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THE ADMINISTRATION'S PROPOSED FISCAL YEAR 2005 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

FEBRUARY 10, 2004

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C O N T E N T S

FEBRUARY 10, 2004

SENATORS

	Page
Specter, Hon. Arlen, U.S. Senator from Pennsylvania	1
Prepared statement	1
Campbell, Hon. Ben Nighthorse, U.S. Senator from Colorado, prepared statement	3
Graham, Hon. Bob, U.S. Senator from Florida	15
Prepared statement	16
Akaka, Hon. Daniel K., U.S. Senator from Hawaii	21
Murray, Hon Patty, U.S. Senator from the State of Washington	22
Nelson, Hon. E. Benjamin, U.S. Senator from Nebraska	24
Jeffords, Hon. James M., U.S. Senator from Vermont	25
Rockefeller IV, Hon. John D., U.S. Senator from West Virginia	27

WITNESSES

Principi, Hon. Anthony, Secretary, U.S. Department of Veterans Affairs; accompanied by Robert H. Roswell, M.D., Under Secretary for Health; John W. Nicholson, Under Secretary for Memorial Affairs; William H. Campbell, Assistant Secretary for Management; D. Mark Catlett, Principal Deputy Assistant Secretary for Management; and Robert Epley, Associate Deputy Under Secretary of Benefits for Policy and Program Management	3
Prepared statement	8
Gaytan, Peter S., Principal Deputy Director, Veterans Affairs and Rehabilitation, The American Legion	39
Prepared statement	40
Fuller, Richard B., National Legislative Director, Paralyzed Veterans of America	53
Prepared statement	173
The Independent Budget	54
Surratt, Rick, Deputy National Legislative Director, Disabled American Veterans	175
Prepared statement	176
Hayden, Paul A., Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States	184
Prepared statement	185
Jones, Richard, National Legislative Director, AMVETS	188
Prepared statement	190

THE ADMINISTRATION'S PROPOSED FISCAL YEAR 2005 BUDGET FOR VETERANS' PROGRAMS

TUESDAY, FEBRUARY 10, 2004

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 3 p.m., in room 418, Russell Senate Office Building, Hon. Arlen Specter (chairman of the committee) presiding.

Present: Senators Specter, Campbell, Graham, Rockefeller, Jeffords, Akaka, Murray, and Nelson.

OPENING STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Chairman SPECTER. Good morning, ladies and gentlemen. The Veterans' Affairs Committee will now proceed. We have a very distinguished panel of witnesses before us at the moment. My full statement will be admitted to the record, without objection.

[The prepared statement of Chairman Specter follows:]

PREPARED STATEMENT OF ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Good afternoon, ladies and gentlemen. And good afternoon to you, Secretary Principi. It is a pleasure to welcome you—and the veterans service organizations, who are scheduled to testify after you—to this hearing.

The subject of today's hearing is the Administration's proposed VA budget for fiscal year 2005. We will hear testimony from Secretary Principi and the senior VA officials who have accompanied him here today. And we will hear from the service organizations who will voice the separate views of each organization, if they so choose, and who—except for The American Legion—will also speak as advocates for the "*Independent Budget*." It is my hope that, armed with this testimony, the Committee will be in a position to render its collective judgment on a number of weighty policy questions. Among them are these:

- What precisely is VA asking for this year in terms of added appropriations to provide medical care benefits to currently-enrolled veterans?
- Will this amount be sufficient to get VA through the year—even assuming that VA continues to bar new enrollments of so-called "Priority 8" veterans? Or will VA need more, just to maintain current levels of services?
- What precisely will VA need in terms of added funding if, for example, the Congress declines to enact certain "policy proposals" requested by VA?
- And finally, what would it take for VA to be able to reopen enrollments to "Priority 8" veterans? That is a prospect that I, for one, have not given up on.

These are critical questions, questions that we raise this year at a critical time while the Nation is at war.

We mourn the deaths of every service member who has fallen in Iraq and Afghanistan, and we assure the families of these brave men and women that their sacrifice—the ultimate sacrifice—will not be forgotten. But while we mourn those who have fallen, we are also mindful of the fact that we have been relatively fortunate. One year ago, we were prepared for the possibility that hundreds—even thousands

or tens-of-thousands—might fall, particularly as our troops approached Baghdad. That did not happen; we are, of course, fortunate that it did not.

But now we face a very difficult situation in Iraq. While our troops were greeted with enthusiasm initially—how can any of us ever forget the scene in Baghdad when the tyrant's statue was pulled down by the Iraqis . . . with some small assistance from United States troops—they now face a very troubling situation. They are viewed by at least some elements of the Iraqi population as enemy occupiers, and they face the threat of enemy small arms fire, and terrorist bombings, daily. Our men and women will overcome these obstacles to peace and stability in Iraq—but not without a price. The Nation—and VA—must be prepared to bind up the bodily and emotional wounds that will ensue as our troops fully stabilize Iraq. After we have done that, the Nation—and VA—must be prepared to offer the readjustment benefits that these veterans will have earned. For we cannot have and we will not have—another generation of veterans, like Vietnam veterans, who were asked to fend for themselves after their return from the battlefield.

I am concerned that this proposed budget may not suffice to meet these requirements. Rather, it seems barely adequate—if it is adequate at all—to meet the existing challenges that face VA. It will be my mission here to find out whether this budget proposal is, at minimum, adequate. And if—as I expect—it is not adequate, it will be my mission to find out what it will take for VA to maintain current services; what it will take to care for and provide services to the new young veterans who will return from Iraq this year; what it will take to work through, and eliminate, clinical appointment waiting times; and what it will take to reopen the VA healthcare system to so-called "low-priority" veterans. That is the budget number I want to identify and secure for VA.

I know that the Secretary shares these goals. He surely is not a man who will fail to meet the needs of the brave new veterans who are earning their benefits in Iraq today. And he is not a man who will fail to meet the needs of veterans who have earned their benefits in prior wars. He has proved that to me repeatedly—most recently, on the Saturday that just passed when he visited with veterans in Oil City, PA and Warren, PA. I think few Cabinet Members would have made such a trip on the weekend through blizzard conditions. But I dare say that Secretary Anthony J. Principi is not like most Cabinet Members. He is, in this Chairman's opinion, the most extraordinary man ever to serve as Secretary of Veterans' Affairs. So I will not be critical of him. I will just seek to learn what VA will need to accomplish the goals that he and I—and the President—share.

Mr. Secretary, I look forward to your testimony. And I look forward to continuing to work with you in service to the Nation's veterans.

Chairman SPECTER. I want to begin by recognizing our distinguished Secretary of Veterans Affairs, Anthony Principi, with special appreciation for his coming to Pennsylvania last Saturday to announce the opening of veterans' clinics in Will City, Pennsylvania, and Warren, Pennsylvania. It was a rare occurrence for a cabinet officer to visit a city of that size, those sizes. We are very grateful to the Secretary. The people of Pennsylvania, more importantly, were very grateful and I think it is a solid sign as to the dedication that the Secretary and the Department have to aiding the veterans of America.

I have said on many occasions, but never too often, my deep commitment to the veterans arises from the first veteran I knew, who was my father, Harry Specter, who was a veteran of World War I, who was promised a bonus, did not get his bonus, and perhaps in this year's appropriations bill we can deliver in a metaphorical sense on my father's bonus.

Senator Campbell, would you care to make an opening statement?

Senator CAMPBELL. No. I think with your permission I will just submit for the record, Mr. Chairman. I have to leave in about half an hour, so I would rather hear Secretary Principi, and welcome, Mr. Secretary.

Chairman SPECTER. Thank you very much, Senator Campbell.

[The prepared statement of Senator Campbell follows:]

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman. I would like to welcome you, Mr. Secretary, and thank you for appearing before the committee today. I am looking forward to your testimony which will give us a better picture of how the Administration is going to address the serious issues facing the VA at this time. And, I also want to welcome the members of the VSO's who are going to comment on the budget today. I will be listening carefully to your testimony as you represent the opinions of veterans throughout the nation.

Though I notice that the fiscal year 2005 budget calls for a small increase in discretionary health care funding for veterans, I continue to be concerned that we find a way to take care of what will be an increasing number of elderly veterans. I think we can all agree that one of our greatest national responsibilities is the welfare of our nation's veterans. It is critical that we find a balanced way to make good on the promises to them.

I am also encouraged that the budget includes monies for construction under the CARES (Capital Asset Realignment for Enhanced Services) initiative. I understand that incorporating change into a huge Federal entity is difficult. But, changing from institutional care to primary and community-based care has left the VA with vacant and under-utilized buildings. Deciding how to use these facilities is difficult and disposing of such assets is a complex process. But, operating hundreds of unneeded buildings can cost billions of dollars each year. I look forward to the draft report of the CARES Commission which I understand is expected sometime this week.

Mr. Secretary, I appreciate your strong commitment to our veterans who have service-connected injuries and illnesses and have always admired you for stepping up to the plate to make the hard calls. However, the proposals to add co-pays and user fees for those not suffering from a military-related disability, will affect many veterans in my State of Colorado whose incomes are close to the cutoff for health care services.

Speaking as a veteran, I believe we need to do all we can to serve those who have so honorably served us all. And, knowing that our soldiers are putting their lives on the line for us at this moment makes it even more important that we make veterans' health care our No. 1 priority.

I will be listening to the veterans who are meeting with me this month and I am looking forward to the testimony of the many veterans' organizations that will be testifying at the joint hearings during the next few weeks.

Mr. Secretary, again, I thank you for being here. I look forward to hearing details of the budget proposal and how you plan to address these issues within the proposed budget. I look forward to working with you and the VSO's to make sure that our veterans receive the care they have been promised.

I thank the chair.

Chairman SPECTER. Then, Mr. Secretary, the floor is yours.

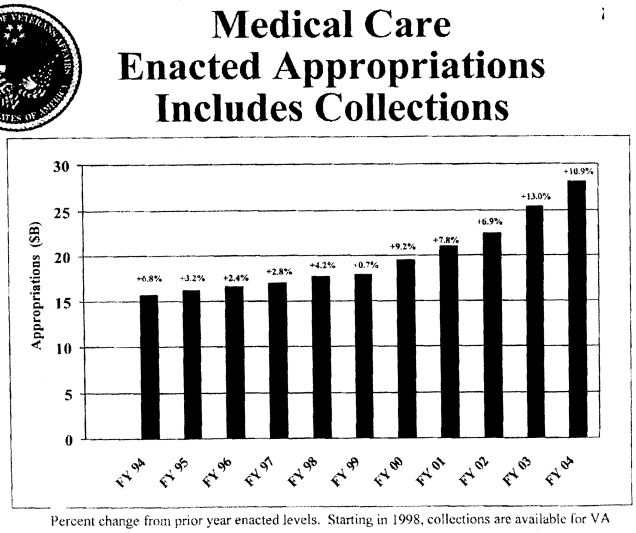
STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH; JOHN W. NICHOLSON, UNDER SECRETARY FOR MEMORIAL AFFAIRS; WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT; D. MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT; AND ROBERT EPLEY, ASSOCIATE DEPUTY UNDER SECRETARY OF BENEFITS FOR POLICY AND PROGRAM MANAGEMENT

Secretary PRINCIPI. Thank you, Mr. Chairman, Senator Campbell, and members and staff of the committee. It is always a pleasure to be before you. It was a great, great pleasure and a privilege to be in Pennsylvania this past weekend and to be around so many heroes of World War II and Korea and Vietnam who were in the audience.

Eight-hundred-thousand more veterans will receive VA medical care this year and next year if this bill is approved than in 2001,

the year I took office as Secretary of Veterans Affairs, and these veterans are the beneficiaries of a series of increased budgets requested by the President and made tangible through active and successful advocacy by the members of this committee and throughout this body, and I thank you for your support for the Department and the men and women we have the privilege to serve.

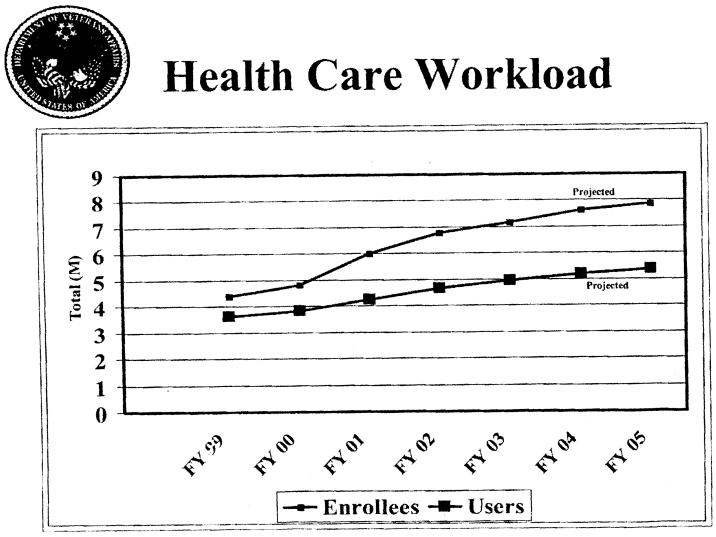
As the first chart shows—please show that first chart—our health care budget with the enactment of the 2005 request have increased more than 40 percent, and on behalf of America's veterans, I thank the members of the committee again for following through on your commitment to our nation's citizen soldiers.



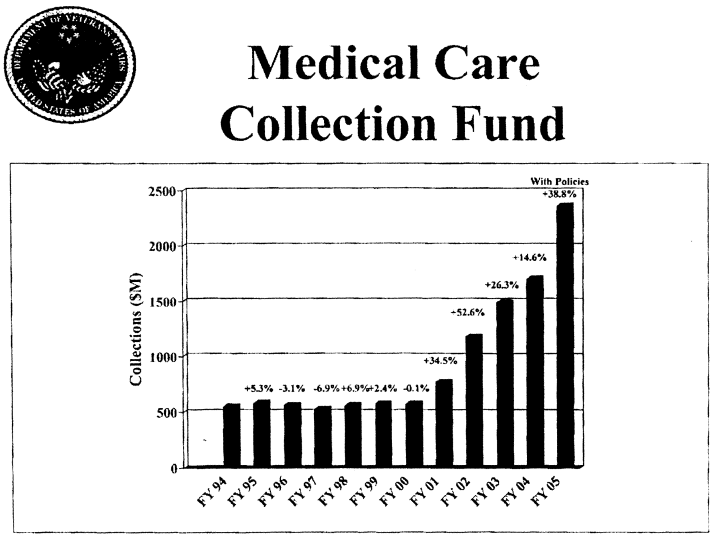
Percent change from prior year enacted levels. Starting in 1998, collections are available for VA

I believe that this is the golden age of VA health care, our quality of care never before so good, veterans' access to VA care never before this broad, and never before have we treated so many veterans at so many locations, and please show the second chart.

Since 2000, 2 years of the previous administration, my predecessor, through 2005, we will have treated one more million veterans than we did in the year 2000. And since the year 2000, and again, our projections through the year 2005 will show that three million more veterans have enrolled in the VA health care system, unprecedented growth in the number of veterans who have come to us for care and who have enrolled in the VA health care system, a significant number who have not used the system but have enrolled in the event that they may need to come to us.



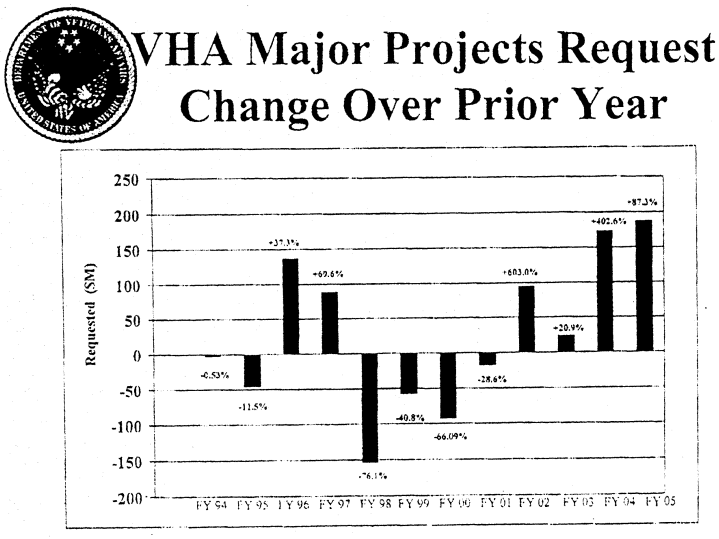
For 2005, our total health care budget authority would increase 4.2 percent over 2004, and to be clear, that figure, that percentage, includes our capital construction as well as our collections. We have counted collections as part of the VA budget since 1998, when the Congress made the decision to allow those resources to remain in the VA health care system rather than going into the United States Treasury as miscellaneous receipts. I believe that we will be able to sustain the forward momentum we have achieved over the last 3 years.



If the President's request is endorsed by Congress, we will have the resources we need to meet our goal of scheduling non-urgent primary care for 93 percent of veterans within 30 days and 99 percent within 90 days. Our goal is to totally eliminate our waiting list within 90 days.

If the 2005 budget is approved, we will be able to provide timely quality treatment to all the veterans we believe will come to us seeking health care this year and next, and we will continue to focus on the medical care needs of the men and women who were disabled in uniform, our service-connected disabled veterans. I believe our highest priority needs to be for them. For the lower-income veterans, the poorest of the poor who have few other options for health care in this country, and those who need our specialized services—spinal cord injury, blind rehabilitation, they too have been identified by Congress as the highest priority.

Compared to the current fiscal year, this budget request more than doubles our appropriation request for construction of CARES identified new and improved facilities. Would you please show the construction chart, which is that one there.



This has been a big concern to all of us, I know to members of the committee and certainly to me, the aging of our infrastructure, the modernization that needs to take place. Using the authority granted by Congress this past year, we will also apply up to $400 million of the 2004, this year's medical care appropriation, to CARES projects. These actions will enable us to commit approximately $1 billion more in 2004 and 2005 toward transforming VA's medical facilities into a 21st century health care system.

Mr. Chairman, members of the committee, I know that you have a concern and share with me a goal of ensuring that we provide high quality medical care for our young men and women returning home from our overseas conflicts Enduring Freedom and Iraqi

Freedom, and I am absolutely confident that this budget will enable us to meet our commitment to this new generation of freedom's defenders.

The numbers are relatively small so far. Of the 83,000 service members, including Guard and Reserve, who have separated from the military and served in Iraqi Freedom conflict, roughly 12 percent have come to us for care, about 9,700 of those veterans. Of the 15,000 who have been discharged and served in Enduring Freedom, Afghanistan, roughly 1,400 have come to us for care since they have been discharged, and I expect those numbers will increase, but they are relatively low compared to Persian Gulf I and, of course, Vietnam and some of our other conflicts. But we need to be prepared to take care of this new generation of men and women who have fought.

We still have challenges. Of that, there is little doubt. We are responding to those challenges with policy initiatives. First, we emphasize our commitment to the highest priority veterans by asking Congress to raise the income threshold to $16,500 from $9,800 for exempting low-income veterans from pharmacy copayments, lifting the burden of copayments from the poorest of our veteran population who seek care in the VA. We also ask that you eliminate all copayments imposed on former POWs. We also proposed to eliminate hospice care copayments, hospice care provided in the home, hospice care provided under contract. We ask for the authority to reimburse our patients for the copayments that they must pay their insurance companies when they seek emergency care in private sector hospitals.

At the same time, we ask Congress to approve both a modest increase in pharmacy copayments and an annual fee totaling less than $21 per month, a very small portion of the cost of care, for higher-income non-service-disabled veterans using our system. I want to be very clear to our veterans that this is not an enrollment fee. It would be an annual use fee collected only from veterans receiving care and could be paid on a monthly or annual basis, depending upon the needs of the veteran.

For many, many years, Congress has mandated such a fee for enlisted personnel—tech sergeants, staff sergeants, petty officers—who spent at least 20 years in the military and retire and enroll in the Department of Defense health care system, Tricare. They are required to pay $254 a year to be enrolled in the DOD health care system after serving 20 years on active duty, and we are just asking those who have no service-connected disabilities, do not stay in the military and retire, and have higher incomes, usually higher than what a petty officer or staff sergeant retires on, to pay a modest use fee.

We can meet some of our other challenges on our own. For example, I approved the recommendation of the Under Secretary of Health, Dr. Roswell, to address regional funding imbalances by including all veterans, Category 7 and Category 8 veterans, using our system and our resource allocation model.

In addition to improving access to health care, the President directed me to bring our benefits processing under control, and by last year, thanks to the hard work of the people in VA, we were able to reduce our inventory of rating-related claims, the time it

takes a veteran to receive a decision for a disability claim or pension, down to 253,000 from a high of 432,000, and the percentage of veterans waiting more than 6 months for a decision was down to 18 percent from 48 percent. I don't think this would have happened without the increase requested by the President and the decisions of this body in giving us additional people to handle the claims workload. Our backlog has gone up recently due to a September 2003 court decision, but Congress has corrected that issue and we are now back on track to achieve our goals.

I think it is very telling that the number of veterans receiving service-connected disability compensation is projected to increase to 2.6 million from 2.3 million in 2001, and we see a sizable increase in the funding, the mandatory funding for disability compensation. In 2005, the President is asking for almost $2.8 billion in additional funding for disability compensation.

