled veterans, the Administration relies upon unreliable third-party collections, "management efficiencies," and a controversial scheme to charge some veterans an annual $1500 deductible. *The Independent Budget* believes that there are no more "management efficiencies" of the magnitude relied upon in the Administration's budget request available to make up for inadequate appropriations, and is strongly opposed to the Administration's deductible proposal.

In addition, *The Independent Budget* calls for a separate appropriation of $250 million in recognition of the VA's fourth mission – to serve as a backup to the Department of Defense in times of war or national emergency as well as being a key agency in assisting states and localities respond to disasters. Surprisingly, the Administration has not requested any significant resources to meet these statutory duties.

The Independent Budget health care funding recommendation charts a more prudent approach to caring for our Nation's veterans. *The Independent Budget* recommends an increase of $3.1 billion in appropriated dollars for VA health care. This amount would provide the resources needed to provide timely, high-quality health care in the coming fiscal year, as well as provide funding needed to make up for shortfalls from previous years. This $3.1 billion increase would also enable the VA to begin to address systematic problems relating to waiting times and access to care. This recommendation does not rely upon uncertain third-party collections, phantom "management efficiencies," or controversial deductible schemes. *The Independent Budget* requested increase honors the federal government's duty to provide health care to sick and disabled veterans, health care earned by these veterans' service to our Nation.

CHAIRMAN SMITH TO AMVETS

Questions for the Record
Chairman Chris Smith
Committee on Veterans' Affairs
February 13, 2002

Hearing on Department of Veterans Affairs
Fiscal Year 2003 Budget

Question 1. Mr. Jones: it appears that *The Independent Budget* recommendation for the National Cemetery System is within $5 million of the Administration's budget. However, *the IB* recommends increasing the burial and plot allowances paid to the family when a veteran dies. Are there areas of the VA budget that *the IB* believes could be reduced in order to pay for these suggested increases?

Response 1. Mr. Chairman: Yes, the *IB* request for $138 million, while the same as the administration's request, does not include the Office of Personnel offset and is therefore, $5 million above the administration's request for $138 million. We do *not* support the administration's legislative proposal to shift accrual costs for pension and post-retirement benefits to VA from the Office of Personnel Management.

Regarding the *IB* recommendation for increases in a series of burial benefits, the IBVSOs note that these benefits, while never intended to cover the full costs of burial, now pay for only a fraction of what they covered when they were initiated in 1973. Their value has seriously eroded over the years.

While federal budget pay-as-you-go rules, prior to fiscal year 2003, required an offset of new direct spending legislation by an equivalent amount of direct spending reductions, we are informed that PAYGO rules do not apply to fiscal year 2003 spending. In this regard, we do not believe that new direct spending legislation requires a zero sum game based solely on veterans benefits and services. We recommend that the Committee request an adjustment to its mandatory account ceiling to accommodate the suggested change.

CHAIRMAN SMITH TO PARALYZED VETERANS OF AMERICA

Questions for the Record
Chairman Chris Smith
Committee on Veterans' Affairs
House of Representatives
February 13, 2002

Hearing on the Department of Veterans Affairs Fiscal Year 2003 Budget

The following are answers to questions submitted to the Paralyzed Veterans of America:

1. **Mr. Fuller: Your testimony also mentions long waiting times. What would you think of requiring VA to enter into an arrangement with health care organizations currently managing other federal health programs (such as Tricare)? Under this proposal, the veteran would pay a premium to VA, and VA would either provide the requested care itself within certain time limits, or it would refer the veteran to a health care provider who is currently authorized to provide health care to other Federal beneficiaries. Would PVA support such a solution to current waiting time problems?**

Answer: *The Independent Budget* is opposed to turning the VA into an insurer of health care, rather than a provider of health care. The problem of extended waiting times for health care, in effect de facto health care rationing, is a serious problem facing veterans seeking care in the VA system. The remedy is simple – provide adequate resources and personnel to shorten waiting times and provide timely health care. To turn the VA into an insurer would provide fewer incentives to meet the federal responsibility to veterans, and would lead, inexorably to the demise of the VA health care system. The problem of long waiting times does not need extensive study – provide adequate resources to meet the federal responsibility to veterans.