VA is not only health care and benefits, we also honor our veterans in their final rest. Advanced by the President's budget request, we will continue the greatest expansion of the national cemetery system since the Civil War. One new cemetery has just been opened. We will open five more new cemeteries over the next year, and we have proposed to add six new cemeteries to the system by the year 2009. This will increase our gravesites by 85 percent over the current number within our 120 existing national cemeteries, so this is indeed a major, major expansion of our national cemetery system, and, of course, it is required because of the large number of veterans, World War II and Korea, passing from us, some 1,800 a day. So we are very, very pleased with this expansion.

I am confident that the President's request and the actions of the Congress will allow us to continue to build on our record of commitment and success. I thank the committee for all you have done to help us achieve our goals and I look forward to your questions. Thank you.

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

[The prepared statement of Secretary Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2005 budget proposal for the Department of Veterans Affairs (VA). The focal point of this budget is our firm commitment to continue to bring balance back to our health care system by focusing on veterans in the highest statutory priority groups.

The President's 2005 budget request totals $67.7 billion (an increase of $5.6 billion in budget authority): $35.6 billion for entitlement programs and $32.1 billion for discretionary programs. Our request for discretionary funds represents an increase of $1.2 billion, or 3.8 percent, over the enacted level for 2004, and supports my three highest priorities:

- provide timely, high-quality health care to our core constituency—veterans with service-connected disabilities, those with lower incomes, and veterans with special health care needs;
- improve the timeliness and accuracy of claims processing; and
- ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.

The growth in discretionary resources will support a broad array of benefits and services that VA provides to our Nation's veterans. Including medical care collections, funding for the medical care program rises by $1.17 billion over the 2004 enacted level. As a principal component of our medical care budget, we are requesting $524 million to begin implementing recommendations stemming from studies associated with the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our budget request using a slightly modified new budget account structure that we proposed for the first time last year. This new structure more clearly presents the full funding for each of the benefits and services we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program. I am committed to providing Congress with the information and tools it needs to be comfortable with enacting the change.

MEDICAL CARE

The President's 2005 request includes total budgetary resources of $29.5 billion (including $2.4 billion in collections) for the medical care program, an increase of 4.1 percent over the enacted level for 2004, and more than 40 percent above the 2001 level. With these resources, VA will be able to provide timely, high-quality health care to nearly 5.2 million unique patients, a total 21 percent higher than the number of patients we treated in 2001.

I have taken several steps during the last year to refocus VA's health care system on our highest priority veterans, particularly service-connected disabled veterans who are the very reason this Department exists. For example, we recently issued a directive that ensures veterans seeking care for service connected medical problems will receive priority access to our health care system. This new directive provides that all veterans requiring care for a service connected disability, regardless of the extent of the injury or illness, must be scheduled for a primary care evaluation within 30 days of their request for care. If a VA facility is unable to schedule an appointment within 30 days, it must arrange for care at another VA facility, at a contract facility, or through a sharing agreement.

By highlighting our emphasis on our core constituency (Priority Levels 1–6), we will increase our focus on the Congressionally identified highest priority veterans. The number of patients within our core service population that we project will come to VA for health care in 2005 will be nearly 3.7 million, or 12 percent higher than in 2003. During 2005, 71 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2003 was 66 percent. In addition, we devote 88 percent of our health care funding to meet the needs of these veterans.

While part of our strategy for ensuring timely, high-quality care for our highest priority veterans involves a request for additional resources, an equally important component of this approach includes a series of proposed regulatory and legislative changes that would require lower priority veterans to assume a small share of the cost of their health care. These legislative proposals are consistent with recent Medicare reform that addresses the difference in the ability to pay for health care. We are submitting these proposals for Congress' reconsideration because we strongly believe they represent the best opportunity for VA to secure the necessary budgetary resources to serve our core population. Among the most significant legislative changes presented in this budget are to:

- assess an annual use fee of $250 for Priority 7 and 8 veterans; and
- increase co-payments for pharmacy benefits for Priority 7 and 8 veterans from $7 to $15.

We will work with Congress to enact our legislative proposal to eliminate the pharmacy co-payment for Priority 2–5 veterans, who have fewer means by which to pay for these costs, by raising the income threshold from the pension level of $9,894 to the aid and attendance level of $16,509 (for a single veteran). This would allow about 394,000 veterans within our core constituency to receive outpatient medications without having to make a co-payment.

The 2005 budget includes several other legislative and regulatory proposals that are designed to expand health care benefits for the Nation's veterans. Among the most significant of these is a provision that would give the Department the authority to pay for insured veteran patients' out-of-pocket expenses for urgent care services if emergency/urgent care is obtained outside of the VA health care system. This proposal would ensure that veterans with life-threatening illnesses can seek and receive care at the closest possible medical facility. In addition, we are proposing to eliminate the co-payment requirement for all hospice care provided in a VA setting and all co-payments assessed to former prisoners of war. Currently, veterans are charged a co-payment if hospice care cannot be provided in a VA nursing home bed either because of clinical complexity or lack of availability of nursing home beds.

The President's 2005 budget for VA's medical care program also continues our effort to expand access to long-term care for veterans. This budget includes a legislative proposal to focus long-term care on non-institutional settings by expanding the

1998 average daily census nursing home capacity requirement to include the following categories of extended care services—nursing homes, community residential care programs, residential rehabilitation treatment programs, home care programs, non-institutional extended care services under VA's jurisdiction, and long-term care beds for which the Department pays a per diem to states for services in State homes. As part of this effort, we aim to significantly enhance access to non-institutional care programs that allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

We are continuing our work with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who cannot enroll in VA's health care system, can gain access to the new "VA Advantage" program. This would allow these veterans to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide.

In return for the resources we are requesting for the medical care program in 2005, we will continue to aggressively pursue my priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. During the last 3 years, we have significantly enhanced veterans' access to health care. We have opened 194 new community clinics, bringing the total to 676. Nearly 9 out of every 10 veterans now live within 30 minutes of a VA medical facility. This expanded level of access has resulted in an increase in the number of outpatient visits from 44 million in 2001 to 51 million in 2003, as well as a 26 percent rate of growth in the annual number of prescriptions filled to a total of 108 million last year. To further highlight the Department's emphasis on the delivery of timely, accessible health care, our standard of care for primary care is that 93 percent of appointments will be scheduled within 30 days of the desired date and 99 percent of all appointments will be scheduled within 90 days. For appointments with specialists, the comparable performance goal is 90 percent within 30 days of the desired date.

As I mentioned earlier Mr. Chairman, a key component of our overall access goals is the assurance that veterans seeking care for service-connected medical problems will receive priority access to health care. In addition, we have dramatically reduced the number of veterans on the waiting list for primary care. We will eliminate the 6-month waiting list no later than April 2004.

VA's health care system continues to be characterized by a coordinated continuum of care and achievement of performance outcomes that improve services to veterans. In fact, VA has exceeded the performance of private sector and Medicare providers for all 18 key health care indicators, from diabetes care to cancer screening and immunizations. The Institute of Medicine has recognized the Department's integrated health care system, including our framework for using performance measures to improve quality, as one of the best in the nation. Additionally, VA's quality score based on a survey conducted by the Joint Commission on Accreditation of Healthcare Organizations exceeds the national average quality score (93 versus 91).

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We expect to show improvements in both of our principal measures of health care quality. The clinical practice guidelines index will rise to 71 percent in 2005, while the prevention index will increase to 84 percent.

The 2005 budget includes additional management savings of $340 million that will partially offset the need for additional funds to handle the increasing utilization of health care resources, particularly among our highest priority veterans who require much more extensive care, on average, than lower priority veterans. We will achieve these management savings through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies such as consolidations.

Our projection of medical care collections for 2005 is $2.4 billion. This total is 38 percent above our estimated collections for 2004 and is more than three times the collections level from 2001. Approximately $407 million, or 61 percent, of the increase above 2004 is possible as a result of the proposed medical care policy initiatives. The Department continues to implement the series of aggressive steps identified in our revenue cycle improvement plan in order to maximize the health care resources available for the medical care program. We are establishing industry-based performance and operational metrics, developing technological enhancements, and integrating industry-proven business approaches, including the establishment of centralized revenue operation centers. For example, during the last year we have lowered the share of reimbursable claims receivable greater than 90 days old from 84 percent to 39 percent, and we have decreased the average time to produce a bill from 117 days to 49 days. Further, the Department is implementing the Patient Fi-

nancial Services System in Veterans Integrated Service Network 10 (Ohio). This will be a single billing system that we will use for both hospital costs as well as physician costs, and involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DoD) to enhance the coordination of the delivery of benefits and service to veterans. To address this Presidential initiative, our two Departments established a high-level Joint Executive Council to develop and implement significant collaborative efforts. We are focusing on three major systemwide issues: (1) facilitating electronic sharing of enrollment and eligibility information for services and benefits; (2) establishing an electronic patient health record system that will allow rapid exchange of patient information between the two organizations by the end of 2005; and (3) increasing the number of shared medical care facilities and staff. The sharing of DoD enrollment and eligibility data will reduce the burden on veterans to provide duplicative information when making the transition to VA for care or benefits. Shared medical information is extremely important to ensure that veterans receive safe and proper care. VA and DoD are working together to share facilities and staff in order to provide needed services to all patients in the most efficient and effective manner.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The 2005 budget includes $524 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative, a figure more than double the amount requested for CARES for 2004. This is a multiyear program to update VA's infrastructure to meet the needs of veterans in the 21st century and to keep our Department on the cutting edge of medicine. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access. The resources we are requesting for this program will be used to implement the various recommendations within the National CARES plan by funding advance planning, design development, and construction costs for capital initiatives.

Mr. Chairman, the independent commission that is reviewing our draft CARES plan will be delivering their report to me soon. The commission had originally intended to complete their work by the end of November, but due to the intense interest in this project and the overwhelming volume of information they are faced with examining, their report has been delayed a few months. I look forward to reviewing the commission's analysis and recommendations. We will thoroughly evaluate their report and seriously consider their recommendations before making our final realignment decisions and preparing for the next phase of the CARES program.

MEDICAL AND PROSTHETIC RESEARCH

The President's 2005 budget includes total resources of $1.7 billion to support VA's medical and prosthetic research program. This request is comprised of $770 million in appropriated funds, $670 million in funding from other Federal agencies such as DoD and the National Institutes of Health, as well as $230 million from universities and other private institutions. Our budget includes an initiative to assess pharmaceutical companies for the indirect administrative costs associated with the clinical drug trials we conduct for these organizations.

This $1.7 billion will support nearly 2,900 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, aging, diabetes, heart disease, mental illness, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

VETERANS' BENEFITS

The Department's 2005 budget request includes $36 billion for the entitlement costs associated with all benefits administered by the Veterans Benefits Administration (VBA). Included in this total, is an additional $2.740 billion for disability compensation payments to veterans and their survivors for disabilities or diseases incurred or aggravated while on active duty. Recipients of these compensation benefits will have increased from 2.3 million in 2001 to over 2.6 million in 2005. The budget includes another $1.19 billion for the management of these programs: disability compensation; pensions; education; vocational rehabilitation and employment; housing; and life insurance. This is an increase of $26 million, or 2.2 percent, over the enacted level for 2004.

We have made excellent progress in addressing the Presidential priority of improving the timeliness and accuracy of claims processing. Not only have we hired and trained more than 1,800 new employees in the last 3 years to directly address our claims processing backlog, but the productivity of our staff has increased dramatically as well. Between 2001 and 2003, the average number of claims we completed per month grew by 70 percent, from 40,000 to 68,000. Last year the inventory of rating-related compensation and pension claims peaked at 432,000. By the end of 2003, we had reduced this backlog of pending claims to just over 250,000, a drop of over 40 percent. We have experienced an increase in the backlog during the last few months, due in large part to the impact of the court decision (PVA v Secretary of Veterans Affairs) that interpreted the Veterans Claims Assistance Act of 2000 as requiring VA to wait a full year before denying a claim. However, this rise in the number of pending claims will be temporary, and we expect the backlog to be back down to about the 250,000 level by the end of 2004. We thank the Committee for the legislation that eliminated the mandatory 1-year waiting period.

In 2002 it took an average of 223 days to process a claim. Today, it takes about 150 days. We are on track to reach an average processing time of 100 days by the end of 2004 and expect to maintain this timeliness standard in 2005. One of the main reasons we will be able to meet and then sustain this improved timeliness level is that we have reduced the proportion of claims pending over 6 months from 48 percent to just 19 percent during the last 3 years.

To assist in achieving this ambitious goal, VA established benefits delivery at discharge programs at 136 military installations around the country. This initiative makes it more convenient for separating servicemembers to apply for and receive the benefits they have earned, and helps ensure claims are processed more rapidly. Also, the Department has assigned VA rating specialists and physicians to military bases where servicemembers can have their claims processed before they leave active duty military service.

We expect to see an increase in claims resulting from the return of our brave servicemen and women who fought to protect the principles of freedom in Operation Enduring Freedom and Operation Iraqi Freedom. We propose to use $72 million of the funds available from the war supplemental during 2004 to address the challenges resulting from an increasing claims processing workload in order to assist us in reaching our timeliness goal of 100 days by the end of 2004. We propose to use the remaining $28 million in 2005 to help sustain this timeliness standard.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2005 performance goal for the national accuracy rate for compensation claims is 88 percent, well above the 2001 accuracy level of 80 percent.

This budget request includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $2 million for the Virtual VA project, the ultimate goal of which is to replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. The 2005 funding will maintain Virtual VA at the three Pension Maintenance Centers. We are seeking $3.4 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2005 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

The Veterans Service Network (VETSNET) development is nearing completion and is scheduled to begin deployment in April 2004. This system offers numerous improvements over the legacy Benefits Delivery Network (BDN) that it is replacing (e.g., correction of material weaknesses and implementation of comprehensive claims processing within a modern corporate environment). Sufficient platform capacity is required to successfully deploy VETSNET and to ensure the continued and uninterrupted payment of approximately $24 billion annually in benefits to around 3.4 million deserving veterans and their beneficiaries. Therefore, $5 million in funding is requested to procure the capacity required. This platform capacity will ensure successful deployment and operation of VETSNET throughout VBA's Regional Offices and in a modern corporate environment that integrates all components of claims processing (e.g., establishing the claim, rating the claim, preparing the claim award, and paying the claim award). Without sufficient platform capacity, the Veterans Benefits Administration will be unable to operate this critical new system.

In support of the education program, the budget proposes $5.2 million for continuing the development of the Education Expert System. These resources will be used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment cer-

tification. This initiative will contribute toward achievement of our 2005 performance goals for the average time it takes to process claims for original and supplemental education benefits of 25 days and 13 days, respectively.

VA is requesting $9.6 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

In order to make the delivery of VA benefits and services more convenient for veterans and more efficient for the Department, we are requesting $1.5 million for the collocation and relocation of some regional offices. Some of this will involve housing regional office operations in existing VA medical facilities. In addition, we are examining the possibility of collocations using enhanced-use authority, which entails an agreement with a private developer to construct a facility on Department-owned grounds and then leasing all or part of it back to VA. At the end of these long-term lease agreements, the land and all improvements revert to VA ownership.

In recognition of the fact that the home loan program is primarily a benefit that assists veterans in making the transition from active duty life to veteran status, the 2005 budget includes a legislative proposal to phase in an initiative to limit eligibility for this program to one-time use. Under our proposal, one-time use of the loan program would apply to any person who becomes a veteran after the date this proposed legislation becomes law. Those who are already veterans, or who will achieve veteran status prior to enactment of the proposed law, would retain their eligibility to use the home loan benefit as many times as they need to for a period of 5 years after the law takes effect. Once that 5-year period has passed, they would no longer be able to use this benefit more than once. This legislative proposal does not change eligibility for active duty personnel who would retain the ability to use this benefit as many times as they need it. VA home loans are important for first-time buyers because they require no down payment-making them riskier than other loans. After the first use, home equity can be used to obtain more favorable terms from conventional loans, or through the Federal Housing Administration. Therefore, limiting this benefit to its original intent of one-time use after leaving the military will lower loan volume and risk, save money over the long-term, and coordinate Federal programs.

BURIAL

The President's 2005 budget includes $455 million for the burial program, of which $181 million is for mandatory funding for VA burial benefits and payments and $274 million is for discretionary funding, including operating and capital costs for the National Cemetery Administration and the State Cemetery Grant program. The increase in discretionary funding is $9 million, or 3.4 percent, over the enacted level for 2004, and includes operating funds for the five new cemeteries opening in 2005.

This budget request includes $926 thousand to complete the activation of new national cemeteries in the areas of Detroit, MI and Sacramento, CA. These are the last two of the six locations identified in the May 2000 report to Congress as the areas most in need of a national cemetery. The other four cemeteries will serve veterans in the areas of Atlanta, GA, South Florida, Pittsburgh, PA, and Fort Sill, OK.

With the opening of new national cemeteries and State veterans cemeteries, the percentage of veterans served by a burial option within 75 miles of their residence will rise to 83 percent in 2005. The comparable share was less than 73 percent in 2001.

The $81 million in construction funding for the burial program in 2005 includes resources for Phase 1 development of the Sacramento National Cemetery (CA) as well as expansion and improvements at the Florida National Cemetery (Bushnell, FL) and Rock Island National Cemetery (IL). The request includes advanced planning funds for site selection and preliminary activities for six new national cemeteries to serve veterans in the following areas: Bakersfield, CA; Birmingham, AL; Columbia/Greenville, SC; Jacksonville, FL; Sarasota County, FL; and southeastern Pennsylvania. Completion of these new cemeteries will represent an 85 percent expansion of the number of gravesites available in the national cemetery system since 2001, almost doubling the number of gravesites during this time period. In addition, the budget includes $32 million for the State Cemetery Grant program.

In return for the resources we are requesting for the burial program, we expect to achieve extremely high levels of performance in 2005 and to continue our noble work to maintain the appearance of national cemeteries as shrines dedicated to honoring the service and sacrifice of veterans. Our performance goal for the percent of

survey respondents who rate the quality of service provided by the national cemeteries as excellent is 96 percent, and our goal for the percent of survey respondents who rate national cemetery appearance as excellent is 98 percent. In addition, we will continue to place emphasis on the timeliness of marking graves. Our performance goal for the percent of graves in national cemeteries marked within 60 days of interment is 82 percent in 2005, a figure dramatically above the 2002 performance level of 49 percent.

MANAGEMENT IMPROVEMENTS

Mr. Chairman, we have made excellent progress during the last year in implementing the President's Management Agenda. Our progress in the financial, electronic government, budget and performance, and DoD/VA coordination areas is currently rated "green." Our human capital score is "yellow" due only to some very short-term delays. However, VA's competitive sourcing rating is "red" because existing legislation precludes us from using necessary resources to conduct cost comparisons of competing jobs such as laundry, food and sanitation service. The Administration will work with Congress to develop legislation to advance this effort that would free up additional resources to be used to provide direct medical services to veterans. We will continue to take the steps necessary to achieve the ultimate goals the President established for each of the focus areas.

We have several management improvement initiatives underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. We are currently realigning our finance, acquisition, and capital asset management functions into business offices across the Department. There will be one business office in each of the 21 Veterans Integrated Service Networks and a single office for the National Cemetery Administration. For the Veterans Benefits Administration, the majority of the field functions will be centralized into product lines. In addition, we are establishing an Office of Business Oversight in our Office of Management that will provide much stronger oversight of these functions by our Chief Financial Officer, will improve operations through more specialization, and will achieve efficiencies in staffing. The realignment of these business functions will reduce and standardize field business activities into a more manageable size, limit the number of sites to be reviewed, provide for more consistent interpretation of policies and procedures, and promote implementation of performance metrics and data collection related to these business functions. As a result of the realignment, we will significantly strengthen compliance and consistency with finance, acquisition, and capital asset policies and procedures.

We continue to make excellent progress in implementing the recommendations of our Procurement Reform Task Force, as 43 of the 65 recommendations have been completed. By the end of 2004, we expect to implement all of the remaining recommendations. These procurement reforms will optimize the performance of VA's acquisition system and processes by improving efficiency and accountability. We expect to realize savings of about $250 million by the end of 2004 as a result of these improvement initiatives. This figure will rise after we have completed all 65 recommendations.

During 2005 VA will continue developing our enterprise architecture that will ensure that all new information technology (IT) projects are aligned with the President's E-government initiatives as well as the Department's strategic objectives. The enterprise architecture will help eliminate redundant systems throughout VA, improve IT accountability and cost containment, leverage secure and technologically sound solutions that have been implemented, and ensure that our IT assets are built upon widely accepted industry standards and best practices in order to improve delivery of benefits and services to veterans. One of our primary focus areas in IT will be cyber security. We will concentrate on securing the enterprise architecture and providing continuous protection to all VA systems and networks. This will require purchases of both hardware and software to address existing vulnerabilities.

We are continuing the development and implementation of our CoreFLS project to replace VA's existing core financial management and logistics systems with an integrated, commercial off-the-shelf package. CoreFLS will help us address and correct management and financial weaknesses in the areas of effective integration of financial transactions from Department systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. We have conducted initial tests at selected sites and are still on schedule for full implementation during 2006.

The Department has developed a comprehensive human capital management plan and has started implementing some of the strategies outlined in this plan. In addition, we are implementing a redesigned performance appraisal system to better en-

sure that all employees' performance plans are linked with VA's mission, goals, and objectives.

CLOSING

Mr. Chairman, VA has achieved numerous successes during the last 3 years that have significantly improved service to our country's veterans. We have enhanced veterans' access to our health care services that set the national standard with regard to quality; improved the timeliness of health care delivery; expanded programs for veterans with special health care needs; dramatically lowered the time it takes to process veterans' claims for benefits; and expanded access to our national cemetery system. The President's 2005 budget will provide VA with the resources necessary to continue to improve our delivery of benefits and services, particularly for veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

Chairman SPECTER. I turn now to our distinguished ranking member, Senator Graham, for an opening statement.

Senator GRAHAM. Thank you very much, Mr. Chairman. I have a statement that I would like to file for the record.

Chairman SPECTER. Without objection, it will be made a part of the record in full.

STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

Senator GRAHAM. I would like to summarize some of the issues that I raise in that opening statement. I am concerned about the resource commitment that this budget makes, which has been calculated as a 1.8 percent increase for medical care and calls for the reduction in other areas, such as 540 staff responsible for processing veterans' claims. I am also concerned about the question of the additional pressures that are being placed upon the VA medical system.

For an example, there will be a significant number of those American men and women who have been wounded in Afghanistan or Iraq who will return to the United States, separate from the military, and then be statutorily entitled to 2 years of medical care provided by VA. I am concerned as to whether we are prepared to meet that challenge.

I am also concerned about the reliance on annual user fees on higher-income veterans,—those with income of as little as $24,000 a year. Also, the doubling of copayments for prescription drugs is a matter of concern at a time when we are trying to expand coverage of prescription drugs in the Medicare program. I will ask some questions about the consistency here.

In my State, we have had difficulty with delays in veterans being able to get access to health care providers. There is a standard being suggested that enrolled veterans would be seen within 30 days for primary care. Does this budget provide the resources necessary to achieve that goal?

At the Gainesville VA Hospital, there are several hundred veterans who have been waiting well beyond 30 days for their initial visit and there are 600 veterans who have waited more than a year for services like audiology at the Fort Myers clinic. How will this budget impact on those delays?

Mr. Principi, not to just focus on some of the areas of concern, I want to commend you and the VA for the professionals that you

have been able to bring in and retain within the VA system. I recently spent time at the VA hospital in Miami and at the outpatient clinic in Ocala, and I was very impressed with the quality of providers and the level of not just satisfaction, but enthusiasm, of those veterans who had received care from those professionals.

Mr. Chairman, I have other points that are made in the statement that will be in the record, but at this point, I would defer to other members of the committee and then to questions.

Chairman SPECTER. Thank you very much, Senator Graham.

[The prepared statement of Senator Graham follows:]

PREPARED STATEMENT OF BOB GRAHAM, U.S. SENATOR FROM FLORIDA

I join Senator Specter in welcoming our witnesses to today's hearing and I look forward to working with the Chairman, Members of this Committee, Secretary Principi, and the veterans service organizations to meet the needs of the men and women who have served our nation.

Today, we begin the long process of ensuring that the fiscal year 2005 budget allows VA to provide veterans with the care and benefits they have earned. To say that the proposed budget is tough is an understatement. The request includes only a 1.8 percent increase for medical care, and it calls for cutting 540 staff that process veterans benefits.

This budget, unfortunately, reflects the priorities of this Administration and, if enacted, will have devastating effects on the men and women who have served this country with honor. The Administration has said the proposed VA budget will "provide the best possible health care and benefits to our veterans."

I would disagree, and I believe we will hear similar sentiments from our witnesses on the second panel. As we shape VA's budget for the next year, we must move beyond hopeful rhetoric and political gamesmanship and take an honest assessment of the needs of veterans. We must then match this assessment with real dollars.

When you take away the new and higher fees that are to be paid directly by veterans and the theoretical management efficiencies, the Administration has asked for an appropriation that fails to cover half of the expected inflationary increases. I take issue with a budget that relies on an annual user fee levied upon so-called "higher income" veterans—especially when "higher income" can mean as little as $24,000 a year.

It is insulting to laud this budget, but continue to bar veterans from VA health care. It is unfair to double the prescription drug co-payments for other veterans. And it is nothing short of hypocrisy to deliberately reduce demand for health care services and then to count that as savings.

I am relieved to hear that waiting times for care will disappear in early fiscal year 2004, but am mystified as to how this will occur. Does this mean that all enrolled veterans will be seen within 30 days for primary care? Or does this mean that veterans will not have to wait to be assigned an appointment, but will quickly get an appointment that is scheduled up to a year later? Will the hundreds of veterans who must wait more than a year to see a doctor at the Gainesville VA Hospital or the 600 veterans waiting more than a year for audiology care at the Ft. Myers clinic be seen promptly? VA's committed professionals are already struggling to handle the increased patient load, and for the next fiscal year they will be doing it without a corresponding increase in resources.

It is not only the VA health care system that stands to suffer under this budget. The Administration proposes a cut, for the second year in a row, in the number of staff who process VA benefits, including those who decide veterans' disability claims. I commend the progress that VA professionals have made in reducing the staggering backlog of claims over the past year, but I fear that these cuts will erode the gains VBA has made. In addition, this budget request does not account for recent changes to the system. Specifically, last year's concurrent receipt legislation will allow military retirees that are more than 50 percent disabled to receive both their disability pay and pension payments.

However, this new benefit may bring a rush of claimants into the system who believe they are eligible, creating an additional backlog. The Administration's budget does not account for additional claims that service members returning from Iraq and Afghanistan will file during the next 2 years.

In addition, the Administration has failed to consider the health care needs of these returning service members, re-directing $100 million intended for their care. Even without these demands, veterans are currently forced to wait 189 days for VA

to make a determination of eligibility for benefits. With the proposed funding level, I have trouble believing VA will be able to meet, much less sustain, the ambitious target of 100 days for processing new claims.

As we begin discussing next year's budget proposal, there will be talk of fiscal discipline. It is true that the deficit is a serious problem we must tackle, but we must make choices. Should we choose to make a permanent tax cut our nation's priority? Or should we fulfill our commitment to those who have served our Nation honorably? We cannot send the signal to our men and women in uniform that we will not care for them upon their return. I fear the Administration's budget proposal may send that signal.

Chairman SPECTER. We will now proceed with our customary approach of 5-minute rounds of questions on the early bird principle of order of arrival.

Mr. Secretary, I commend you for the candid testimony which you gave to the House last week as reported in CQ that you asked for a $1.4 billion addition, which was denied by the Office of Management and Budget. I think that kind of candor is really necessary. I know the custom in many quarters is to not be candid, but we understand the budget constraints. We know about the deficit. We understand the problems with the economy and the very heavy costs of the wars, the ones against terrorism, Al Qaeda, and the other in Iraq. That kind of candor is very impressive.

We have noted your request for copayments and we will consider them carefully, but in a spirit of candor from this side of the table, they are very, very difficult. When you start making evaluations of ability to pay, that is very hard. And in an era where we are calling on our servicemen and women to do so much and recruiting depends in significant manner on what is happening to veterans who have been discharged as well, we take that into account before we make our own budgetary considerations.

There has been a good deal of talk about Medicare subvention, where the veterans' budget would be supplemented by the care you give which could have been, perhaps should have been, borne by Medicare. You have a new program called VA Advantage. Would you describe that new approach and what you anticipate from that by way of increased revenues?

Secretary PRINCIPI. Yes, Mr. Chairman. Secretary Thompson and I over the past year have worked to develop a program, a concept, wherein veterans who are in Category 8, because of this dramatic increase in workload and the Congress directs that I make an annual enrollment decision, have not been able to enroll in the VA health care system would be able to come to the VA for care under this VA Advantage program and we would be reimbursed from Medicare.

Over the past 6 to 8 months, we have been working very closely with the folks at HHS and CMS to work through the many, many legalistic and regulatory issues on getting reimbursed from Medicare, but I am hopeful by the end of this year those veterans can come to the VA for health care and VA would get reimbursed by the Medicare Trust Fund. I am not sure we have a projection on how much we would receive, but the cost of their care would be covered in full by Medicare. So it is the first time that we have been able to develop a program with Medicare and I am hopeful that we can work through the many regulatory issues that Medicare has so that we can implement this program as soon as possible.

Chairman SPECTER. That would certainly be a big boost to the VA budget if that can be accomplished.

We have also looked to supplementing the VA income by proceeds of those who are insured. Would you give us a brief summary as to what you anticipate in that respect?

Secretary PRINCIPI. Well, again, starting in 1998, the Congress authorized the VA to keep the revenues from third-party payments, payments from insurance companies. Rather than those dollars going into the Treasury as miscellaneous receipts and then coming back to the VA indirectly in increased appropriation, Congress said, you keep them there and you count them as new resources in addition to your appropriation. President Clinton started that, rightfully so, and it has been that way—it has been programmed that way since.

We are making great progress in doing better collecting from insurance companies. We still have some difficulty with HMOs, and, of course, Medicare is off the table, the largest insurance company in the nation, so to speak. But this year, we project to collect—or for 2005, a little over one billion dollars in revenues. That is used to enhance our medical care appropriation and expand the reach of health care, buy more pharmaceuticals, more outpatient visits, more inpatient visits.

So it is a great program. We just need to do better in our accounts in collecting those dollars from insurance companies. We are improving, but we still have a ways to go.

Chairman SPECTER. Your answer ended just with the expiration of my time so I will not ask you another question and I will yield now to Senator Graham.

Senator GRAHAM. Thank you.

Chairman SPECTER. He is the one exception to the early bird rule, the Ranking Member.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to ask in this round about the responsibility of the VA to provide medical care for combatants who have separated from the service. During the 2003 consideration of the VA's budget, I proposed an amendment to add $375 million to meet the health care needs of returning service members. This amount was based on a formula taking the percentage of veterans who sought VA health care and benefits following the first Gulf War, multiplying that by the VA's average per patient cost today, and the result of that is $375 million.

In conference with the House, that amount was reduced to $100 million. It is now my understanding that the Administration believes that the right number is not $375 million or $100 million, but is zero, and intends to redirect the full amount from health care to the Veterans Benefit Administration.

Mr. Secretary, is that policy correct, and if so, what is the basis of the Administration's determination that there will be no budgetary cost in terms of providing benefits as statutorily required to returning servicemen and women?

Secretary PRINCIPI. Senator Graham, I applaud you and I applaud the Congress for adding that $100 million. But the law in the appropriation, or the language of the appropriation bills says for an additional amount for costs associated with processing claims of

veterans who may have incurred injuries with service in the Persian Gulf, war combat arena, $100 million. It did give me the authority to use the dollars for health care, as well, and the reason that I have elected to use the $100 million for veterans' benefits and veterans' claims is because in 2004, the President's request and the Congress's actions increased our health care budget by 11.5 percent. I think that is probably a record. We received close to $3 billion in 2004, 4 months, 5 months late, but nonetheless a very dramatic increase.

Senator, I am absolutely confident that this increase that you have given us in 2004 is more than adequate to ensure that we take care of the health care needs of veterans coming back from Iraq and Afghanistan. Otherwise, that money would be there, believe me.

At the same time that we received this dramatic increase in health care spending in 2004, for our Benefits Administration, the processing of claims, I think there was zero increase. We really are struggling in the Veterans' Benefits Administration to ensure that these claims that veterans who are coming back wounded, filing for disability compensation, are processed in a timely manner and that was the basis for the decision.

The law said veterans' benefits, and I could move money over to health care if I need it. I found that I didn't need to do so, Senator. The $100 million is very important and that is how we have applied it.

Senator GRAHAM. Are you saying $100 million to process benefit claims is going to be focused exclusively on combatants returning from Afghanistan or Iraq?

Secretary PRINCIPI. No, sir. I am trying to use that money to—you know, obviously, by improving our timeliness, by having the right equipment, the right people on board—we are giving them a very, very high priority, but it is going to help us improve our benefit delivery process in general. So no, I would not make the statement, be misleading and say all $100 million is going to be for the veterans returning from Iraq and Afghanistan who are filing disability claims. There are not that many claims. But in general, this whole system needed the resources. But——

Senator GRAHAM. That 11 percent increase that you stated was given to veterans' medical benefits, what was that on a per capita basis? For each VA patient, how much additional resources did the 11 percent allow?

Secretary PRINCIPI. Rounded, about $500 per patient.

Senator GRAHAM. What is that as a percentage?

Secretary PRINCIPI. Eleven percent increase in funding for our medical care, of which we have—how many users—4.8 million users of our health care system, so that almost $3 billion increase that you gave us this year is very, very significant, Senator.

Senator GRAHAM. I would like to return to this. My round is now over. That will give you something to look forward to.

[Laughter.]

Chairman SPECTER. Thank you, Senator Graham.

Senator Campbell.

Senator CAMPBELL. Thank you, Mr. Chairman.

Mr. Secretary, as I understand your testimony, the waiting time that a veteran has to wait to get in to see a doctor is going down. I think that is really terrific. The backlog, from your testimony, is going to continue going down. I am sure that is good news to all the veterans.

The last 3 years, we have put in more money from Congress than the President requested in his budget, and even at that, we hear every year from the veterans' associations it is not enough, and more than likely after you have testified today, when the VSO's testify, we are going to hear the same thing, that we are not putting enough resources into it.

I guess with a $450 billion deficit or maybe more, who knows what it is going to be by the end of the year, it is going to be a real tug-of-war around here to get money. I, like many of the people on this committee, happen to really try to prioritize veterans' health, being a veteran myself. But I, like Senator Graham and maybe some of the other members, am a little concerned about these user fees, too.

I guess I would like you to clarify a little bit, when you talked about the veterans who are better off, how is that going to be determined? Is there going to be some kind of a threshold by which they would have to pay a higher user fee? Who is going to determine that?

Secretary PRINCIPI. Yes. Congress established seven priority groups when open enrollment went into effect in 1998, and then about a year or two ago added an eighth priority group. The Priority Group 7s and 8s are veterans who have no military disabilities and have—they are not high incomes, but they have higher incomes. I believe it is around—Category 7 is about $25,000 for a single veteran, higher if you are married with dependents.

The copayment—these fees would only be assessed against the Category 7 and 8 veterans. We are proposing to eliminate copays, on the other hand, for the poorer veterans. Today, if you have an income above $9,800, you start paying copays. We are asking Congress to say, raise that level to $16,500.

So yes, indeed, I believe it is reasonable to ask the higher-income non-disabled to pay a little bit, a very small proportion of their care and the poorer veterans to be alleviated of that burden.

Senator CAMPBELL. I understand that. It may be a little more complicated on determining some of the things that were military related. I guess the most common, of course, is smoking and the long-term effects. I remember when I was in the service, we got cigarette rations. Even though I didn't smoke, I still got cigarette rations. We were encouraged to smoke. What happens to a veteran who is encouraged as a youngster to smoke and years later he develops cancer? Is there a possibility that somehow he would be forced to pay higher user fees because he didn't develop the cancer until after he got out, even though the roots of it began when he was in the service?

Secretary PRINCIPI. If he is service-connected disabled for cancer, he would not pay any copays or user fees. This would only be those who come to the VA health care system or enroll in the VA health care system and have no military-related disabilities.

Senator CAMPBELL. OK. Maybe I phrased my question very poorly. How do you determine whether it was a military disability when the cancer didn't appear until after he was out sometime?

Dr. ROSWELL. Senator Campbell, if I may, that is why I think our efforts to work on disability claims are so important and the $100 million that Senator Graham spoke about. As the Secretary alluded, over 300 additional veterans are now receiving service-connected compensation this year, which I think is a direct reflection on how we are able to reach out to veterans, to help them file disability claims for illnesses such as lung cancer, which can be service connected, for example, for veterans who served in Vietnam, and help them file those claims so that they receive disability compensation. They, in turn, not only receive that compensation, but they then receive priority health care.

Senator CAMPBELL. I think I have no further questions, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Campbell.

Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA, U.S SENATOR FROM HAWAII

Senator AKAKA. Thank you very much, Mr. Chairman.

I would like to add my welcome to Secretary Principi and our other witnesses here. I want to express my appreciation to you for all you have done. I know it is so difficult to carry on the programs we want with the kind of revenue and appropriations that you receive.

I have two questions I would like to ask. Secretary Principi, as the chairman mentioned about Priority 8, I am also concerned about that. Last year, as you know, I signed a joint letter objecting to your decision to end the eligibility for enrollment of Priority 8 veterans in the VA health care program. I am still concerned about that. After hearing the fiscal year 2005 budget, I see that Priority 8 veterans are still barred from enrolling in the VA health care system and I also see that prescription drug copayments are increasing for middle-income veterans.

I realize, as you mentioned, that Priority 8 veterans are considered high-paid veterans. My question to you is, what would be the impact in your budget if Priority 8 veterans could enroll—could enroll—into the VA health care system, as well as the impact on the budget if the increases in copayments were not implemented?

Secretary PRINCIPI. Yes, Senator. If I just very briefly, historically, as you know, in 1998, we went from approximately three million eligible for comprehensive VA health care to 25 million, a very, very dramatic jump in eligibility. That, coupled with the opening—my predecessor and I have continued to open community-based outpatient clinics. We now have almost 700, a great pharmaceutical benefit, and high quality. We have seen this enormous, enormous increase in demand for health care, so much so that consistent with the law, I have to make an annual enrollment decision based upon resources made available in the Appropriation Act.

It was only because we had a growing number of veterans on waiting lists, as Senator Graham talked about in Florida, it was close to over 300,000 waiting more than 6 months for care, that I

made that decision, because we were enrolling veterans and had no expectation of providing them with timely care.

To reopen the door to Category 8s—and I continually look at it to see if we can do it—in 2005 would be $590 million. Of course, enrolling veterans has an impact not only in the year that we do so, but as they become older and perhaps sicker, that the number increases. So it does have a rather significant, financial impact.

Senator AKAKA. I am also concerned about VA's ability to meet its production goal of processing new claims in 100 days. It appears to me that VA's 2005 budget does not include an anticipated increase in claims by service members returning from service in Iraq or Afghanistan. Additionally, the VA's budget request assumes a 1.5 percent increase in Federal pay. However, the Federal pay increase is expected to be 3.5 percent.

Given these factors, Mr. Secretary, I am very concerned that the VA will need to cut other resources which will result in additional time processing new claims and will compromise health care service to veterans. Given this background, I would like to hear your thoughts regarding these.

Secretary PRINCIPI. It is very challenging. I set those goals of never having more than 250,000 claims in our inventory, which would allow us to process claims in 100 days. I felt that veterans having to wait years to get a decision on a claim is just unconscionable, and that is why I set those goals and put in place new processes, and with the support of the President, with the support of the Congress, we added some 1,300 new rating specialists to the VA and we have been able to dramatically bring down the backlog, and also hundreds of millions of dollars that you gave us for information technology enhancements to improve our productivity.

I think the combination of these things, now that these 1,300 people are trained and being very productive, that we will be able to achieve these goals. But it is going to be challenging, Senator, you are absolutely right, and that is why, as Senator Graham said, I have used some of that money for claims processing.

Chairman SPECTER. Senator Akaka, we have eight members here and a second panel of five witnesses.

Senator AKAKA. Thank you very much.

Chairman SPECTER. Thank you, Senator Akaka.

Senator Murray.

STATEMENT OF HON. PATTY MURRAY, U.S SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman, for holding this very timely hearing, and Mr. Secretary, thank you for being here and all the work you do on behalf of veterans and especially for your willingness to request an additional $1.2 billion for the VA budget. I was disappointed that the President didn't follow through on that, but I appreciate your putting it out there.

I have a lot of very serious reservations about the President's budget. I think with the new generation of veterans coming home that are going to be reliant upon the VA for health care and services, we really have an obligation to take care of them and I think this budget request we have seen really falls short.

I agree with the comments about the new fees on veterans. I think it is highly unlikely that Congress is going to approve that and the health care is going to be far short of what we need. I am very concerned about the major medical construction dollars in here, $180 million, and I understand the administration is going to transfer $400 million from health care to construction, which will make our construction account about $600 million. If that is accurate, that is far short of what the CARES initiative plans were to spend. I think we have all been assured more than once that the CARES process was—that we would accept significant changes based on new construction and service delivery, and if that falls short, it is going to leave a lot of us really feeling like we were not told the whole story and our veterans are not going to be served.

I want to ask you about that, but before I do, I want to bring up a separate issue and that is on the Department of Labor rule that is eliminating overtime compensation that will affect some veterans. I think you are aware that the proposed rule could very well undermine many of our young people who enlist in the military because it is going to change the definition of professional employees. It basically will mean veterans working in professional fields will now be classified as professional employees and lose their overtime.

I wanted to know if you had made comments on that, and as the nation's leading advocate for veterans, if you intend to express your opposition to the Department of Labor on that issue.

Secretary PRINCIPI. I guess I am not as knowledgeable about it as I should, Senator. To say that veterans would lose income by being designated a professional employee, which is based upon education, experience, and I would hope that being designated a professional would somehow provide more upward mobility and more increase in compensation and benefits. But I guess we could debate that.