2. **Mr. Fuller: The Secretary's testimony included very specific ideas about how to achieve significant savings in the health care area. Mr. Evans has introduced legislation to revise the manner in which VA procures health care items, a bill that he believes will save VA money. The VA Inspector General has found that many VA medical centers are paying higher prices than necessary for many health care items. Given this evidence of mismanagement, how can the *Independent Budget* say that "there are no more efficiencies to be wrung out of the system"?**

Answer: First off, *The Independent Budget* does not condone mismanagement and we do not believe that mismanagement and "management efficiencies" are synonymous. What we do oppose, and what we testified against, is the continual use of "management efficiencies" as a slogan meant to artificially fill gaps in inadequate health care budgets. The VA, already in FY 2002, is supposed to find over $200 million in "management efficiencies" to pay for the continued enrollment of priority 7 veterans. The recently released FY 2003 budget expects the VA to find $316 million in "management efficiencies" in the coming fiscal year. In FY 2001, the VA was expected to find $360 million in "management efficiencies." What *The Independent Budget* questions is the availability, year after year, of hundreds of millions of dollars worth of management efficiencies that seem to pop up right before the budget is submitted to Congress. We applaud, and expect the VA to take actions to save money and provide better health care to veterans.

CHAIRMAN SMITH TO DISABLED AMERICAN VETERANS

Questions for the Record
Chairman Chris Smith
Committee on Veterans' Affairs
February 13, 2002

Hearing on Department of Veterans Affairs
Fiscal Year 2003 Budget

Question 1. Mr. Surratt: you mentioned the need to pass legislation to exclude disability compensation from countable income for Federal Programs. The Independent Budget provides one example where compensation is considered—the HUD Senior Housing Program. First, do you know whether this rule is statutory or regulatory? Second, are you aware of similar rules in other Federal Programs? Which ones? Third, please explain why the IB would exclude cash income attributable to a service-connected disability from being considered as available to meet some of the veteran's day-to-day living expenses.

Answer. For the various HUD housing programs available to seniors and others, the term "income" for purposes of eligibility to low-income housing means "income from all sources of each member of the household." 42 U.S.C.A. § 1437a(b)(4) (West Supp. 2001); *see also* 12 U.S.C.A. § 1701q(i), (k)(8) (West 2001) (cross-referencing 42 U.S.C.A. § 1437a(b)(2) for definition of "very low-income" for purposes of supportive housing for the elderly), 42 U.S.C.A. § 1471(b)(4), (5) (West 1994) (cross-referencing 42 U.S.C. A § 1437 for definitions of "income," "adjusted income," "low income," and "very low income," for farm assistance for elderly and others), 42 U.S.C.A. § 1485(q) (West 1994) (cross-referencing 42 U.S.C.A. § 1437 for determining income for elderly or other persons of low income). There is no express exception for veterans' benefits. For "adjusted income," public housing agencies have some discretion to exclude "[s]uch other amounts for other purposes, as the public housing agency may establish." § 1437a(b)(5)(B)(iii).

For benefits subject to income limitations, we assume the general rule is often that "income" includes all money received except that expressly excluded. We are aware of one statute that expressly includes veterans' benefits as countable income for purposes of the program concerned. *See* 42 U.S.C.A. § 1382a(2)(B) (West Supp. 2001) (including veterans' compensation and pension as income for purposes of Supplemental Security Income benefits under the Social Security program). We are aware that the United States Department of Education takes veterans' benefits into consideration in connection with financial aid programs for students. We are unaware of any exclusion of VA compensation from consideration in other income-based programs such as Medicaid.

The IB believes it entirely justified to exclude from consideration in means-tested Federal programs cash income from compensation for service-connected disabilities. A fundamental principle of veterans' benefits is that veterans, by virtue of their service and sacrifices, deserve special benefits that are separate and in addition to benefits the Government provides to other citizens. As presented, this question appears to probe the issue of whether compensation, as a replacement for lost earnings income, has any special status warranting its exemption from countable income for purposes of income-based government benefits. While, in theory, some of the rates of disability compensation correspond, "as far as practicable, [to] average impairments of earning capacity," 38 U.S.C.A. § 1155 (West 1991), it is undebatable that the bases for compensation reach far beyond loss of earnings. Generally, disability has been recognized to result in several compensable elements: "The compensable elements of disability, aside from medical care, are the loss of earning capacity, the loss of physical integrity, the loss of physical vitality, pain and suffering, and perhaps others. The loss of physical vitality is manifested in higher mortality rates for a group and consequently a shortened after-lifetime or life expectancy." The President's Commission on Veterans' Pensions, *Compensation for Service-Connected Disabilities*, H.R. Comm. Print No. 84-231, at 134 (1956). Service-connected disabilities diminish the quality of life of veterans as well as create economic loss from impairments in earning capacity. Under VA's *Schedule for Rating Disabilities,* veterans may be compensated for such noneconomic loss as disfigurement and loss of procreative powers. Under flat-rate "statutory" awards, veterans are compensated for anatomic loss or loss of use of bodily members and organs, and other severe disabilities, entirely apart from compensation based on impairment in earning capacity. Veterans are provided compensation based on being bedridden, housebound, or in need of aid and attendance.