I would just, if I can, just take a quick second to say that, yes, I have always tried to be honest with the Congress, and having grown up here, about what I requested. Every year, every Department goes through a very difficult negotiating process with OMB and we achieve a requested level of spending that the President makes to Congress.

I just want to be clear that I believe that the budget we requested, coupled with—I believe we are going to have $800 million or somewhere in that neighborhood that we will be able to carry over into 2005—will allow us to achieve our goals, to take care of the very veterans we are all concerned about as well as, very importantly, the men and women who served in combat in Iraq and Afghanistan.

But on the Department of Labor issue, I think that is one I need to study.

Senator MURRAY. Mr. Secretary, I have actually sent you a letter dated February 9 on that, and if you could take a look at that and respond, I would really appreciate it.

Let me also tell you, I am very concerned about the new generation of veterans that we are creating today. About 40 percent of the U.S. armed forces in Iraq and Afghanistan, as you know, are activated Guard and Reservists. Those men and women are going to have a very different priority from the regular troops. They are

older. They are more likely to have families. They are in a hurry to get back to their jobs and their community and their own life. I am concerned that we could lose track of many of those people when we return home, and I don't think we want them to fall through the cracks.

What is the VA prepared to do in order to capture those veterans and make sure we don't lose them?

Secretary PRINCIPI. You are so right. It is far different than it was during the Vietnam War, what we are asking our Reservists and Guardsmen and women to do today.

We are truly outreaching to them. We have engaged in some over 3,000 of them in TAP programs, Transition Assistance Programs for members of the armed forces. We have engaged in another 2,000 briefings. We have outreached to some 46,000 Reservists and Guardsmen and women around the country to just make sure they understand what their benefits are, that when they are called up to active duty, they are veterans and they are eligible and entitled to the veterans' benefits program. They are entitled to VA health care.

So absolutely, we have an important responsibility to outreach to them and I can assure you we are going to continue to do so.

Senator MURRAY. Good, and I would like to work with you on that. I think it is really important. Thank you.

Dr. ROSWELL. Let me just add that we——

Chairman SPECTER. Senator Murray, your time has expired.

Senator MURRAY. If Dr. Roswell could just respond to the last question in 2 seconds.

Dr. ROSWELL. I was just going to add that we have actually printed a million brochures specifically for Reserve and Guard and have distributed those through all of the Reserve and Guard units. We have opened our readjustment counseling service to the Reserve and National Guard. The Secretary is planning to send letters to all 90,000 people who have been separated thus far, and we have unprecedented cooperation with DOD to make sure that we know everyone who is being discharged, whether they are on active duty, in the Reserves, or in the National Guard.

Chairman SPECTER. Thank you, Senator Murray.

Senator Nelson.

STATEMENT OF HON. E. BENJAMIN NELSON, U.S. SENATOR FROM NEBRASKA

Senator NELSON. Thank you, Mr. Chairman, and may I add my appreciation, Mr. Secretary, for the continuing good work that you do for our veterans. I suspect after all the praise that you have received from all of us today, you have to be sitting there wondering how we can have so many critical things to say and/or to ask of the care for veterans, but I think it is a common thought that we have. You are trying to do a better job. We want to see a better job done, and I hope we can work together to do that.

When Nebraska was moved into a new VISN just some time ago, we were all told that the services wouldn't change for veterans in Nebraska. I remember somebody from your staff saying that one of the reasons they were having headquarters in Minneapolis was because there were more qualified people there and I took issue with

that, being from Nebraska. My staff tells me that a change has occurred, that veterans requiring cardiac surgery are now being required to go to Minneapolis for the care. If it is emergency care, surgery, they will be treated in Nebraska.

Once again, I want to point out that we have excellent cardiac surgeons in Nebraska and this isn't consistent with what we had hoped would happen, where veterans would be treated as close to home as possible. It is not a matter of trying to patronize Nebraska as much as it is to take care of veterans as close to home as possible. I would hope that you would look into that to see what you can find out.

We were also told that, well, Nebraska would become the hub for some other services. But I am not sure that unless there is a particular reason why the care can't be provided in a location that we would try to create hubs for care, and yet I am one who is as hawkish on the budget as can be. I know you want to save every dollar that you can. But we all have to come up short of shortchanging the veterans in the process.

Secretary PRINCIPI. I made a commitment to you that Nebraska would not get shortchanged. I will ensure that that commitment is adhered to. Next week, I happen to be meeting, along with Dr. Roswell, the network director that has Nebraska. I will certainly ask these questions, and——

Senator NELSON. We were told part of the reason is because, and I don't want to overplay my time, the chairman is quite sharp when you do that, but it is because they can provide the care in the veterans' hospital there and it has to be outsourced in Nebraska. But it would seem like we could work out a contractual relationship that would even out the cost if it is a cost factor because it needs to be about the care providing at the closest possible——

Secretary PRINCIPI. I am sure there are a number of factors, and certainly going in for cardiac surgery, open heart, we certainly want to go and make sure the outcomes are good. I mean, that is most important. Sometimes it is a little inconvenient to go to one of those major cardiac care medical centers, and, of course, cost is an issue, but I will certainly look into it and I will get back to you personally to make sure that there are reasons or that there will be a change, so we can discuss it further.

Senator NELSON. As always, I appreciate the ability and the opportunity to work with you. Thank you very much. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Nelson.

Senator Jeffords.

STATEMENT OF HON. JAMES M. JEFFORDS, U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Mr. Secretary, I would like to thank you for coming today and thank you for your leadership over the past few years on behalf of veterans. Your job is not an easy one and I appreciate all you have done for increased funding for the VA over the objections from those who don't want to see any more money spent on veterans. I believe we have an obligation to care for those who have carried the flag and I would like to see that we continue

to hold that banner high. We must not let the banner sag or fall by merely meeting the minimal obligations.

I have a two part question about benefits. First, how does the VA plan to notify newly discharged veterans of their benefits? Second, in anticipation of the increase in claims submitted by these new veterans, please tell me what VA's current plan is in processing veterans' initial claims.

Secretary PRINCIPI. We are taking as many steps as possible to outreach to veterans being discharged. Of course, we have the TAP programs. As I indicated, we have done over 3,000 Transition Assistance Programs for military personnel. Well over 100,000 have attended those briefings. We engage in other briefings for military personnel, Guard and Reservists. We have health fairs. Some 700,000 veterans attended health fairs this past year. We have brochures that we mail out. I am sending a letter to all of the recently discharged servicemen and women coming back from Iran and Afghanistan.

We now have staff on 136 military bases. You know, in the past, you had to wait until you were discharged and then you would have to find your way to a regional office, maybe 4 or 5 hours' drive. Today, at 136 military bases, you can walk across the street from your barracks. You can fill out a claim for disability compensation or whatever it might be, have an exam right there across the street from your barracks, and when you get your discharge papers, you get your disability compensation or you get your GI bill benefit right away. I mean, I think this is what we have to do for our customers, the men and women who served in uniform, bringing the benefit structure to military bases.

We have full-time staff now for the first time in history at Walter Reed and Bethesda to make sure the wounded who are coming back, when they go home on convalescent leave or discharged, they are already enrolled in a VA hospital near their home and they have been given the claims information so that they can get their disability compensation.

I am sure there is more that we can do. I just don't want to see anybody fall through the cracks, and this is especially meaningful to me, because I had two sons serve in Iraq at the same time. So I just feel very strongly, personally and professionally. We are not perfect. We don't, of course, ever have all the resources you need. I am not saying we do, but I think the President, this Congress has treated us very generously and we need to continually strive to do better.

Senator JEFFORDS. I appreciate that answer. As you know, many of us here represent rural States. In the past, the VA has made an effort to open community-based outreach clinics to get access to the VA for more vets. But in the last 2 years, the VA has had a policy of not opening any more clinics. Is there any chance that this policy will change? I believe these clinics perform a very useful service for veterans and would like to know your answer.

Secretary PRINCIPI. I applaud my predecessor for transitioning the VA from a hospital-centric system to a patient-focused health care system and I have continued that process. I think I have opened probably or directed that we open 170, 190 outpatient clin-

ics over the past 3 years and I will continue to open outpatient clinics.

Of course, we have to balance outpatient clinics and inpatient hospitals because we have an inpatient mission as well as an outpatient mission, but we need to continually bring health care closer to the veteran's home so that they don't have to drive long distances to get outpatient care in a VA medical center. They can get it in a community-based outpatient clinic.

I think it is a great program, Senator. We have tried to balance it and watch it and maybe there has been a slowing down, but we will continue to do so.

Senator JEFFORDS. Thank you. I thoroughly appreciate what you are doing. Thank you.

Secretary PRINCIPI. Thank you, Senator Jeffords.

Chairman SPECTER. Thank you very much, Senator Jeffords.

Senator Rockefeller.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to say what others have said and I want to say it with as much or even more feeling, and that is that when you came in here to be confirmed, I remember I asked you the question, if you came up against something which really bothered you, would you go face to face with the President, and he was on "Meet the Press," so you didn't have time. Before that, you did, in a sense, go face to face with the President because you went face to face with the budget officials and asked for $1.2 billion more for VA health care, which represents a real act of courage and you did it publicly.

I really commend you for that. It is a gutsy thing to do. This is an administration which wants people to be in line, and when somebody isn't in line, they don't like it, but you decided that you were going to put the veterans ahead of this. I really congratulate you for that, Secretary Principi, and I think you understand that I mean it when I say that.

As Ben Nelson said, Senator Nelson, we praise you and then we ask for things, but that is because you are under a budget. This is a national budget. It is not a free health care system, so everything is always in competition with something else. If you come from States like mine, you have to fight. That is what we have always done. We have always fought uphill. Arlen Specter knows something about that in the western part of his State, and we have to do that.

Now, in the CARES Commission, which hasn't come out, but they are going to and they are going to suggest cutting some beds, I am told, from the Beckley VA facility. On the other hand, you have recognized, and, in fact, due to your leadership, you have recognized that there are some hospitals that because of certain situations need to be declared critical care hospitals, critical access hospitals.

My understanding is that CARES as a commission does not recognize such designations, wherein we have a quandary because I need to fight very hard for what is the most isolated part of my State. I am not sure how we can do this or if we can do it together

or if it can be done, but I am going to try in every way that I know how. I can't do less than that, because, frankly, the majority of our veterans come from that part, the coal fields, the steepest mountains, the poorest counties of West Virginia, which is 1 of 50 States.

So I ask your attention for that. I don't necessarily need to have a comment from you. I want to have a sense that you hear me loud and clear on that, that it is——

Secretary PRINCIPI. Senator—oh, I am sorry.

Senator Rockefeller. Go ahead, please.

Secretary PRINCIPI. I would just say, I had the pleasure to tour West Virginia with you. I saw firsthand, as you have experienced, the needs of veterans in rural America, in West Virginia. I had the privilege of being in Western Pennsylvania with Senator Specter, an awful lot of poor people, an awful lot of elderly people, veterans, who are lacking health care. So I certainly intend to very carefully review the commission's report, analyze it, and do what is best for veterans.

I know it is going to entail some changes because health care is changing and demographics change, and if we don't change with the changing dynamics in health care, I am afraid we will fail America's veterans maybe 10, 15, 20 years from now, because our infrastructure has been built up over 150 years. So we just need to be mindful of that, but at the same time recognize it is not only in large urban areas, but also in rural areas that we have a responsibility. I just want you to know I am listening and hopefully we will make the right decision.

Senator Rockefeller. Thank you, Mr. Secretary, and I have two other questions which I will simply submit for the record. I thank you, sir, and I thank the chairman.

Chairman SPECTER. Thank you very much, Senator Rockefeller.

Mr. Secretary, I have a thick sheet of 19 questions to ask you for the record on going into some substantial details. May I inquire of my colleagues if they would like another round?

Senator GRAHAM. I would like to ask two more questions, Mr. Chairman.

Chairman SPECTER. Senator Murray. Senator Nelson.

Senator NELSON. Nothing.

Chairman SPECTER. Senator Jeffords. Senator Graham, two questions.

Senator GRAHAM. The first has to do with the assumptions in the budget. The assumptions, as I read them, are that veterans will make $1.3 billion in copayments for their medical care, but only $1 billion will be collected from insurers who are third party responsible persons. That results in nearly $2 billion in claims being rejected by those insurers. It is my assumption that if we could do better with insurance company collections, that would relieve some of the pressures off taxpayers and veterans. What would be your recommendations as to what could be done? What role will Congress play in increasing the percentage of collections made from claims submitted?

Secretary PRINCIPI. As you know, we can't bill Medicare, and that is a Finance, Ways and Means Committee, and that has been an issue, a longstanding issue with regard to that. But I think that Congress can help us with HMOs. I think there is a very signifi-

cant amount of resources that we do not collect from HMOs and it has been a real struggle. So I think legislation that would somehow require HMOs to reimburse us at a certain level, reasonable level for billed charges would certainly generate significant revenues to the VA and that would expand the reach of health care, because you said we can keep those dollars. So I would look to that area and we will work with you, Senator Graham.

Senator GRAHAM. If you could give us what you believe would be the most effective legislative solution in combination with your administrative action, I would be very appreciative.

Secretary PRINCIPI. Yes, sir.

Senator GRAHAM. The second question goes back to a hearing that was held last week with Secretary Thompson of HHS. We were talking about the fact that there seems to be a difference in the way in which the VA is currently negotiating pharmaceutical prices, whereas Medicare in the recent legislation is prohibited from doing so. When asked about this difference, Secretary Thompson said that Medicare was reluctant to negotiate because it might constitute an undue intrusion into the marketplace, i.e., could be described as price setting.

As I understand it, and I know this was true at the VA hospital in Miami where I spent a day in November, it is getting better than a 50 percent reduction off what would be the drug store prices of some $39 million of prescription drugs that they dispense a year. Has it been your finding that the VA's effective use of negotiations has constituted an undue intrusion in the marketplace?

Secretary PRINCIPI. No, not at all. I think we have done extraordinarily well. We have had $1.1 billion in cost avoidance for pharmaceuticals over the past 3 years. We rely very heavily, we use a lot of generic drugs. Sixty-five percent of the drugs we provide are generic. Unfortunately, the brand name drugs, the 35 percent brand name drugs account for 92 percent of our costs.

So I think a combination of factors of how we procure pharmaceuticals, how we manage them, our formulary, I think that it has worked very, very well for our nation's veterans and for the American taxpayer.

Senator GRAHAM. I would urge you to consider having that conversation with Secretary Thompson because there is tremendous savings for the taxpayers and Medicare beneficiaries if his agency would use the same techniques that the VA has done, and I would hope that he would be authorized and encouraged to do so.

Let me ask just one short follow-up question. Are there any other areas in which the VA could use authority to negotiate to reduce costs?

Secretary PRINCIPI. Nothing comes to mind at the moment, Senator Graham, but I would appreciate the opportunity to advise you in writing.

Chairman SPECTER. Thank you very much, Senator Graham.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman. I appreciate the accommodation.

Mr. Secretary, I am really concerned that this budget request is low for major medical construction and it goes back to the CARES process, where we were told that we will get $5 billion in new fa-

cilities for our veterans. Veterans were asked to accept some pretty significant changes to their health care system today in exchange for a future promise of funds for new clinics and hospitals and facilities in the future, and I don't think this budget request even comes close to meeting the CARES promises for new facilities.

One of the areas that is slated for a new clinic is in Central Washington in my home State, and I am concerned that the $5 billion promise in new facilities is an empty promise and at the very least this budget sets us behind in meeting the CARES promise.

Can you comment on this, and specifically whether the administration, do you believe, will request adequate funding for the CARES initiative?

Secretary PRINCIPI. Yes, Senator. The construction portion of CARES has always been viewed as a 5- to 7-year effort, that would not all be funded in the first year. I really do believe that we have put forth a good down payment. It would be misleading to say we have all we need, but we have doubled the CARES money from $280 million to $540 million for 2005. We have increased major construction, I think, from about $180 to, what, to $382 or $362. So I think we are moving in the right direction and it will take additional funding in the out years to do what I hope to approve in the next couple weeks.

Senator MURRAY. You can understand why people are really concerned. They are giving up a lot today on the hope that something big is going to happen tomorrow, and we have seen with budget deficits and cutback programs that that doesn't necessarily occur.

Secretary PRINCIPI. Well, I think CARES is a very, very high priority and I certainly think so in the outpatient clinic arena, so——

Dr. ROSWELL. If I could, Senator Murray, we have actually anticipated the CARES report, though we were unable to anticipate the specific recommendations. But to make sure that we are prepared, we have identified 41 projects for which we have begun the advanced planning. This would put them in a State of readiness so that when the Secretary makes a decision, those 41 projects, which we believe are the highest priority, would be ready to go into the design phase. That design phase requires 10 percent of the total project cost up front, or the typical cost is 10 percent.

So even though it is a small amount of money, you are absolutely right that the promise has to go to $4.6 or $5 billion. We believe that the amount of money that will be available to the Secretary in fiscal year 2004 and 2005 will be sufficient to get this thing jump-started with the expectation that the monies must follow after that.

Senator MURRAY. Let me just ask a quick question and make a comment. Mr. Secretary, on December 6, President Bush signed the Veterans' Health Care Capital Assets and Business Improvement Act. There was a section in that, 231, requiring the VA to develop a plan for meeting the future hospital care needs of veterans who live in North Central Washington State. I know that that report is not due back until April 15, but I would like to know whether you have people who are conducting that study and whether or not my staff can be a resource to you as you do that.

Secretary PRINCIPI. I assume they are, Senator. I don't know for certain, but I will certainly get back to you and make sure that is done.

Senator MURRAY. Would you let me know on that?

Secretary PRINCIPI. Yes.

Senator MURRAY. And finally, Dr. Roswell, my colleague, Senator Cantwell, and I sent you a letter on December 19 regarding our continued belief that the CARES initiative has not properly considered the current and future needs for veterans' health care service in VISN 20. We noted a number of things, including the relatively young veterans population as well as the low-market penetration in our home State. We just sent 3,500 troops off yesterday to Iraq from my State. We know we are going to have some of those new veterans back in our State and we want to make sure that this is part of that. I know you have the letter. I have a copy of it today, but I was hoping that we could get an answer back on that as quickly as possible.

Dr. ROSWELL. We will do everything we can, Senator, to get you a prompt response.

Senator MURRAY. Thank you. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Murray.

Thank you, Secretary Principi, and thank you, gentlemen, for accompanying the Secretary. You have heard praise on your efforts. We recognize the work that you are doing. You have also heard a great many concerns about the ability of the Veterans Administration to deliver the necessary care within the confines of the budget.

We would encourage you, Mr. Secretary and the others, to explore the Medicare subvention, or as you term it VA Advantage, and the insurance premiums and Category A. We hope there will be some way to not bar them from coverage.

We now turn to our next panel, the veterans' service organizations, and ask Mr. Peter Gaytan, Mr. Paul Hayden, Mr. Rick Surratt, Mr. Richard Fuller, and Mr. Richard Jones to come forward.

Thank you very much for coming, gentlemen. We have been asked to change the order to some extent because this distinguished group of witnesses has already had the wisdom to divide up the topic so as to make their words most effective. We regret the limitations on time, but that is one of the problems here in the Capitol, as you know.

Our first witness is Mr. Peter Gaytan, Principal Deputy Director of Veterans Affairs and Rehabilitation in June 2002 for the American Legion. He has a long, distinguished resume which we will have included in the record, but in the interests of time, may the record show a dismissive gesture from Mr. Gaytan to get on with the business at hand. So the floor is yours, Mr. Gaytan.

Mr. GAYTAN. Thank you, Mr. Chairman, and thank you for the opportunity to express the views of the 2.8 million members of the American Legion.

Chairman SPECTER. I am going to have to interrupt you at the very outset because I have to excuse myself for a few minutes. I wonder in advance of your opening statements, Senator Graham, if we might yield to you for a round of questions if you would like.

I will only be a few minutes, but I am going to have to have a brief adjournment of the meeting.

Senator GRAHAM. Or would you like to start the statements? You want to be here for the statements?

Chairman SPECTER. I want to be here for the statements, but if you would like to question.

Senator GRAHAM. OK. Thank you.

Chairman SPECTER. Senator Graham will proceed. He knows what to ask even though he hasn't heard your opening statements.

[Laughter.]

Senator GRAHAM [presiding]. Thank you, gentlemen. We look forward to your statements, and as soon as the Chairman is able to return, we will turn to you. This is a little bit out of order, but let me ask a question that has been already discussed, and that is the potential for Priority 7 and Priority 8 veterans to not come to VA due to the $250 user fee and the increase in drug copayment from $7 to $15.

What group of veterans do you think will be most affected by this, and what are the likely effects?

Mr. GAYTAN. Well, sir, let me just State that the American Legion has opposed the restriction of enrollment for Priority Group 8 veterans since it was announced last January, a year ago January. We also adamantly oppose the provisions in the 2005 budget request that would implement a $250 enrollment fee for Priority Group 7s and 8s. We also oppose the increase in copayments for pharmaceuticals and the increase in copayments for outpatient care.

Mr. FULLER. Senator Graham, I am Richard Fuller with Paralyzed Veterans of America. We, too, have opposed the increases in the fees, and what we basically have been seeing over the past several years is that the administration constantly proposes increasing the costs of health care on the backs of veterans, and more and more they are relying on these fees as part of their appropriations process to reduce appropriations and have one veteran paying for the health care of another veteran out of his own pocket.

We also find it interesting that they keep lumping Category 7s and Category 8s together by implicating that the Category 7s are somehow high-income veterans, whereas, this committee and the Congress a couple of years ago created that particular category to be able to capture people who fell just above the nationwide low income level but who lived in geographic areas of higher cost.

Category 7 veterans are basically low-income Category 5 veterans in some people's minds and in our minds, as well. To think that they can afford to pay these costs and user fees and copayments in the same fashion as, say, some high-income veteran in Category 8 can, we find rather implausible.

Senator GRAHAM. What is the range of income for a person who is designated as a Category 7?

Mr. FULLER. The range is based on a HUD low-income index, which is really rather complicated, but HUD has been using it for gauging low-income housing payments. It varies from, actually from what I understand, even from county to county in the United States. But it is a formula and it is very easy to plug into that formula and find out what the income levels are.

Senator GRAHAM. In my opening statement, I made the statement that Category 7 went as low as $24,000 a year. Is that——

Mr. FULLER. Twenty-four thousand is the national threshold if you are just looking at what the base means test is. Now, if you lived in Miami or you lived in San Francisco or Brooklyn, New York, I haven't seen the actual scales and studied them that closely myself, but you could get up to maybe $27,000, $28,000, something of that nature, but you are not going to be considered rich by any stretch of the imagination. You are basically going to be considered, if you are faced with a catastrophic illness, as medically indigent.

Senator GRAHAM. If I could move on to another question, and thank you for your comments on that first question, this is the issue of claims processing. This has been a very big issue in my State, where there has been a history of long delays.

It is my understanding that this budget calls for cutting the claims processing staff nationwide by some 500-plus persons. I would be interested in what your assessment of the likely impact of that reduction would be and what do you consider to be the minimum appropriate level of claims processors in order to meet the demands and reduce the backlog on claims that have already been filed?

Mr. SURRATT. Senator, as you know, the VA has been struggling with claims backlogs for years. With some focus on fixing their deficiencies and some additional resources from the Congress, they made some gains. But I think VA's own budget projections speak for themselves here.

We just finished fiscal year 2003, so that makes a good comparison with what they are asking for for 2005. Compensation claims, the VA projects they will have 178,966 more in 2005 than they had in the fiscal year we just completed, yet they are reducing staffing. Now, 2004 has a reduced staffing and 2005 goes even below that.

Education, in the education department, they are going to have 10 percent more claims in 2005 than we had last year, some 51,000. Yet again, they propose cutting the budget. It is the same way with voc rehab. They anticipate more claims and they just had a task force that is about to report, and if those task force recommendations are implemented, VA will get more into the employment business. It is vocational rehabilitation and employment, but they have very few people devoted to actual employment now for veterans.

So finding increased efficiencies to stay even is one thing. That is a challenge. But finding increased efficiencies to do more with less, that is—I guess that is the kind of magic we see in Washington sometimes in budgets, but it doesn't seem realistic. We have made specific FTE recommendations and I have covered those in my written statement. But essentially, for most of the services, we have recommended that they keep their—that they have the fiscal year 2003 level. I think we ask for 200 more FTE in vocational rehabilitation and employment.

Mr. GAYTAN. Sir, if I may for the American Legion, we are very concerned about the wait times for benefit claims. We understand the mandated quotas implemented by the Secretary last year and it has improved some of the wait times and reduced the backlog of benefit claims. But we are cautious in this hurried rush to adju-

dicate claims in that we don't want to reduce the quality of the claims as they are processed the first time. We don't want them to have to come back as remands, and some of those will be going back as remands as these claims adjudicators are trying to meet these production quotas. We must be conscious that faster is not always better. We need the quality in the claims in the first process before they are sent back as a remand. We do not agree with reducing the number of FTEs to adjudicate these claims.

Senator GRAHAM. It has, again, been my experience in Florida that there is a relationship between the number of claims and the staff deciding the claims and then the percentage of those claims that denied and then appealed. I think it is the old adage that an ounce of prevention is worth a pound of care. If you do a good job at the front end, then you are less likely to have to replicate it.

Let me raise a question that I asked the Secretary about, and that has to do with the fact that apparently there are approximately $3 billion in annually claims sent to private insurance carriers. I have been told that since the VA can't bill Medicare, none of that is Medicare related, and we are recovering now about $1 billion. I asked if there were any steps that the secretary thought VA could take to increase that level of recovery so as to loosen or reduce the demand on veterans for paying things like the $250 enrollment fee in order to make up the difference in claims that are not collected. Do any of you have any thoughts about that or suggestions?

Mr. FULLER. Senator, historically, VA has done a very poor job in trying to collect these third-party reimbursements, as they are known. They are getting better. There are institutional challenges, however, which makes it difficult, if not impossible, for them to collect from, as the Secretary said, from HMOs and people who they need to negotiate and establish rates and exchange with. I believe that we have been discussing it for several years, that this problem existed and ought to be addressed undoubtedly through legislation and we were glad to hear that the Secretary thought so too so perhaps that can help.

On the Medicare side, VA, of course, has been subsidizing Medicare for years and to great, great savings to the Medicare Trust Fund. There are difficulties involved in opening that door back up, not only institutional but also from the standpoint that every time we think of some way to fund VA health care from non-appropriated funds, what happens is that OMB offsets the appropriation by those collections the next year, so it is just a pass-through of money from one side to the other and is a constant battle.

As we state in The Independent Budget—this is The Independent Budget for 2005, which was provided to all of you which we will be addressing here today. The Independent Budget has never counted the collections as being part of the funding mechanism for VA health care. Some people have said this is rather unrealistic, but we want to keep a pure marker as to what the appropriated dollar need is for the Congress to be aware of and not have the budget obscured by the fact that the collections are becoming an increasingly larger amount of the total that the Administration is asking for.

Senator GRAHAM. Any other comments on my question?

Mr. JONES. May I retract the question, Senator? My concern is with the decision to ban Priority 8's access to VA hospitals. It was suggested when it was done, the year it was done, that the cost savings would be about $340 million by denying access. In the same year, we rescinded from the VA budget $225 million and we rolled over $650 million. Yet the decision was made that we didn't have enough money.

If we did not roll over $650 million and kept that in the medical care system, that money would have provided access to over 300,000 veterans. That is more than was estimated by the VA that came to VA looking for access but were barred. They estimated it at 167,000. I am concerned about that.

VA says that the average cost of the priority veterans is about $2,500 a year, and yet we have rolled over $600 million, we have rescinded $225 million, and we saved $339 million by barring their access. That is one of the things that concerns me, the decision-making.

I think the law says that an assessment is supposed to be made with regard to the resources available. It seems that the decision is being made prior to resources being provided or even to resources being suggested. I am concerned about this. I am concerned about the law. I am concerned that money that is available isn't being used.

The Congress is generous. Your generosity was spoken about earlier today, 11 percent-plus increase, far, way and above, what the President has suggested. But the money isn't being used. It is being rolled over. The estimate for fiscal year 2005 is at $800 million that we rolled over into fiscal year 2005's budget from fiscal year 2004.

That is just what I wanted to say.

Senator GRAHAM. Let me move to a related subject, and that is access to prescription drugs. In the questions to Secretary Principi, I indicated the very significant savings that veterans secure by getting access to prescription drugs through the VA as opposed to through normal channels.

One of the barriers for veterans getting access to prescription drugs is that VA requires an independent evaluation of the patient before the VA will make prescription drugs available to them, even though a non-VA provider has authorized a prescription. Of course, this restriction on Category 8 veterans getting access to health care means that they are also losing their access to the less-expensive prescription drugs.

Is that an accurate assessment of the situation, and what do you think are the policy rationales of requiring veterans to have a second physical before they can get prescription drugs?

Mr. FULLER. Historically, Senator, we have taken the position with an argument along these lines, that the VA health care system is a health care provider. It historically has been a provider of health care from the standpoint they want to have control over the patients, the patients' care, and what the patient is prescribed from the standpoint of both quality and medical interactions.

The concept of veterans taking prescriptions from private physicians to the VA changes the role of the VA in a way that it becomes not a provider but it becomes a drug store. It loses control over

that particular patient as being able to find out if there are complications in mixes of other prescriptions and other types of care that the individual might be getting.

Indeed, it does cost money to be able to put these people into the system and examine them, but at the same time, I believe the Secretary a couple of years ago testified over on the House side that the cost of everybody going to the VA to get their prescriptions filled at such a modest rate would be in the neighborhood of $4 or $5 billion a year. You would be shifting a major part of VA costs from being a health care provider to being a prescription provider.

Of course, if OMB wants to provide that $4 or $5 billion, we would love to have the VA turned into a pharmacy, but I can't quite see that money coming across when they aren't funding the health care system side adequately right now.

Senator GRAHAM. Any other comments on that issue?

Mr. JONES. We know the Secretary did lift the ban earlier last year in order to address the waiting list problem. I haven't seen any costs of that or any studies or reports as to what happened. As you recall, the Secretary trying to address the waiting list offered the opportunity for those who had been on the waiting list for greater than 6 months an opportunity to bring their prescriptions to VA and have them filled if the prescription had been written by a private doctor.

That, I believe, has been suspended at the time, but there was a brief time, a brief moment last year the Secretary used exactly what you are suggesting might be used and perhaps some data could be gained from requesting the Secretary to submit a study or some results from that activity.

Senator GRAHAM. To me, one of the ironies is that the typical veteran over the age of 65 prior to going to the VA probably was getting most of his or her health care financed through Medicare at a Medicare-approved physician. The Federal Government is paying for that cost through Medicare. Now the veteran comes to the VA and is required to spend more Federal money to get an examination before they can get prescription drugs in VA. There needs to be some better coordination, both for the benefit of the veteran, who shouldn't have to wait 6 months to get access to prescription drugs, and for the taxpayers, who shouldn't have to pay twice to do the same essential examination of the patient. If anybody has any suggestions about how to do that better, I am sure we would all be interested.

Another issue is funding for medical research. VA historically has not only provided a great service to American veterans, but to health care literally on a global scale by the quality of its medical and prosthetics research. That budget is now being suggested to be reduced by $50 million, which equates to 149 research projects and 500 VA employees. VA has indicated that the area of those lost projects will include aging, cancer, and heart disease research.

How do the organizations that represent veterans, what value do you put on VA's research budget?

Mr. GAYTAN. Sir, on behalf of the American Legion, we are very concerned about the proposed cuts in the budget for research funding. Not only as you mentioned have the historical research advantages created through the VA benefited the veterans who seek their

health care at the VA, it has also benefited all Americans nationwide.

In addition to those benefits that are accrued the research that is carried forth in the VA, there is also the key factor of the affiliations, the medical schools that are affiliated with the VA who carry out some of these research projects through the VA facilities. Last year, the American Legion initiated a "System Worth Saving," where our National Commander visited over 60 VA medical centers, and one of the areas he tried to focus on was the affiliations and the partnerships between the medical schools and the VA facilities and exactly how much the VA facilities benefited through these affiliations, through volunteers, through students, and mainly through the research, and the American Legion fears this decrease in funding for research and the detrimental effects it will have on not only the veterans who seek care at the facilities, but patients nationwide.

Mr. FULLER. Senator, on behalf of Paralyzed Veterans of America, we were actually astonished at this budget request. This is totally unprecedented. Granted, as we have seen the administration and Congress almost double funding for NIH research, the VA research program sort of limps along with little increases every year of $5 or $10 million or something of that nature. But to swoop in in one stroke and to call for a reduction of $50 million, which we anticipate in both the grant money and the indirect support funding, would reduce VA research back to 1999 levels.

When you are talking about losing 500 researchers, you are not talking about guys and gals who are just sitting in a laboratory. These are clinician researchers. These are doctors and nurses who work certainly in the laboratory doing research, but they are also there at the VA treating a veteran patient and this would be a stunning loss to a program which has received Nobel prizes and then TOP awards both nationally and internationally and we certainly hope that Congress can do something to set this straight.

Mr. JONES. We agree, Senator. The research is clinical research. It is applied to veterans almost immediately on discovery. It is not theoretical or basic research, and that is one of the marks that makes the difference between VA research and National Institutes of Health research. It is applied at the base where delivery of health care is done. So it is an important element and could have adverse effects on the health of veterans.

Senator GRAHAM. If I could move to another issue, The Independent Budget raises some questions about VA's proposal for achieving management efficiencies. In this budget, those efficiencies are projected to result in a cost reduction of approximately $1 billion.

Based on previous VA management efficiency programs, what do you think might result from the one that is suggested in this budget in terms of service to beneficiaries, cuts to employees, and reductions in particularly specialty programs?

Mr. FULLER. When you look at a figure that large, Senator, of $1 billion, and you figure that the VA appropriation, the largest amount of it is in domestic discretionary funding, and the cost of VA health care is basically based upon the cost of FTE, of people, certainly there is equipment and construction and all those other

things, but where you achieve the savings are through people. And, if you have to cut people, then you are cutting services to veterans and you are cutting both the quantity of the services you can provide but also the quality of those services.

This, as you well know, is a standard trick of all administrations in every annual budget to try to force imaginary and unrealistic management efficiencies as just being part of their bottom line and they are never achieved.

Senator GRAHAM. This is especially true in my State, but it is also a national phenomenon that the veteran population is aging. My own brother, who was a radar operator on a B–29 in the Second World War, just had his 80th birthday. How well prepared do you think VA is for this increasingly older population in areas such as providing community care so that veterans don't have to be unnecessarily institutionalized, and where they do require institutionalization, having facilities that will be appropriate to their needs and provide a quality of service?

Mr. GAYTAN. I can say the American Legion is very concerned with the budget proposal that would reduce long-term care beds. We support first meeting the mandates of the Millennium Health Care Act, which they aren't doing, but then aside from not reaching those goals, to propose a budget that would reduce long-term care beds which are going to be needed by that very population of veterans that you mentioned, those aging veterans who are turning to long-term care, and when the VA can't supply it, then they are offering a budget that reduces the existing long-term care beds. The American Legion is very concerned that VA will be unable to meet the mandate of these aging veterans as they turn to long-term health care to the VA.

Mr. FULLER. From PVA's standpoint, of course, long-term care issues are our great interest and a necessity of all our membership. Of course, the last thing in the world we want for anyone, any person with a disability, is to be institutionalized if there is an alternative to that institutionalization.

That being said, of course, we have no real direct long-term care policy in the United States, either in the public or private sector, and it is one of the embarrassments for our country, when we compare our system with other countries of the world.

The VA could serve as the most shining example of how to put together an enlightened long-term care policy if they would provide the resources to do it. The Congress and this Committee required the VA a couple years ago by statute to maintain a floor for the number of nursing home beds. They have ignored that statutory requirement and this particular budget calls for a reduction of 5,000 nursing home beds. They claim, on the other hand, that they are going to be increasing their home and community-based programs, which is admirable, but, of course, they never really meet the targets that they say that they are going to meet. You wind up with a gap in the middle of services between inpatient and home and community-based programs. There really ought to be a way for the Congress to—and you have done yeoman work in this committee in trying to force the VA into doing the right thing as far as long-term care is concerned, but we have got a long way to go, still.

Chairman SPECTER [presiding]. Senator Graham, thank you very much for holding the fort and thank you for your patience and the fact that you have been patient. It is hard to get our time to any extent, as you have found out, but now we will begin the testimony.

Mr. Gaytan, I had introduced you, so if you will proceed.

STATEMENT OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

Mr. GAYTAN. Thank you, Mr. Chairman. The American Legion, as you know, continues a proud tradition of advocating for funding to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. As American service members continue to fight for our freedom in a number of countries worldwide, it is the responsibility of this Congress to provide a budget that will allow VA to fulfill its mission.

In the fiscal year 2005 budget request, there is a continued emphasis on the treatment of the core mission veteran population. The term "core mission veteran population" does not appear in Title 38. In 1998, eligibility reform ensured all eligible veterans could seek health care through VA, not simply those designated as the core mission veteran population. Since then, we have seen VA shut its doors to Priority Group 8 veterans.

Tailoring the patient population to meet the budget was not the intent of Congress when VA eligibility was reformed. The American Legion urges this committee to fund VA at a level that will ensure all veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

Today, veterans continue to suffer as a result of a system that has been routinely underfunded, is now ill-equipped to handle the large influx of veterans waiting to use their services. Veterans continue to experience long waiting times for medical appointments as well as long waiting times for claims adjudication.

The American Legion applauds Secretary Principi for his efforts to reduce the extreme backlog of patients waiting to receive care at VA facilities and we urge VA to continue to implement practices that will eliminate the backlog systemwide.

Last year, as I mentioned earlier, the American Legion initiated the "System Worth Saving" initiative. National Commander Ron Conley visited 60 Veterans' Affairs medical centers, and so far this year, a team of Legionnaires has visited more than 30 facilities. We are learning that one of the main issues of concern is the increased medical care collection fund targets. Medical center directors are concerned over the significant increases in their medical care collection fund goals and what impact the restriction on enrolling any Priority Group 8 veterans will have on their ability to meet these goals.

The American Legion shares their concern and we are also concerned about the impact of certain proposals included in the fiscal year 2005 budget request. The American Legion opposes the continuation of the suspension of enrollment of new Priority Group 8 veterans. Denying veterans access to VA health care, particularly while the Nation is at war, is the wrong message to send, not only

to the members of the all-volunteer force, but also to the young men and women who may be considering a life of service in the U.S. Armed Forces.

The American Legion also opposes the implementation of a $250 annual enrollment fee for non-service connected Priority Group 7 and 8 veterans. The American Legion would urge Congress to once again reject this proposal, just as it did last year. While the American Legion applauds the initiative to exempt any hospice care from copayments and to exempt former POWs from copayments for extended care services, we do not support increasing the pharmacy copay from $7 to $15.

Additionally, the American Legion opposes the proposed regulatory change that would increase outpatient primary care copayments from $15 to $20. The American Legion would rather VA seek reimbursement from CMS for all enrolled Medicare-eligible veterans being treated for non-service connected medical conditions before they try to balance the budget on the backs of Priority Group 7 and 8 veterans.

The American Legion is very concerned with the proposed reduction in long-term care beds, as I mentioned earlier. VA must meet the mandates of the Millennium Health Care bill, and eliminating long-term care beds is not the answer.

The American Legion recommends $30 billion for VA medical care without the inclusion of MCCF collections. The American Legion continues to advocate for all MCCF collections to be added to the budget numbers and not be treated as an offset to the budget.

Regarding Veterans' Benefits Administration, the American Legion is committed to ensuring VA will adjudicate veterans' claims fairly and impartially within a reasonable amount of time, and I think I expressed that during our Q and A earlier.

The American Legion is pleased, however, with the fiscal year 2005 budget request proposal to address the influx of claims resulting from returning service members from Operation Enduring Freedom and Operation Iraqi Freedom. These deserving veterans should not be told to wait in line when turning to VBA.

Chairman SPECTER. Mr. Gaytan, would you mind summarizing?

Mr. GAYTAN. Yes.

Chairman SPECTER. You are 50 percent over time now.

Mr. GAYTAN. Yes, sir. I apologize. I just want to mention or reaffirm the American Legion's support for mandatory funding. We fully support designating VA medical care as a mandatory funding item within the Federal budget.

I apologize for extending my time and I appreciate your patience.

Chairman SPECTER. Thank you. Thank you very much, Mr. Gaytan.

[The prepared statement of Mr. Gaytan follows:]

PREPARED STATEMENT OF PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present the views of the 2.8 million members of The American Legion regarding the Department of Veterans Affairs' (VA) fiscal year (FY) 2005 budget request. The American Legion continues to advocate adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. As America's soldiers, sailors, airmen, and Marines continue to fight in more than 130 countries

worldwide, this Nation must fulfill its obligation ". . . to care for him who has borne the battle, and for his widow and his orphan."

In the fiscal year 2005 VA budget request, there is a continued emphasis on focusing resources for medical treatment of the core-mission veteran population. The term core-mission veteran population does not appear in Title 38, United States Code. In 1996, Congress passed VA eligibility reform legislation. It was not until 1998 that VA finally established the rules to enforce the statute. Eligibility reform ensured all eligible veterans could seek health care through VA, not simply those designated as the core-mission veteran population. Tailoring the veteran population to meet the budget was not the intent of Congress when it reformed access eligibility. The American Legion believes VA must be funded at a level that will ensure all eligible veterans have access to the VA health care system. The VA budget must reflect the true demand for care.

Once again, the Administration attempts to place the burden of financing VA health care on the backs of veterans. The fiscal year 2005 budget request contains provisions that would increase prescription co-payments and create an annual enrollment fee. These legislative initiatives target those Priority Group 7 and 8 veterans who are currently enrolled in the system. At the same time, VA continues to deny enrollment of any future Priority Group 8 veterans who could help shoulder this burden. These are the very veterans required to pay VA's co-payments and make third-party reimbursements for their health care. Rationing health care to America's veterans is not the solution to VA's accessibility crisis. The American Legion supports repealing the suspension of enrollment of Priority Group 8 veterans.