If a veteran's receipt of compensation is used to reduce entitlement to benefits available to other citizens—to offset or disqualify veterans from obtaining other government services—the value of compensation is negated and its purposes defeated. Disability compensation becomes a liability, a disadvantage, and an encumbrance in obtaining government services available to similarly situated non-veterans. Because the compensation is offset against other entitlement, it is in effect deducted from the programs generally available to other citizens, and the veteran really receives nothing additional for his or her disability and is thus not compensated. If the Government uses compensation to reduce entitlement to other services, the veteran receives nothing more than the non-veteran citizen. A veteran who meets the income requirements for government assistance, but for compensation, should not be penalized because of the receipt of compensation, a special benefit provided by a grateful nation for disabilities incurred in military service. This measure of additional and special assistance for disabled veterans will result in no windfall.

Accordingly, a veteran's receipt of compensation for the effects of service-connected disability should not disqualify him or her for benefits that are available to others and would be available to the veteran if he or she were not disabled. However, perhaps it is more appropriate to exclude VA compensation from consideration in HUD housing than in programs that somewhat duplicate VA benefits, such as those that provide direct disability payments or medical care to low income persons.

Question 2. Mr. Surratt: we have been trying to get VA to face up to the fact that there's a huge unfounded liability in the SDVI program, one that seems to get larger every year. If we changed the SDVI program and required them to use modern methods to calculate the premiums, how would it affect this unfounded liability? Are you concerned that VA hasn't come up with a plan to fund this liability?

Answer. The government undertook the responsibility of insuring servicemembers during World War I because they were not an acceptable risk for life insurance on the commercial market. United States Government Life Insurance (USGLI) replaced War Risk policies in 1919, and individuals could maintain their life insurance after service under these policies. The government continued to insure servicemembers and veterans during World War II and Korea. Thus, the government got into the life insurance business on a long-term basis. In the 1950s, the government moved away from activities that competed with commercial enterprise in the private sector. Although commercial insurers wanted to sell life insurance to veterans, they did not want to insure disabled veterans, who were considered poor risks. The solution was for private companies to cover ordinary risks and the government to continue responsibility for higher indemnities associated with the increased risks of insuring disabled veterans. Government life insurance programs have limited basic coverage to $10,000 since their inception under the War Risk Insurance Act in 1917.

For service-connected disabled veterans, the Service Disabled Veterans' Insurance (SDVI) program offers this small amount of coverage at, what were intended to be, standard rates. Premiums are based on the rates a healthy individual would have been charged when the program was established in 1951. In addition, rates on term policies are capped at the age 70 renewal rate to provide financial relief from high premiums thereafter. Premiums are waived for total disability, and veterans entitled to waiver of premiums may, before age 65, obtain $20,000 supplemental coverage for which they must pay premiums under the same rates applicable to the base policy. The extra-hazard costs of insuring veterans in poorer health by reason of service-connected disabilities are appropriately borne by the government. In addition to the costs from insuring substandard risks at standard rates, the extra-hazard costs arise from waiver of premiums. Because the SDVI program is subsidized by appropriations, the policies pay no dividends.

Under 38 U.S.C.A. § 1921(a) (West 1991) ("Extra hazard costs"), "[t]he United States shall bear the excess mortality cost and the cost of waiver of premiums on account of total disability traceable to the extra hazard of military or naval service, as such hazard may be determined by the Secretary." Accordingly, this funding is included in the "Veterans Insurance and Indemnities" appropriation, a "mandatory program" account that also covers extra-hazard costs of other insurance programs, such as disability payments and excess mortality costs. We therefore believe that extra-hazard costs for SDVI, as costs contemplated and provided for in a

mandatory program, are not an unfunded liability arising from any discretionary actions by VA. As such, these costs are not a matter over which VA has any control or any responsibility to devise funding sources.