We applaud the Administration efforts to alleviate co-payments for veterans receiving hospice care and former prisoners of war. The American Legion supports provisions within the budget request that would increase the income threshold from the Pensions level of $9,894 to the aid and attendance level of $16,509 for certain Priority Group 2–5 veterans. This would help reduce the pharmacy co-payment for those veterans struggling to meet the sky-rocketing cost of health care.

In addition, The American Legion supports provisions to allow VA to pay for emergency room care at non-VA facilities for enrolled veterans. This will prevent any delays in treating life threatening injuries or illnesses for enrolled veterans not in close proximity to a VA facility. During visits to VA facilities under The American Legion's "System Worth Saving" initiative, Past National Commander, Ronald Conley discovered many VA facilities operated under a "divert" policy that imperiled veterans by denying them immediate access to health care.

The American Legion is equally concerned with VA's continued efforts to create the new "VA Advantage" Medicare plan that would offer limited health care services to Priority Group 8 veterans 65 or older with Medicare Part B. Keep in mind that only nonservice-connected veterans who fall above the geographical means test and are Medicare-eligible will be considered under this proposal. Priority Group 8 veterans who are not Medicare-eligible will simply continue to be denied access to VA medical care.

Indian Health Services and TRICARE for Life are classic examples of effective Medicare and Medicaid Federal partners. Since over half of VA's enrolled patient population are Medicare-eligible veterans, The American Legion strongly believes Congress should consider passing legislation to ensure VA is reimbursed for treatment of Medicare-eligible veterans for allowable, nonservice-connected medical conditions.

The fiscal year 2005 budget request must provide an adequate level of funding to eliminate the backlog of veterans waiting to receive care, to meet the needs of returning servicemembers who must now receive health care from VA, and to once again allow Priority Group 8 veterans to receive timely access to quality VA medical care through the very system created to meet their unique health care needs.

THE AMERICAN LEGION'S BUDGET REQUEST FOR SELECTED DISCRETIONARY PROGRAMS FOR VA IN FISCAL YEAR 2005

The American Legion strongly recommends Congress provide VA with the following specified funding in fiscal year 2005:

Counts	Budget Request
Medical Care	$30 billion*
Medical & Prosthetics Research	$445 million
Construction:	
Major	$325 million
Minor	$255 million

Counts	Budget Request
State Grants for Extended Care Facilities	$120 million
State Grants for Veterans' Cemeteries	$40 million
National Cemetery Administration	$160 million
General Administration	$1.8 billion

*Third-party reimbursements should supplement rather than offset discretionary funding.

VETERANS HEALTH ADMINISTRATION

Medical Care

Over the past 20 years, VA has dramatically transformed its medical care delivery system from a struggling collection of hospitals and homes to an integrated health care system of excellence that leads private and other government health care providers in almost every measure. The quality of care that is provided through the VA health care system is exemplary. However, the quality of care is irrelevant when access to that care is impeded.

Today, there are over 25 million veterans. As more veterans choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law 104–262, the Veteran's Health Care Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until this time, were restricted from VA health care in the 1980's were once again able to gain access. Veterans recognize that the Veterans Health Administration provides affordable, quality care that they cannot receive anywhere else.

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. As mentioned earlier, fiscal year 2003 saw the suspension of enrollment of new Priority Group 8 veterans due to this growth in enrollees. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

The simple fact is VHA does not have the funding needed to treat all veterans seeking care from VA. VHA operates under a constant cloud of fiscal uncertainty. The fiscal year 2004 VA appropriations battle delayed much-needed funds until more than 5 months into the fiscal year. Future spending projections, staffing levels, equipment purchases, and structural improvements are all stalled if the funding is not a certainty. Delayed funding means delayed services for deserving veterans who rely on VA for their care.

In an effort to provide a stable and adequate funding process, The American Legion supports mandatory funding for veterans' medical care, as well as Medicare reimbursement for VA.

MANDATORY FUNDING FOR VETERANS MEDICAL CARE

The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans. The American Legion has called for the current discretionary funding process, in which VA must compete with other agencies for scarce budget dollars, to be replaced by a mandatory funding formula for VA medical care. VA must be adequately funded to meet its own growth and end intolerable waiting periods.

For over a decade, The American Legion has advocated allowing veterans to spend their health care dollars on the health care system of their choice. The American Legion believes the VHA can efficiently expand to meet the health care needs of the men and women who have honorably served this Nation in its armed forces—in war and in peace.

When Congress opened access to the VA health care system, many veterans believed VA was their best health care option and newly eligible veterans began seeking care at VA. Since the Centers for Medicare and Medicaid Services (CMS), the nation's largest public health insurance program, does not offer its beneficiaries the full continuum of care or a substantive prescription benefit program, many Medicare-eligible veterans chose to enroll in VHA specifically to receive quality health care and access to an affordable prescription program. Although the Department of Defense's TRICARE and TRICARE for Life require military retirees to make co-payments or pay premiums, they do not provide for specialized care (like long-term care) many military retirees may need; therefore, many military retirees chose to also enroll for VA care to meet their unfulfilled medical needs.

Veterans continue to suffer as a result of a system that has been routinely under funded and is now ill-equipped to handle the large influx of veterans waiting to use their services. Veterans continue to endure extensive waiting times for medical appointments, as well as unacceptably long waiting times for claims adjudication.

Funding for VA health care currently falls under discretionary spending within the Federal budget. The VA health care budget competes with other agencies and programs for limited Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

However, under mandatory spending, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing annual appropriations for the earned health care benefits of veterans.

The American Legion believes it is disingenuous for the government to promise health care to veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who unselfishly put our nation's priorities in front of their own needs. Mandatory funding for VA health care will help ensure timely access to quality health care for America's veterans.

Mandatory funding of VA medical care would not prohibit the use of other revenue streams to meet fiscal obligations, such as co-payments and third-party reimbursements from all health care insurers, both public and private.

THIRD PARTY REIMBURSEMENT AND MEDICAL CARE COLLECTION FUNDS

Public Law 105–33, the Balanced Budget Act of 1997, established the VA Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third party insurance, outpatient prescription copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Government.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the Treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISN's and VAMC's. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

Implementation by VHA of the Revenue Cycle Enhancement Plan has a dramatic effect on the amount of revenue collected. Resuming in early fiscal year 2002 it has resulted in significantly higher receipts than projected. VHA doubled the amount expected in fiscal year 2004 from $1.3 billion to 2.1 billion. However, any system can stand improving and agency models are available that clearly illustrate the efficiencies that can be gained through practical application. Considering that VA is prohibited from collecting third-party reimbursements from the nation's largest health care insurer—CMS—and the vast majority of VA enrolled patient population are Medicare-eligible, VA's MCCF program has the potential of becoming even more effective in the recovery of third-party reimbursements.

MEDICARE REIMBURSEMENT TO MCCF

As do all working citizens, veterans pay into the Medicare system without choice. A portion of each earned dollar is allocated to the Medicare Trust Fund. Although veterans must pay into the Medicare system, they cannot use their Medicare benefits at any VA health care facility. VA cannot bill Medicare for the treatment of Medicare-eligible veterans. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the treatment of allowable, non-service-connected medical conditions of enrolled Medicare-eligible veterans. As a Medicare provider, VHA should be authorized to bill and collect allowable third-party reimbursements from the Medicare Trust Fund for the treatment of non-service-connected medical conditions of enrolled Medicare-eligible veterans.

Since VA is working with CMS contractors for the purpose of providing VA with a Medicare-equivalent remittance advice (MRA) for veterans who are using VA services and are covered by Medicare, the American Legion recommends including all Medicare-eligible veterans assigned to Priority Groups 7 and 8. Under the Veterans Equitable Resource Allocation (VERA) formula, enrolled Priority Group 7 and 8 vet-

erans are not included in the current VERA formula that ultimately results in an inequitable distribution in resources.

The fiscal year 2005 budget optimistically projects a $2.4 billion revenue stream attributed to third-party collections, but still supports the suspension of Priority Group 8 veterans from enrolling in VA.

As The American Legion continues to visit VA facilities nationwide as part of the "System Worth Saving" initiative, we are hearing first-hand from facility leadership of the problems that exist with increased third-party collection rates. During a recent visit to a VAMC, the facility staff stated that their fiscal year 2004 MCCF collection goal was "not realistic". They added that the goal is probably "not attainable as long as Category 7 & 8 veterans who bring in the MCCF dollars are excluded from using the system".

The American Legion recommends $30 billion for Medical Care in fiscal year 2005 in addition to MCCF collections, as well as eliminating the MCCF offset and authorizing VA to collect third-party reimbursements from Medicare for the treatment of allowable, nonservice-connected medical conditions.

MEDICAL AND PROSTHETICS RESEARCH

VA Medical and Prosthetic Research has a history of productivity in advancing medical knowledge and improving health care, not only for veterans, but all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The VA Medical and Prosthetic Research budget has not kept pace with inflation during the past 15 years. It is essential that Congress and the Administration support strong medical and prosthetic research programs within VA so that veterans and all citizens continue to benefit from the exceptional research capability of the Department.

The American Legion supports adequate funding for VA biomedical research activities. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans—such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others—jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $445 million for Medical & Prosthetics Research in fiscal year 2005.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. Buildings continue to be neglected and the persistent deterioration results in unsafe environments similar to unsanitary conditions discovered at the VAMC in Kansas City, Missouri. Of course, those that pay the price of this neglect are the veterans who are receiving care at these facilities.

A 1998 study recommended that VA fund two to 4 percent of Plant Replacement Value (PRV) per year to reinvest in new facilities to replace aging facilities. The conclusion of this analysis was that VA's reinvestment rate of .84 percent was significantly lower than the benchmark of 2 percent. This equates to hundreds of millions of dollars that conceivably could be used for major construction projects. 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 yet funding continues to be woefully short of what is actually needed to correct this problem.

The American Legion supports legislation that would provide $1.8 billion over the next three fiscal years to improve, replace, update, renovate or establish facilities within the existing VA infrastructure. These funds would be exempt from 38 USC § 8103 (a)(2) which requires enabling legislation for construction procurements in excess of $4 million or leases in excess of $600,000 per year. This money would be available at the discretion of VA for:

- Seismic protection;
- Life safety upgrades;
- Utility improvements; and
- Accommodations for disabled persons.

Facilities eligible for improvements include:

- Blind rehabilitation centers;

• Inpatient and residential programs for seriously mentally ill veterans and veterans with substance abuse disorders;
• Physical medicine and rehabilitation activities;
• Long term care including adult day care, nursing facilities and geriatric research and education facilities;
• Amputation care facilities including prosthetics and orthotics and sensory aids;
• Spinal cord and traumatic brain injury centers;
• Women's veterans' health programs; and
• Hospice and palliative care facilities.

The American Legion is concerned that veterans are needlessly being placed in harm way within existing VA facilities. There are over 60 patient care and other related use buildings in danger of collapse or heavy damage in the event of an earthquake. The sorely needed seismic corrections, along with the necessary ambulatory care and patient safety projects, will require a significant increase in funding to address VHA's current major construction requirements. This legislation will go a long way toward correcting these deficiencies.

The American Legion further supports legislation that would authorize the following major medical construction projects at the amounts specified:

• Construction of two bed towers to consolidate inpatient sites in inner-city Chicago at the West Side Division in an amount not to exceed $98.5 million.
• Construction in Clarke County, Nevada of a multi-specialty outpatient clinic to replace the leased Las Vegas ambulatory care center and a satellite office for the Veterans Benefits Administration in an amount not to exceed $97.3 million.
• Seismic corrections to strengthen Medical Center Building 1 at VA health Care System at San Diego, California not to exceed $48.6 million.
• Renovation of all inpatient care wards at the VA West Haven, Connecticut healthcare facility at a cost not to exceed $50 million.

The American Legion recommends $325 Million for Major Construction in fiscal year 2005.

MINOR CONSTRUCTION

Similar to VA's major construction program, VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase is crucial.

The American Legion recommends $255 Million for Minor Construction in fiscal year 2005.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

State Veterans Homes were founded for indigent and disabled Civil War veterans beginning in the late 1800's and have continued to serve subsequent generations of veterans for over one hundred years. Under the provisions of 38 USC, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans Homes. Today, there are 109 State Veterans Homes facilities in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The State Veterans Home Program has proven to be a cost-effective provider of quality care to many of the nation's veterans and this program is an important adjunct to VA's own nursing, hospital, and domiciliary programs. The Grants for Construction of State Veterans Home Program provides funding for 65 percent of the total cost of building new veterans homes. VA has not been able to keep pace with the number of grant applications; and currently there is over $120 million in unfunded new construction projects pending.

Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system. The American Legion supports increasing the amount of authorized per diem payments (40 percent) for nursing home and domiciliary care provided to veterans in State Veterans Homes. The American Legion also supports the provision of prescription drugs and over-the-counter medications to State Homes Aid & Attendance patients, along with the payment of authorized per diem to State Veterans Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans Home. The National Association of State Veterans Homes and VA should develop mutual planning efforts, enhanced medical sharing agreements, and enhanced-use construction contracts with qualified providers.

The American Legion recommends $120 Million for the State Extended Care Facility Grants Program in fiscal year 2005.

NURSING HOME CARE

Except for the occasional congressional initiative to build nursing homes in individual states or congressional districts and some CARES planning initiatives, VA has no plans to expand its own nursing home capacity.

VA has failed to fulfill the promise of its landmark mid–1980's study, *Caring for the Older Veteran*. That study recommended large increases in both inpatient and alternative programs, such as respite, hospice, adult-day and home-based care, so that VA could approach the needs of World War II veterans with meaningful, health and end-of-life care programs, on both institutional and non-institutional bases. This has not been achieved.

Millennium Act required VA to maintain its in-house NHU bed capacity at the 1998 level of 13,391. This capacity has significantly eroded rather than been maintained. In 1999, there were 12,653 VA NHU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimates it will have only 9,900 beds in 2003 and 8,500 in 2004. VA has claimed that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act.

VA should be required to maintain its nursing home capacity as intended by Congress. VA must create incentives and receive appropriate funding to maintain its NHCU beds rather than abandon them to alternative sources. These beds are a vital component of the VA Long Term Care (LTC) continuum of care, and they are essential in addressing the needs of the aging veteran population.

According to VA's fiscal year 2002 Annual Accountability Report Statistical Appendix, in September 2002, there were 93,071 World War II and Korean War era veterans receiving compensation for service-connected disabilities rated seventy percent or higher. The American Legion opposes provisions in the fiscal year 2005 budget request that would reduce funding for VA nursing homes by $270.5 million and reduce staffing by 2,500 full time employees. VA should comply with the intent of Congress to maintain an adequate LTC nursing home capacity for those disabled veterans who are in the most resource intensive groups; clinically complex, special care, extensive care and special rehabilitation case mix groups. The Nation has a special obligation to these veterans. They are entitled to the best care that the VA has to offer.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care, domiciliary, and outpatient mental health care needs into the future, specifically to 2012 and 2022, these critical health care services were omitted from the CARES planning. An extensive look, such as that proposed by the CARES initiative, cannot possibly be accomplished when an assessment of need for those services is missing from the process.

The Draft National Plan contains several proposals to realign campuses and consolidate services. These realignments were introduced in the eleventh hour, with no stakeholder input sought by VA. There are 13 such realignments proposed in the plan. The American Legion does not support the closing of a VA facility just for the sake of saving money while veterans are denied care.

The Draft National CARES Plan expects substantial renovations and expansions as consolidations happen. A great deal of money will have to be allocated up front to ensure the new construction and renovations are completed. The American Legion understands that CARES is an ongoing process and when dealing with vacant space and renovations, incremental changes may have to take place. The price tag for all of the construction and renovations proposed is in the billions of dollars. With the proposed consolidations and transferring of services, it is imperative that veterans not experience delays in the delivery of their care. No facilities should be closed, disposed of, or downsized until the proposed movement of services is complete and veterans are being treated in the new locations.

Funding should be provided to ensure that any realignment resulting from the CARES initiative does not lead to the suspension of services for veterans seeking care.

VETERANS BENEFITS ADMINISTRATION

Over the years, Congress has established a system of laws that provide veterans and their survivors a spectrum of the services and benefits earned by virtue of the veteran's service in the Armed Forces of the United States. Since 1938, VA has had

the responsibility of implementing these laws in a pro-claimant, informal, ex parte, and nonadversarial manner. The American Legion continues to closely monitor the programs and policies of the Veterans Benefits Administration (VBA) and assess whether or not these are truly meeting the needs of veterans and their families. The American Legion has a number of concerns about the current State of claims adjudication and the level and quality of service being provided by VBA and the Board of Veterans Appeals.

The American Legion emphasizes that it is committed to ensuring that VA carries out its historic and statutory responsibility to provide medical care and benefits to those who have served and sacrificed in the defense of this nation. Veterans have the right to expect that VA will adjudicate their claims fairly and impartially within a reasonable period of time. We believe there are still too many instances where veterans and other claimants are being arbitrarily denied the benefits to which they are entitled.

Over the course of fiscal year 2002 and fiscal year 2003, VBA has been able to make notable progress toward realizing Secretary Principi's often stated goal of the reducing the number of pending cases down to 250,000 and cutting the average processing time down to 100 days by the end of this month. This has been a major challenge for VBA. In March 2002, at its peak, the regional offices had a backlog of over 423,000 cases that required rating action. Of these, 40 percent were over 6 months old. There were another 147,000 cases in which some other type of action was pending. In addition, there were approximately 107,000 pending appeals, which included over 22,000 cases that had been remanded by the Board of Veterans Appeals. In human terms, thousands of these sick and disabled veterans or their survivors were waiting a year or more for a regional office to make a decision on their claim. If the claim was denied and they pursued an appeal, their wait could extend another two to 3 years or more. Such delays caused increased stress as well as serious financial hardship. The American Legion has commended the Secretary for his commitment to improving the regional office claims adjudication process. Recognizing the fact that many of these backlogged claims were from elderly veterans, one of the Secretary's first service improvement initiatives was the establishment of the Tiger Team at the Cleveland VA Regional Office. This unit has been primarily responsible for expedited action on the claims of older veterans, particularly those aged 70 and older, whose cases have been pending for a year or more.

The Tiger Team initiative has been a success and they too should be commended for their efforts and dedication. However, it is regrettable that a sick and disabled veteran has to wait months, if not a year or more for action on their claim for benefits. Because of processing delays and necessity of an appeal to the Board of Veterans Appeals (the Board or BVA) or the Federal courts, many veterans have died before receiving a final decision on their case. In the view of The American Legion, the regional offices should be more concerned with people than process.

It is clear that there has been a dramatic reduction in the claims backlog in the past year and a half. This decline means that regional offices are taking less time to adjudicate claims than in the past. Last year at this time, there were some 358,000 claims awaiting final action. Of these, almost 36 percent were over 6 months old. At the end of August, VBA reported there were about 265,000 pending claims and, of these, about 20 percent are over 6 months old. The average processing time has been reduced from 224 days in June 2002 to about 160 days currently. However, given the complexities of the claims adjudication process and requirements of the law, numbers do not tell the whole story and "faster" is not always "better."

In its annual budget request over the past several years, VBA has reported a steady decrease in claims adjudication error rate. At the end of 1997, the error rate had been 36 percent. In 1998, it was 30 percent. It increased slightly in 1999 to 32 percent. In 2000, there was a dramatic increase to 41 percent. The reported error rate declined to 22 percent in 2001. It was 20 percent in 2002 and, in 2003, it had declined to only 12 percent. The error rate goal for fiscal year 2004 is 10 percent. Over this same period, The American Legion's regional office quality review visits do not confirm a substantial and dramatic improvement in the overall error rate.

There is little doubt that the vast majority of regional office adjudicators are dedicated, hardworking men and women. They continue to operate under tremendous stress to meet the Department's and veterans' expectations. However, The American Legion believes the effectiveness of VBA's quality improvement efforts has been severely compromised by the drive to achieve the Secretary's mandated production quotas. Veterans and other claimants are being short-changed by VBA policies and procedures that tend to promote less than adequate claims development, premature denials, and under-evaluations.

The lack of proper and appropriate action on thousands of claims continues to result in a high level of claimant dissatisfaction and a steady influx of new appeals to the regional offices. There are now over 134,000 pending appeals with some 111,500 requiring adjudicative action. Even though there is a concerted effort to resolve appeals at the regional office through the Decision Review Officer program, most of these cases will eventually go to the Board of Veterans Appeals for a final decision on the merits of the claim.

The straight line staffing level requested for fiscal year 2004 is based on the assumption that, with the accomplishment of the Secretary's backlog reduction goals, VBA would be able to refocus its efforts to more effectively address the quality-related problems and other long-standing issues. Given past performance, The American Legion continues to believe that this is an unrealistic policy and will not afford VBA the flexibility to cope with current workload demands, let alone some unanticipated contingency, such as supporting the Department of Defense new Combat-related Special Compensation Program and the additional resources that will be required to comply with the Huston decision. The American Legion recognizes that VBA has made a concerted effort to hire additional staff in the last several years. This policy of continuing growth is both prudent and necessary, given the increasingly complex nature of the claims and appeals process, the heavy volume of new claims, and the ongoing need to buildup the core adjudication staff in anticipation of the retirement of the more experienced regional office decisionmakers.