Under 38 U.S.C.A. § 1922(a) (West 1991), premium rates for SDVI insurance "shall be based on the Commissioners 1941 Standard Ordinary Table of Mortality." Because life expectancy has improved since the inception of this program, premiums based on the higher mortality rates of 1941 no longer fulfill congressional intent to provide life insurance to service-connected disabled veterans at standard rates. Indeed, because service-connected disabled veterans are paying premiums higher than today's standard rates, they are, in effect, subsidizing their own service-connected disabilities.

As noted, the intent of the SDVI program was to make life insurance available to disabled veterans at rates comparable to rates offered by commercial insurers to healthy persons. Yet, because they are not based on current mortality experience, the premium rates for SDVI are much higher than standard premium rates for insurance in the commercial market. For example, the government charges a veteran age 50 $14.28 annually for each $1,000 of coverage under an SDVI 5-year term policy, compared to an average $3.81 per $1,000 of coverage for the same policy at standard, non-smoker rates in the commercial market. The SDVI premium is 375% of the commercial premium. Premium rates on ordinary, or whole life, plans under SDVI are similarly much higher than commercial rates. For example, for a veteran age 50, the SDVI annual premium for each $1,000 of coverage is $38.76 compared to $25.50 for males and $20.45 for females in commercial policies.

As it does with other veterans' programs, Congress should make necessary adjustments to this program to bring it back in line with its original intent and beneficial purpose. Such change would be consistent with the Government Performance and Results Act of 1993 (GPRA), the purpose of which is to ensure government programs achieve their intended results.

We do not have actuarial expertise and are therefore unable to project how reducing premiums in accordance with current mortality experience would affect spending in this mandatory account. Regardless of the cost, it is change that must be made to maintain the worth of this program. The alternative would constitute an admission that Congress no longer feels an obligation to restore parity between disabled veterans and other Americans regarding the cost of life insurance and that Congress is no longer concerned about the insurability of disabled veterans, insurability they lost or had impaired because of service-connected disabilities.

Question 3. For veterans benefit programs, in your statement for the record on page 2 you make a number of recommendations for legislation. What are the highest five priorities from that list?

Answer. The recommendations we choose for the IB are ones important to and agreed upon by the coauthors. They are all important to us. Bills have been introduced or are in preparation to cover some of these recommendations. One of our very highest priorities is concurrent receipt of disability compensation and military retired pay. However, we do not include that in response to this question because that issue is primarily under the jurisdiction of the Armed Services Committee. For the benefit programs, the following are our five highest priorities in the order in which they appear in the IB:

- exemption of temporary total disability awards from delayed effective dates for payment (IB at 13)
- increase in housing and home adaptation grants with provisions for automatic annual adjustments for increased costs (IB at page 15)
- increase in automobile grant with provisions for automatic annual adjustments for increased costs (IB at page 16)
- removal of limitation on payment of accrued benefits (IB at page 16 and H.R. 3733)
- restoration of protection against award of veterans' benefits to third parties in divorce actions (IB at page 19)

We also ask that the Committee take action this year on the recommendations we make for improving judicial review of veterans' matters (IB at 32-34). These are especially important issues.

Question 4. On page 5 of your written statement, you assert that $16 million, not $6.3 million, is the real funding level needed for The Education Expert System (TEES) automation initiative for VBA's education service. How did you arrive at that number?

Answer. The TEES initiative is a multi-year project to be completed in two phases, followed by enhancement or replacement of existing education applications that support electronic processing. The total non-recurring acquisition costs of approximately $45-$50 million include development costs; hardware costs; non-recurring labor costs; travel during development, testing, and installation; and establishment of an independent test and development system. The necessary funding is predominantly for contractor support to design, build, integrate, test, and deploy the new system and the costs of enhancing and replacing current education applications.

The $16 million requested by the IB is to cover primarily contract work on software development in phase I. This would include approximately $4.5 million for contract redesign of the "On Line Approval File" (OLAF) to allow educational institutions to electronically submit program approvals to VA through State Approving Agencies. It would include approximately $6.5 million to develop the "Out of System Award Payment" (OSAP) system, which would automate education awards that are currently processed outside the Benefits Delivery Network (BDN). These awards include Licensing and Certification, Flight, Correspondence, On the Job Training, and Apprenticeship. The remainder of this $16 million would include various labor and other costs for VBA, along with some initial costs for Phase II and the enhancement/replacement part of the effort.

By delaying until later years much of the work that was planned for FY 2003, the President's budget delays the necessity to request the level of funding recommended by the IB. Implementation of Phase II, which was originally planned for FY 2005 and which is expected to cost approximately $20 million, would be delayed until FY2007 under the President's budget. Our recommendation in the IB is an approximation of the cost of this project in FY 2003 if undertaken according to original timetables and plans. In essence, the $16 million was the cost of that part of the total project VA planners originally wanted to complete in FY 2003. To avoid worsening of processing times for education claims, this technology should be developed and deployed as soon as possible.

Hearing on the Fiscal Year 2003 Budget
For the Department of Veterans Affairs
February 13, 2002

Follow-up Question for Rick Surratt
Deputy National Legislative Director
Disabled American Veterans
From the Honorable Silvestre Reyes
Ranking Democratic Member
Subcommittee on Benefits
House Committee on Veterans Affairs

Question. The Independent Budget recommended that $16 million be provided for upgrading and expanding capabilities of The Education Expert System ("TEES"). Please explain how you arrived at the $16 million figure and how this amount would improve services to veterans.

Answer. VBA's Education Service has experienced a decline in the timeliness with which it processes claims for education benefits. In 1999, the average processing time for original applications for education benefits was 26.1 days. In 2001, that time had grown to 50 days. VA attributes this decline in timeliness to backlogs resulting from a higher volume of work. By electronic data exchange and automated claims processing through an "expert" system, VA projects it can more efficiently process claims and reduce waiting times for beneficiaries. We noted in *The Independent Budget*:

> To upgrade and expand the limited application and capabilities of its present electronic data interchange and electronic funds transfer systems, VA is undertaking development of The Education Expert System (TEES). This new system will replace and integrate several existing processes. It will improve electronic data exchange, automate claims processing and payment, and perform auditing functions. This system is an investment in efficiency and modernization.

For VA's education programs, this system will modify or replace several existing processes and systems to perform a variety of functions:

- adjudicate basic eligibility for and entitlement to education benefits with a rules-based decision
- process enrollments and payments
- track continuing entitlement
- handle inquires, reporting, audit, and quality control functions
- generate letters, reports, accounting, and audits.

Thus, fully funding this important project to ensure its full and prompt development will provide VA with the means and get VA on the road to delivering education benefits to veterans and other eligible beneficiaries, who must depend on these benefits to attend school, in a timely manner. The speed with which all business interactions occur in today's modern environment requires that VA have modern technology to deal with educational institutions and the volume and variety of processes necessary to administer the vast educational programs under its jurisdiction. This initiative is consistent with movement from outdated, patchwork systems to an "enterprise architecture" in information technology as required by the Clinger-Cohen Act of 1996. *See* Department of Veterans Affairs, *FY 2003 Budget Submission* vol. 6 (Departmental Performance Plan), pp. 99-102.

The Independent Budget does not recommend a higher level of funding than the President's budget because *The Independent Budget* wants VA to have more than it needs for this project. *The Independent Budget* is concerned with real needs for VA and the priority veterans' programs deserve. It is a self-evident principle that the President's budget tailors funding requests to accommodate competing interests and overall political objectives of the Administration.

The TEES initiative is a multi-year project to be completed in two phases, followed by enhancement or replacement of existing education applications that support electronic processing. The total non-recurring acquisition costs of approximately $45-$50 million include development costs; hardware costs; non-recurring labor costs; travel during development, testing, and installation; and establishment of an independent test and development system. The necessary funding is predominantly for contractor support to design, build, integrate, test, and deploy the new system and the costs of enhancing and replacing current education applications.

The $16 million requested by the IB is to cover primarily contract work on software development in phase I. This would include approximately $4.5 million for contract redesign of the "On Line Approval File" (OLAF) to allow educational institutions to electronically submit program approvals to VA through State Approving Agencies. It would include approximately $6.5 million to develop the "Out of System Award Payment" (OSAP) system, which would automate education awards that are currently processed outside the Benefits Delivery Network (BDN). These awards include Licensing and Certification, Flight, Correspondence, On the Job Training, and Apprenticeship. The remainder of this $16 million would include various labor and other costs for VBA, along with some initial costs for Phase II and the enhancement/replacement part of the effort.

By delaying until later years much of the work that was planned for FY 2003, the President's budget delays the necessity to request the level of funding recommended by the IB. Implementation of Phase II, which was originally planned for FY 2005 and which is expected to cost approximately $20 million, would be delayed until FY2007 under the President's budget. Our recommendation in the IB is an approximation of the cost of this project in FY 2003 if undertaken according to original timetables and plans. In essence, the $16 million was the cost of that part of the total project VA planners originally wanted to complete in FY 2003. To avoid worsening of processing times for education claims, this technology should be developed and deployed as soon as possible.