The American Legion is concerned with support in the budget request for legislation that would reverse the Allen vs. Principi court decision. Clearly, the intent of this proposal is to overturn the 2001 decision of the United States Court of Appeals for the Federal Circuit (the Federal Circuit or the Court) in *Allen* v. *Principi* 237 F.3d 1368 (Fed. Cir., 2001). The Court held that Congress, in enacting P.L. 96–466, the "Omnibus Budget Reconciliation Act of 1990" (OBRA 90), did not intend to preclude compensation for an alcohol or drug-related disability resulting from or secondary to a non-willful misconduct service-connected disability. Prior to OBRA 90, VA considered alcoholism and drug abuse disabilities unrelated to a service connected psychiatric disorder as willful misconduct. The term "willful misconduct" was defined in VA regulations as a deliberate and intentional act involving conscious wrongdoing or known prohibited action, with knowledge of or wanton and reckless disregard of the probable consequences.

However, the definition noted that the mere technical violation of police regulations and ordinances would not, per se, constitute willful misconduct unless it is the proximate cause of injury, disease, or death. VA's policy was that the misconduct bar to benefits did not apply to those veterans whose alcohol or drug addiction was secondary to a service connection mental or physical disability. OBRA 90 specifically provided in 38 U.S.C. §§ 1110 and 1131, that an injury or disease resulting from the abuse of alcohol or drugs is not considered to have been incurred in the line of duty and VA may not pay compensation for disabilities that are the result of "the veteran's own willful misconduct or alcohol or drug abuse." Under OBRA 90, VA as a matter of policy and practice, would not grant secondary service connection for substance abuse, but would, where appropriate, incorporate the symptoms of alcohol and drug abuse into the overall evaluation of the primary service connected disability. As an example, a veteran may have been rated for "PTSD with alcoholism." In 1998, the United States Court of Appeals for Veterans Claims (CVAC), in *Barela* v. *West* (11 Vet. App. 280) (1998), held that, while OBRA 90 provided for service connection of alcohol and drug-related disabilities as being secondary to a service connected disability, VA could not pay compensation for such disabilities.

BOARD OF VETERANS APPEALS

The reduction in the number and the average processing time of pending claims represents only one aspect of VA's overall case backlog, since not all claims can or should be approved. When a veteran or other claimant receives an unfavorable decision either denying the claim in whole or in part, they have the right to appeal. The number of appeals filed each year is a direct reflection of the level of claimant satisfaction with the quality of the regional office adjudication. The action taken by the Board of Veterans Appeals (BVA) is a further reflection and commentary on the quality of regional office decisionmaking. Of those appeals decided in the first 10 months of fiscal year 2003, the Board affirmed the decisions of the regional office only 38 percent of the time and rejected their decision in about 59 percent of the cases. Such poor performance by the regional office adjudicators is of grave concern to The American Legion, since it represents a tremendous waste of time and taxpayers' money, and a hardship for thousands of veterans and their families. Clearly,

VBA's efforts to date have not effectively addressed the persistent systemic problems that adversely affect regional office claims processing and adjudication.

COURT OF APPEALS FOR VETERANS CLAIMS AND THE COURT OF APPEALS FOR THE FEDERAL CIRCUIT

The regulations and procedures of both the VBA and the BVA will be fundamentally changed by several recent court decisions. The courts have held that VA, as a matter of policy, had promulgated regulations that were misleading, basically unfair, and a violation of claimants' right to full due process.

In 2002, there was a combined effort by the Board of Veterans Appeals and VBA to try and improve the timeliness and quality of action on remanded appeals. By alleviating some of the regional offices' appellate workload, this would enable the regional offices to devote more resources to resolving previous remands and further reduce the backlog of pending claims. This initiative was prompted by the fact that remands often sat in a regional office for months or even years with little or no action taken. In many instances, the development that was done would be inadequate or incomplete and the Board had to remand the case two or three times, which meant greater delay and hardship for the appellant. Rather than sending a case back to the regional office, a unit was established within the Board to undertake the development specified in the remand decision. If the decision included a benefit grant, the unit could initiate the award, so there would be no delay in payment. The American Legion supported the intent of this service improvement effort.

In a decision early last summer, the United States Court of Appeals for the Federal Circuit held that the BVA's Development Unit was unlawful. As a result, there are about 8,000 remands plus new remands that are in the process of being transferred from the BVA Development Unit to VBA's Appeals Management Center (AMC), which is located at the Washington VA Regional Office, for further development and readjudication. While generally supportive of the effort to try and improve the handling of remands, there are problems in handling cases where the Board has awarded benefits. The lack of action by the AMC to expedite payment action has prompted several veterans to contact The American Legion for assistance. We are hopeful that appropriate steps have now been taken by VBA to ensure this type of problem does not recur. The AMC is projected to be fully staffed and operational by December 2003. In the interim, remands are being referred to the Huntington, West Virginia Regional Office and the Tiger Team in Cleveland for action. However, the prior BVA Development Unit initiative and the current AMC leave unaddressed the larger and more difficult issues relating to poor regional office decisionmaking, incomplete development, inadequate VCAA notices, and premature denials. Furthermore, there does not appear to be any incentive for the regional offices to improve their case development, nor is there any disincentive to keep them from certifying cases, because the AMC have to do what they should have done. VBA must ensure that the AMC does not become a dumping ground for the regional offices.

In a system with tens of thousands of claims to be processed, there is a constant tension between management's need to have cases decided as quickly as possible and the statutory need to protect the claimant's right by ensuring that any decision made is proper and consistent with the law and regulations. For the past two and a half years, VBA management has been emphasizing speed and production volume. Under such pressure, there has been a tendency among some VBA managers and adjudicators to ignore the law and VA's own regulations and put bureaucratic convenience ahead of quality decisionmaking and the welfare and well being of the individual veteran and his or her family.

In the opinion of The American Legion, one of the key impediments to progress on improving the quality of regional office decisionmaking and, thereby, claimant satisfaction, has been VBA's lack of compliance with both the letter and spirit of the "Veterans' Claims Assistance Act of 2000" (PL 106–475) (VCAA). The American Legion was actively involved in the development of this landmark legislation. It was designed to overcome the deficiencies and lack of clarity in the way VBA communicated with claimants and the way in which it developed claims. It made clear the exact nature and extent of VA's obligations and responsibilities to notify and to assist claimants. The idea was that, if claims were better developed, they could be promptly and more accurately adjudicated, thereby improving service to claimants. In the long run, these improvements should also reduce the overall appeals workload for the regional offices and the Board of Veterans Appeals. It was to be a "win/win" situation for all parties. However, as we have seen thus far, VBA has generally given lip service to the requirements of VCAA.

While claimants are provided what is termed a "VCAA" letter, little time or effort goes into trying to help the individual veteran understand his or her claim and what

evidence is going to be needed and who is responsible for developing it. Such letters usually lack essential information regarding the individual's claim and the evidence needed to grant the benefit sought in the particular case. These are unnecessarily long, confusing, nonspecific letters, which are filled with bureaucratic jargon. In some of the cases reviewed during The American Legion's regional office quality review visits, the information in many VCAA letters was found to be incorrect or not even appropriate to the claim. Rather than facilitating the adjudication process, as they were intended, these notice letters set the stage for an appeal to the BVA and the Federal courts.

The American Legion's concerns regarding the deficiencies in the VCAA letters have been brought to Secretary Principi's attention as well as discussed in testimony before the Veterans' Affairs Committees on a number of occasions. Despite these efforts, VBA policy on the use of this type of letter remained unchanged. However, as a result of the July 2003 decision by the United States Court of Appeals for Veterans Claims (CVAC), in *Huston* v. *Principi*, VBA will now be forced to comply with the duty to notify and duty to assist provisions of title 38, United States Code, sections 5103(a) and 5103A. VA will now be obligated to clearly tell the claimant what evidence to submit in order to obtain the benefits claimed. The American Legion is disappointed that it took a court order to make VBA do what it should have been doing since the enactment of the VCAA. We will be watching very closely how VBA and Board of Veterans Appeals implement the Huston decision. Continued strong oversight by the Veterans' Affairs Committees will also be important in ensuring the VBA is, in fact, meeting its historic and statutory responsibilities to the veterans of this nation.

GI BILL EDUCATIONAL BENEFITS

The American Legion commends the 108th Congress for its actions to improve the current Montgomery GI Bill (MGIB). A stronger MGIB is necessary to provide the Nation with the caliber of individuals needed in today's Armed Forces. The American Legion appreciates the efforts that this Congress has made to address the overall recruitment needs of the Armed Forces and to focus on the current and future educational requirements of the All-Volunteer Force.

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. This is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average 4-year public institution, as a commuter student during the 1999–2000 academic year was nearly $9,000. PL 106–419 recently raised the basic monthly rate of reimbursement under MGIB to $650 per month for a successful 4-year enlistment and $528 for an individual whose initial active duty obligation was less than 3 years. The current educational assistance allowance for persons training full-time under the MGIB—Selected Reserve is $263 per month.

The Servicemen's Readjustment Act of 1944, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that act. Consequently, these servicemen and servicewomen made a substantial contribution not only to their own careers, but also to the economic well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that the government actually made a profit because veterans who had graduated from college generally earned higher salaries and therefore paid more taxes. Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also, making a greater contribution to their community, state, and nation.

The American Legion recommends the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify.
- The educational cost index should be reviewed and adjusted annually.
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package.

• Enrollment in the MGIB shall be automatic upon enlistment, however; benefits will not be awarded unless eligibility criteria have been met.
• The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated.
• If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans.
• If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of Title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB.
• A veteran may request an accelerated payment of all monthly educational benefits upon meeting the criteria for eligibility for MGIB financial payments, with the payment provided directly to the educational institution.
• Separating service members and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device.
• Eligible veterans shall have 10 years after discharge to utilize MGIB educational benefits.
• Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years from their date of separation to use MGIB educational benefits.

HOME LOAN GUARANTY PROGRAM

The American Legion believes that the current limit of VA Home Loan Guarantee of $252,500 should be raised to $300,000 and that higher limits be established for areas of the country where justified by prevailing real estate market conditions. In San Francisco, California in 2002 the median price of a home was $482,300, an actual decrease of .3 percent from 2001. In Boston, Massachusetts the median price of a home was $358,000; in the New York City Metro area, 285,600; and here in Washington D.C. the median home cost $229,100 in 2002, up 19.8 percent from $183,700 in 2001. Clearly, in these cities, the difference between many veterans being able to secure financing for a decent home for his or her family and being shut out of the market is due to the inadequate levels of the VA Home Loan Guarantee Program.

The American Legion also supports the recognition of VA Home Loan Guaranty benefits in cases where both members of a married couple are eligible for the benefit. If both members are eligible to receive the benefit, both members should be allowed to use the benefit.

The American Legion is also concerned with a provision in the budget request supporting legislation that would limit the VA Home Loan program to one-time use for military members who separate after the legislation is passed and for all current veterans 5 years after enactment. Veterans have earned the right to this benefit and it should not be limited to one-time usage.

The VA Home Loan program is one of the core elements of the original Servicemen Readjustment Act of 1944, the GI Bill of Rights. This legislation is often referred to as "one of the most important pieces of social legislation ever enacted." Successful participation in the VA Home Loan program should be rewarded, not restricted or terminated. Due to the transient nature of our society, many Americans may experience several relocations based on business opportunities or upgrades in their financial situations. Living the American dream of homeownership should be encouraged and promoted as continuous economic stimulus opportunity.

NATIONAL CEMETERY ADMINISTRATION (NCA) THE NATIONAL CEMETERY SYSTEM

VA's National Cemetery Administration (NCA) is comprised of 120 cemeteries in 39 states and Puerto Rico as well as 33 soldiers' lots and monuments. NCA was established by Congress and approved by President Abraham Lincoln in 1862 to provide for the proper burial and registration of graves of Civil War dead. Since 1973, annual interments in NCA have increased from 36,400 to over 84,800. Annual burials are expected to increase to more than 115,000 in the year 2010 as the veteran population ages. Currently 59 national cemeteries are closed for casket burials. Most of these can accept cremation burials, however, and all of them can inter the spouse or eligible children of a family member already buried. Another 22 national cemeteries are expected to close by the year 2005, but efforts are underway to forestall some of these closures by acquiring adjacent properties.

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding, how-

ever, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports the Under Secretary for Memorial Affairs in his goal of completing the NCA's National Shrine Commitment in 5 years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must increased to reflect the true requirements of the National Cemetery Administration to fulfill this Commitment.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or State cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

P.L. 107–117 required NCA to build six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five (Atlanta, Detroit, South Florida, Pittsburgh and Sacramento) are in various stages of completion. Additional acreage is currently under development in 10 national cemeteries, columbaria are being installed in 4 and additional land for gravesite development has been acquired at national cemeteries in 5 states. 9 national cemeteries are expected to close to new interments between 2005 and 2010. The rate of interments in national cemeteries has increased from 36,400 in 1978 to 84,800 in 2001. This rate is expected to rise to 115, 000 in 2015.

The average time to complete construction of a national cemetery is 7 years. The report of a study conducted pursuant the Millennium Bill concluded that an additional 31 national cemeteries will be required to meet the burial option demand through 2020. Legislation is currently pending in this session that will authorize the establishment of 10 new national cemeteries in areas of the country facing a shortage of burial space. Together with the 6 national cemeteries under development, this will go a long way toward fulfilling this need. NCA will be able to keep pace with current demand for burial space if this legislation is enacted and fully funded this year.

The American Legion urges Congress to provide sufficient major construction appropriations to permit NCA to accomplish its mandate of ensuring that burial in a national cemetery is a realistic option for 90 percent of our nation's veterans.

The American Legion recommends $156 Million for the National Cemetery Administration in fiscal year 2005.

STATE CEMETERY GRANTS PROGRAM

The National Cemetery Administration (NCA) administers a program of grants to states to assist them in establishing or improving state-operated veterans cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, the matched-funds program helps to provide additional burial space for veterans in locations where there are no nearby national cemeteries. Through fiscal year 2002, more than $169 million in grants has been awarded to states and the Territories of Guam and the Northern Marianas, including 5 new State cemeteries and the improvement and/or expansion of 9 existing ones.

Under the Veterans Programs Enhancement Act of 1998, PL 105–261, VA may now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. States are solely responsible for the acquisition of the necessary land.

The American Legion recommends $40 Million for the State Cemetery Grants Program in fiscal year 2005.

Mr. Chairman, this concludes my testimony. I again thank the Committee for this opportunity to express the views of The American Legion on VA's fiscal year 2005 Budget Request and look forward to working with you and the members of the Committee to ensure VA is funded at a level that will allow all veterans to receive the care they have earned through their service.

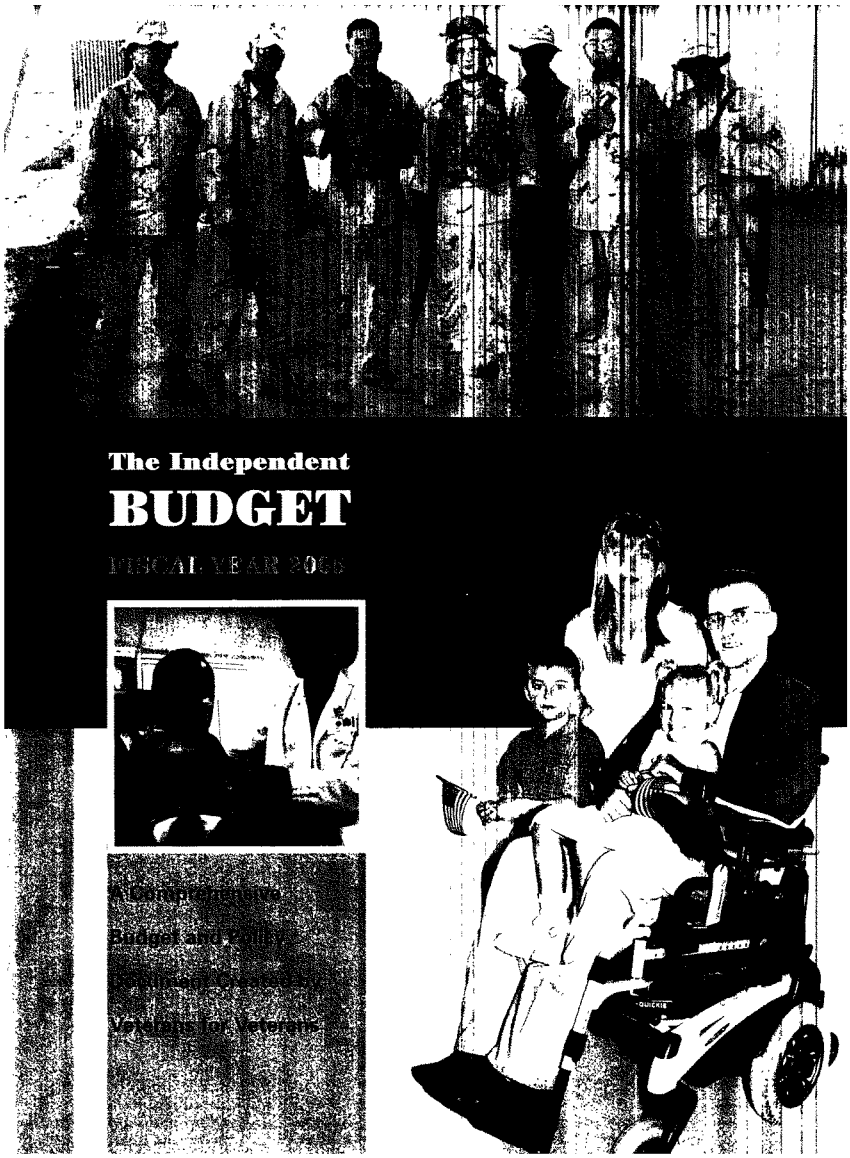
Chairman SPECTER. Our next witness is Mr. Richard Fuller, National Legislative Director of the Paralyzed Veterans of America. Thank you for joining us, Mr. Fuller, and your full biographical resume will be placed in the record.

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

Mr. FULLER. Thank you, Mr. Chairman. The balance of the panel here represent the four organizations who co-authored *The Inde-*

pendent Budget every year. This year's 2005 *Independent Budget* is available for every member of the committee and will be sent to every member of the Senate.

[The Independent Budget follows:]


The Independent
BUDGET
FISCAL YEAR 2006
A Comprehensive
Budget and Policy
Document Created by
Veterans for Veterans

VA ACCOUNTS –February 3, 2004 (Traditional Structure)
(In Thousands)

	FY 2004 P.L. 108-199	FY 2005 Request	FY 2005 IB	Difference 2005 & 2004	Difference IB & 2004	Difference IB & 2005 Request
Medical Care[1]	26,630,030	26,939,774	29,791,488	+309,744	+3,161,458	+2,851,714
Medical Research	405,593	384,770	460,000	-20,823	+54,407	+75,230
NPA/ MAMOE[2]	78,673	78,826	86,690	+153	+8,017	+7,864
GOE	1,275,701	1,324,753	1,617,515	+49,052	+341,814	+292,762
Inspector General	61,634	64,711	62,000	+3,077	+366	-2,711
National Cemetery	143,352	148,925	175,000	+5,573	+31,648	+26,075
Construction, Major	271,081	458,800	571,000	+187,719	+299,919	+112,200
Construction, Minor	250,656	230,779	545,000	-19,877	+294,344	+314,221
Grants, State Homes	101,498	105,163	150,000	+3,665	+48,502	+44,873
Grants, State Cemeteries	31,811	32,000	37,000	+189	+5,189	+5,000

[1] Medical Care figures for FY04 and FY05 Request include $270 million reflected as collections in Administrations budget request.
[2] MAMOE is currently known as National Program Administration (NPA). Amounts in FY04 and FY05 Request reflect NPA request less $8.3 million realigned from Medical Care reimbursements

Prologue

This is the 18th year *The Independent Budget* has been developed by four veterans service organizations (VSOs): AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

The Independent Budget is built on a systematic methodology that takes into account changes in the size and age structure of the veteran population, Federal employee wage increases, medical care inflation, cost-of-living adjustments, construction needs, trends in health-care utilization, benefit needs, efficient and effective means of benefits' delivery; and estimates of the number of veterans to be laid to rest in our national and state veterans' cemeteries.

As in years past, the budget and appropriations for veterans programs for fiscal year 2005 will line up as discretionary spending in tortured competition with all other domestic discretionary programs funded by the Federal Government. *The Independent Budget* VSOs have become increasingly alarmed that this annual battle for funding is failing to meet the true needs of the veteran population. Dollar amounts are never adequate in the push and pull of the Congressional process. Furthermore, judging from the experiences of the past 2 years alone, Congress has failed to even pass a VA appropriations bill until months into the fiscal year, leaving VA hospitals limping along on wholly inadequate continuing resolutions. The system does not suffer in this process; veterans do—veterans waiting months for a doctor's appointment or hours for a nurse to answer a call button.