CONGRESSMAN EVANS TO THE AMERICAN LEGION

ANSWERS TO POSTHEARING QUESTIONS
CONCERNING FEBRUARY 13, 2002, HEARING

FOR THE VETERANS SERVICE ORGANIZATION PANELISTS

FROM CONGRESSMAN LANE EVANS
RANKING DEMOCRATIC MEMBER
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS

1. **The Legion clearly did not anticipate the legislative proposal to shift certain OPM retirement accrual accounts to the individual agencies. What is your position on shifting these accounts?**

   The American Legion does not take issue with the actual administrative shifting of the accounts. The American Legion objects to the fact that the amount shifted from certain OPM retirement accrual accounts was made to look like an increase in actual dollars for medical care when in reality it was not.

2. **Medicare subvention continues to be a high legislative priority for The American Legion. You have stressed the need for this authority to ensure proper congressional oversight to protect against waste, fraud and abuse. Do you believe this authority is necessary to ensure appropriate oversight to the billing and collections process in VA?**

Medicare has identified fraud waste and abuse as a well documented problem throughout the health care industry. The American Legion believes Medicare subvention should greatly reduce incidents of fraud, waste and abuse that the private sector experiences in billing because the billing will occur between two Federal agencies with congressional oversight. There is no incentive for wrongdoing. Having said that, we remain very concerned with the VA's track record regarding billing and collections. Although VHA has begun to implement the Revenue Cycle Improvement Plan - designed to improve collections – they have a long road ahead of them. Of the seven performance measures VHA is using as indicators of performance and improvement, they lag behind the private sector benchmarks for these indicators by a considerable margin in nearly all of them. Additionally, the overall timeframe to implement the 24 identified actions to improve the core business processes of the revenue cycle will take nearly three years. We believe that appropriate oversight to ensure the timely implementation of this process is needed.

3. **As your statement suggests, private-sector Medicare+Choice plans are failing across the country. Do you believe that VA can improve upon their practices and make Medicare Subvention profitable or at least not a drain on VA health care resources?**

The American Legion does not advocate VA making a profit from Medicare subvention, but rather help pay the cost of care for priority Group 7 veterans. It is our opinion that the treatment of Priority 7 veterans is already a drain on VA health care resources, treatment for which the VA is not getting reimbursed. Enrollment in that priority group has increased by 500% since 1996. This increase is the very reason Secretary Principi proposed the $1500 deductible in the FY 2003 budget. The VA had to find a way to pay for the Priority 7 veteran health care or stop enrollment. We believe that VA, if given the authority for Medicare subvention will be successful. The American Legion also believes that these collections must not be used as an offset to the VA budget.

As stated earlier, The American Legion's concern is with VA's lack of experience in their work force in billing. Granted they haven't had to cultivate expertise in this area until recently, and so have not built a base upon longevity and survivability that the private sector has done or the Indian Health Service (IHS). The American Legion recently met with representatives from the IHS to discuss their experience with Medicare

subvention. We thought it important to evaluate the experience of an agency that had already been down this road.

We learned that in 1990, IHS collected only about $200,000. After absorbing significant cost increases that were never funded in 1992 or 1996, an emphasis was placed on collections for sheer survival. IHS now collects about $.5 billion a year. Of this, about $100 million is from Medicare billing. The bulk of collections come from Medicaid, which is consistent with the circumstances of the Indian population which historically is less affluent and has a shorter life span.

There was an initial investment in training and a learning curve involved in the business process. Coding in particular was a problem. These problems as stated previously were overcome, as there was no alternative. Survival was contingent upon their ability to collect the available funds.

IHS and DoD use electronic medical records that can then generate billing information. It was noted that software solutions are available that make this feasible. We believe VA can also succeed in the business practice if given the authority to bill Medicare.

Although The American Legion is very concerned with VHA's ability to effectively and efficiently bill and collect third party payers, we feel that like IHS, their survival may depend on it. We therefore recommended that VA be directed to dramatically improve their internal Medical Care Collection Fund (MCCF) collections or contract out this function. It is unconscionable to us that the denial of a veteran's entitlement to access his or her earned entitlement to Medicare would be denied because a group of employees were not capable of completing the paperwork.

The American Legion would welcome a hearing on Medicare subvention.

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