This year, as in the past, we call on Congress to find a better way to fund veterans health-care spending by removing the veterans' budget from the battle over annual discretionary spending. We call on Congress to establish a formula to provide VA health-care funding from the mandatory side of the Federal budget, assuring an adequate and timely flow of dollars to meet the needs of sick and disabled veterans.

S. John Sisler
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AMVETS

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National Commander
Disabled American Veterans

Joseph L. Fox, Sr.
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Paralyzed Veterans of America

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FY 2005 *INDEPENDENT BUDGET* ENDORSERS

82nd Airborne Division Association, Inc.

Administrators of Internal Medicine

Alliance for Academic Internal Medicine

AdvaMed

Alliance for Aging Research

American Federation of Government Employees, AFL-CIO (AFGE)

American Military Retirees Association, Inc.

American Osteopathic Association

American Psychiatric Association

American Thoracic Society

Association for Assessment and Accreditation of Laboratory Animal Care International (AAALAC)

Association of American Medical Colleges

Association of Professors of Medicine

Association of Program Directors in Internal Medicine

Blinded Veterans Association (BVA)

Catholic War Veterans, USA, Inc.

Clerkship Directors in Internal Medicine

CO State Veterans Nursing Home

Jewish War Veterans of the U.S.A.

Legion of Valor of the United States of America, Inc.

Military Officers Association of America

Military Order of the Purple Heart

National Alliance for the Mentally Ill

National Association of County Veterans Service Officers

National Association of Veterans' Research and Education Foundations

National Mental Health Association

Nurses Organization of Veterans Affairs (NOVA)

Veterans Affairs Physician Assistant Association

Veterans of the Vietnam War, Inc.

Vietnam Era Veterans Association

Vietnam Veterans of America

Guiding Principles

- Veterans must not have to wait for benefits to which they are entitled.
- Veterans must be ensured access to high-quality medical care.
- Veterans must be guaranteed timely access to the full continuum of health-care services, including long-term care.
- Veterans must be assured burial in state or national cemeteries in every state.
- Specialized care must remain the focus of the Department of Veterans Affairs (VA).
- VA's mission to support the military medical system in time of war or national emergency is essential to the Nation's security.
- VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans health-care system and to the advancement of American medicine.
- VA's mission to support health professional education is vital to the health of all Americans.

ACKNOWLEDGEMENTS

We would like to thank the staff from the four *Independent Budget* veterans service organizations for their contributions in creating this document. We especially thank Steering Committee members Rick Jones, AMVETS; Joseph Violante, DAV (FY 2005 chairman); Richard Fuller, PVA; and William Bradshaw, VFW, for their guidance on, and review of, the document.

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Table of Contents

Prologue i

FY 2005 *Independent Budget* Endorsers iii

Guiding Principles v

Acknowledgements vi

List of Tables ix

List of Charts ix

Introduction 1

Benefit Programs 3
- Benefits Issues 4
  - Compensation and Pensions 4
    - Compensation 4
  - Readjustment Benefits 14
    - Montgomery GI Bill 14
    - Housing Grants 15
    - Automobile Grants and Adaptive Equipment 16
    - Home Loans 17
  - Insurance 19
    - Government Life Insurance 19
    - Service-Disabled Veterans' Insurance (SDVI) 19
    - Veterans' Mortgage Life Insurance (VMLI) 20
  - Other Suggested Benefit Improvements 21
    - Protection of Veterans' Benefits Against Claims of Third Parties 21

General Operating Expenses 23
- General Operating Expense Issues 24
  - Veterans Benefits Administration 24
    - VBA Management 24
    - Departmental Policy for Veterans' Programs 25
    - Compensation and Pension Service 27

Education Services 31
Vocational Rehabilitation and Employment 31
General Administration 32
Board of Veterans' Appeals 32

Judicial Review in Veterans' Benefits 35
Judicial Review Issues 36
Court of Appeals for Veterans Claims 36
Scope of Review 36
Preservation of Informalities of VA Claims Process 37
Court Facilities 38
Court of Appeals for the Federal Circuit 39
Review of Challenges to VA Rulemaking 39

Medical Care 41
Medical Programs 41
Medical Care Account 43
Medical Care Issues 44
Financing Issues 44
Access Issues 50
Prosthetics and Sensory Aids 55
Specialized Services Issues 64
Long-Term Care Issues 70
VA Medical and Prosthetic Research 74
Medical and Prosthetic Research Issues 76
Aministrative Issues 78
Medical Administration and Miscellaneous Operating Expenses (MAMOE) 82
MAMOE Account 82
MAMOE Issues 83

Construction Programs 85
Major Construction Account 87
Minor Construction Account 88
Construction Issues 88
CARES Issues 93

Vocational Rehabilitation and Employment 99
Vocational Rehabilitation and Employment Issues 100

National Cemetery Administration 107
NCA Account 108
NCA Issues 110

Tables

Department of Veterans Affairs (Discretionary Budget Authority) 2

Recommended FY 2005 Independent Budget Medical Care Account Initiatives 43

VA Long-Term Care Workload 71

MAMOE Recommended Budget Appropriation 83

Construction, Major Projects, Recommended Appropriation 87

Construction, Minor Projects, Recommended Appropriation 88

National Cemetery Administration Recommended Budget Appropriation 109

Charts

1. Unique VHA Patients and Enrolled Veterans 41
2. Historical Appropriations for VA Major and Minor Construction 86
3. Major Construction Buying Power Adjusted for Inflation 87

Introduction

For the 18th year, *The Independent Budget* veterans service organizations (IBVSOs) and their endorsers face the task of predicting the needs of veterans in the coming fiscal year and determining the resources needed to meet those needs. The Department of Veterans Affairs (VA) and the veterans it serves are severely challenged by the skyrocketing cost of health care, surging demand for services from an aging veteran population, and eroding value of benefits. In addition, VA once again is faced with entering the second quarter of FY 2004 operating on a continuing budget resolution at the FY 2003 level.

Again this year *The Independent Budget* (IB) recommends Congress take action to enact legislation providing adequate mandatory funding for the VA health-care system. The annual budget crisis only adds to the continuing struggle veterans face in obtaining timely and quality health care. Demand on the system continues to rise; prescription drug, medical equipment, supplies, and staffing costs continue to soar, yet VA is expected to operate on last year's funding level.

The Independent Budget is a needs-based budget. This FY 2005 recommendation builds on our FY 2004 proposal, based on commonly accepted percentages for staffing and inflation adjustments for the coming fiscal year. The *IB* uses existing VA projections for health-care demand and acknowledges the importance of the VA Medical and Prosthetic Research Program with a suitable increase. This year's *IB* recommends a sizeable increase in funding for major and minor construction to help eliminate the backlog caused by a virtual moratorium on facility improvement funding and to provide a "down payment" on advance planning and construction for enhancements provided for in the Capital Asset Realignment for Enhanced Services (CARES) recommendations to be announced in the second quarter of FY 2004. With the loss of increasing numbers of our senior generation of veterans, we call for major expansion and improvements in the VA Cemetery Program.

On the benefits side, *The Independent Budget* continues to be concerned over the backlog in claims processing. VA has made determined efforts to streamline and improve the adjudication process; however, the backlog and the time it takes to process a claim remain entirely too long. The *IB* also reiterates its concern over the declining value of benefits, such as automobile adaptive equipment, specially adapted home grants, burial benefits, and insurance programs that continue to decline in value because of a lack of increases, in some cases, for years.

The Independent Budget covers the broadest possible spectrum of veterans' benefits and services with recommendations on each to make certain we keep the Nation's obligation to those who have served and sacrificed so much in its defense.

The Independent Budget covers the broadest possible spectrum of veterans' benefits and services with recommendations on each to make certain we keep the Nation's obligation to those who have served and sacrificed so much in its defense.

Department of Veterans Affairs
(Discretionary Budget Authority)
(Dollars in Thousands)

	FY 2004 Omnibus P.L. 108–199	FY 2005 IB Recommended Appropriation
Veterans Health Administration		
Medical Care	$26,630,030[1,2]	$29,791,488[3]
Medical and Prosthetic Research	405,593	460,000
Medical Administration and Miscellaneous Operating Expenses	78,673	86,690
Subtotal, Veterans Health Administration	27,114,296	30,338,178
Departmental Administration		
Veterans Benefits Administration (VBA)	999,071	1,286,765
General Administration	276,630	330,750
General Operating Expenses Subtotal (GOE)	1,275,701	1,617,515
National Cemetery Administration	143,352	175,000
Office of the Inspector General	61,634	62,000
Subtotal, Departmental Administration and Miscellaneous Programs	1,480,687	1,854,515
Construction Programs		
Construction, Major Projects	271,081	571,000
Construction, Minor Projects	250,656	545,000
Medical Center Master Planning		100,000
CARES Facility Planning & Individual Project Development	-	-
Parking Revolving Fund	-	-
Grants for Construction of State Extended Care Facilities	101,498	150,000
Grants for Construction of State Veterans' Cemeteries	31,811	37,000
Subtotal, Construction Programs	655,046	1,403,000
Total, Discretionary Programs	**$29,250,029**	**$33,595,693**

[1]Amounts include mandated rescission of .59 percent and are displayed in the traditional appropriations structure.
[2]Includes third-party collections offset.
[3]Does not include third-party collections.

Benefit Programs

Ours is a nation that holds a special appreciation and high regard for those who have served in our Armed Forces. Ours is a nation that recognizes a profound indebtedness to those who have borne extraordinary burdens and made extraordinary sacrifices to defend our national interests. Through our Government, we therefore provide special assistance to veterans and their dependents to fulfill our Nation's obligation to make up for the effects of disadvantages from disabilities incurred in connection with military service and education and employment opportunities forgone or lost during service in our Armed Forces.

For budgetary classification, the benefit programs are grouped into three major categories:

(1) compensation and pensions, which also includes the appropriations for burial benefits, miscellaneous assistance, and special benefits for children of Vietnam veterans;

(2) readjustment benefits, which includes specially adapted housing grants, vocational rehabilitation programs, educational benefits, housing loans, and automobiles and adaptive equipment; and

(3) insurance programs.

Disability compensation payments fulfill our primary obligation to make up for the economic and other losses veterans suffer due to the effects of service-connected diseases and injuries. When veterans' lives are cut short due to service-connected causes or following a substantial period of total service-connected disability, eligible family members receive dependency and indemnity compensation (DIC). Disability pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes attorney fee awards under the Equal Access to Justice Act and other special allowances for smaller select groups of veterans and dependents. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly monetary allowance, medical treatment, and vocation rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide monetary assistance to veterans undertaking education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available for children and spouses of veterans who are permanently and totally disabled or die as a

result of service-connected disability. Qualifying students pursuing Department of Veterans Affairs (VA) education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

The Post-Vietnam Era Veterans Education Program provides educational assistance to veterans who entered service between December 31, 1976, and July 1, 1985. This assistance is funded by the contributions participating veterans made during their service and matching funds from the Department of Defense (DOD).

Under its home loan program, VA guarantees home loans for veterans, certain surviving spouses of veterans who have not remarried, certain servicemembers, and eligible reservists and National Guard personnel. VA also makes direct loans to supplement specially adapted housing grants. Under a program authorized until December 31, 2005, VA makes direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserves. A group plan also covers servicemembers and members of the Ready Reserves and their family members. Mortgage life insurance protects veterans who have received specially adapted housing grants.

Through collaborative efforts of Congress, VA, and veterans' organizations, these benefit programs have been carefully crafted. Experience has proven that they generally serve their intended purposes and taxpayers very well. Over time, however, we learn of areas in which adjustments are needed to make the programs better serve veterans or to meet changing circumstances. Unfortunately, failure to regularly adjust the benefit rates for increases in the cost of living and failure to make other needed changes threatens the effectiveness of some veterans benefits.

Veterans' programs must remain a national priority. Additionally, they must be maintained, protected, and improved as necessary. To maintain or increase their effectiveness, we recommend the following.

Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

Congress should provide a cost-of-living adjustment (COLA) for compensation benefits.

Veterans whose earning power is limited or completely lost due to service-connected disabilities must rely on compensation for the necessities of life. Similarly, surviving spouses of veterans who died of service-connected disabilities often have little or no income other than DIC. Compensation and DIC rates are modest, and any erosion due to inflation has a direct detrimental impact on recipients with fixed incomes. Therefore, these benefits must be adjusted periodically to keep pace with increases in the cost of living. Observant of this principle, Congress has traditionally adjusted compensation and DIC rates annually.

Recommendation:

Congress should enact a COLA for all compensation benefits sufficient to offset the rise in the cost of living.

Full Cost-of-Living Adjustment for Compensation:

To maintain the effectiveness of compensation for offsetting the economic loss resulting from service-connected disability and death, Congress must provide cost-of-living adjustments equal to the annual increase in the cost of living.

Disability and dependency and indemnity compensation rates have historically been increased each year to keep these benefits even with the cost of living. However, as a temporary measure to reduce the Federal budget deficit, Congress enacted legislation to require monthly payments, after adjustment for increases in the cost of living, to be rounded down to the nearest whole dollar amount. Finding this a convenient way to meet budget reconciliation targets and fund spending for other purposes, Congress seemingly has become unable to break the habit of extending this round-down provision and has extended it even in the face of budget surpluses. Inexplicably, VA recommends year after year that Congress make the round-down requirement a permanent part of the law. While rounding down compensation rates for 1 or 2 years may not seriously degrade its effectiveness, the cumulative effect over several years will substantially erode the value of compensation. Moreover, extended (and certainly permanent) rounding down is entirely unjustified. It robs monies from the benefits of some of our most deserving veterans and dependents, who must rely on their modest compensation for the necessities of life.

Recommendation:

Congress should reject Administration recommendations to permanently extend provisions for rounding down compensation COLAs and allow the temporary round-down provisions to expire on their statutory sunset date.

Standard for Service-Connection:

Service-connected benefits should be provided for all disabilities incurred or aggravated in the line of duty.

The core veterans' benefits are those provided to make up for the effects of "service-connected" disabilities and deaths. When disability or death results from an injury or disease incurred or aggravated in the "line of duty," the disability or death is service-connected for purposes of entitlement to these benefits for veterans and their eligible dependents and survivors. A disability or death from injury or disease is in the line of duty if incurred or aggravated "during" active military, naval, or air service, unless due to misconduct or other disqualifying circumstances. Accordingly, a disability or death from an injury or disease that occurs or increases during service meets the current requirements of law for service-connection.

These principles are expressly and clearly set forth in current law. Under the law, the term "service-connected" means, with respect to disability or death, "that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in the line of duty in the active military, naval, or air service." The term "active military, naval, or air service" contemplates, principally, "active duty," although duty for training qualifies when a disability is incurred during such period. The term "active duty" means "full-time" duty in the Armed Forces.

A member on active duty in the Armed Forces is at the disposal of military authority and, in effect, on duty 24 hours a day, 7 days a week. Under many circumstances, such member may be directly engaged in performing tasks involved in his or her military vocation for far more extended periods than a typical 8-hour civilian workday and may be on call or standing by for the remainder of the hours in a day. Under other typical circumstances, a servicemember may live

on or near the workstation 24 hours a day, such as duty on submarine, ship, or remote outpost. Even when a military member is not actively or directly engaged in performing functions of his or her military occupation, the member is indirectly on duty or involved in general military duties and ongoing responsibilities. In the military service, there is no distinction between on duty and off duty for purposes of legal status, and there is often no clear practical demarcation between being on and being off duty. Moreover, in the overall military environment, there are rigors, physical and mental stresses, and known and unknown risks and hazards unlike and far beyond those seen in civilian occupations and daily life. Military members stationed in foreign countries are often exposed to increased risks of injury and disease, both on and off military facilities.

For these reasons, current law requires only that an injury or disease be incurred or aggravated "coincident with" military service; there is no requirement that the veteran prove a causal connection between military service and a disability for which service-connected status is sought. For these same reasons, a requirement to prove service causation would be unworkable as long as it is the purpose of the law to equitably dispose of questions of service-connection and provide benefits when benefits are rightfully due those who lay their health and lives on the line to bear the extraordinary burdens of defending our national interests. Of course, if it were to become the object of our Government to limit as much as possible its responsibility for veterans' disabilities rather than to have a fair and practical legal framework for justice, requiring proof of service causation would accomplish that object quite effectively by making it impossible to prove many meritorious claims.

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service-connection would not generally be in order unless a veteran could prove that a disability was caused by actually performing military duties per se. Although this scheme was not enacted into law, the defense authorization bill did provide for the establishment of a commission to study the foundations of disability benefit programs for veterans, presumably with the same ultimate goal in mind. This action is consistent with current systematic efforts to reduce spending on military personnel and veterans to devote more resources to military hardware and the other costs of war.

It is self-evident that current standards governing service-connected status for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations (IBVSOs) urge Congress to reject any revision of this standard for the purpose of permitting the Government to coldly and expediently avoid its responsibilities for the human costs of war and national defense.

Recommendation:

Congress should reject any suggestion to change the terms for service-connection of disabilities and deaths.

Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and VA disability compensation concurrently.

Some former servicemembers who are retired from the Armed Forces on the basis of length of service must forfeit a portion of the retired pay they earned through faithful performance of military service to receive compensation for service-connected disabilities. This is inequitable because military retired pay is earned by virtue of a veteran's long service on behalf of the Country.

Entitlement to compensation, on the other hand, is for an entirely separate reason—because of service-related disability. Many nondisabled military retirees pursue second careers after service to supplement their income, thereby justly enjoying the full reward for completion of a military career along with the added reward of full pay for the civilian employment. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential. Their earning potential is reduced commensurate with the degree of service-connected disability. To put them on equal footing with nondisabled retirees, they should receive full military retired pay and compensation to substitute for diminution of earning capacity.

To the extent that military retired pay and disability compensation now offset each other, the disabled retiree is treated less fairly than the nondisabled military retiree. Although the offset is being phased out for veterans 50% or more disabled, this is especially inequitable where the military retiree is totally precluded from employment by service-connected disability and is still adversely affected during the 10-year phase-out period.

Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after his or her enlistment expires can receive full compensation and full civilian retired pay. A veteran who has served this country for 20 years or more should have that same right. The veteran should not be penalized for choosing the military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Compensation should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of compensation the veteran receives, our Government is in effect paying the veteran nothing for the service-connected disability he or she suffers. The IBVSOs urge Congress to correct this serious inequity.

Recommendation:

Congress should enact legislation to totally repeal the inequitable requirement that veterans' military retired pay based on longevity be offset by an amount equal to their VA disability compensation.

Continuation of Monthly Payments for all Compensable Service-Connected Disabilities:

Lump-sum settlements of disability compensation should not be used as a way to decrease the Government's obligation to disabled veterans and save the Government money.

Under current law, the Government pays disability compensation monthly to eligible veterans on account of and at a rate commensurate with diminished earning capacity resulting form the effects of service-connected diseases and injuries. By design, compensation continues to provide relief from the service-connected disability for as long as the veteran continues to suffer its effects at a compensable level. By law, the level of disability determines the rate of compensation, thereby requiring reevaluation of the disability upon change in its degree. Lump-sum payments have been recommended as a way for the Government to avoid the administrative costs of reevaluating service-connected disabilities and as a way to avoid future liabilities to service-connected disabled veterans when their disabilities worsen or cause secondary disabilities. Under such a scheme, VA would use the immediate availability of a lump-sum settlement to entice veterans to bargain away their future entitlement. Such lump-sum payments would not, on the whole, be in the best interests of disabled veterans, but rather would be for Government savings and convenience. The IBVSOs strongly oppose any change in law to provide for lump-sum payments of compensation.

Recommendation:

Congress should reject any recommendation that it change the law to permit VA to discharge its future obligation to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

Recovery of Taxes on Disability Benefits:

To permit veterans to recover taxes improperly withheld, Congress should enact an exception to the 3-year limitation on amendment of tax returns.

Section 104(4) of title 26 United States Code (U.S.C.) exempts from taxable income "allowance for personal injuries or sickness resulting from active service in the armed forces." Similarly, 38 U.S.C. § 5301(a) provides that benefits due or to become due under any law administered by VA "shall be exempt from taxation." In *St. Clair v. United States*, 778 F. Supp. 894 (E.D. Va. 1991), the district court affirmed that the law excludes disability severance pay from taxable income.

The Internal Revenue Service (IRS) acquiesced in the district court's ruling, and veterans may amend their tax returns to recover amounts illegally taxed. Nonetheless, taxes are still being withheld from disability severance pay, and veterans must claim a refund or file an amended return to recover these taxes. However, the 3-year statute of limitations on amending tax returns prevents veterans whose improper taxation occurred more than 3 years before the court's decision or their learning of this unlawful taxation from recovering amounts the IRS unlawfully withheld.

Additionally, where entitlement to disability compensation is established retroactively but not paid because the veteran received military retired pay during the period, the portion of the taxable retired pay that VA would have paid as nontaxable disability compensation but for the delayed award becomes nontaxable. The veteran may file an amended return to recover the excess taxes paid. Again, the 3-year limitation bars recovery of taxes for periods beyond that time.

Therefore, because of Government error, disability severance pay was improperly taxed, and this may have occurred more than 3 years previously. Additionally, retroactive compensation entitlement for more than 3 years would occur only where awards were delayed because of error reversed on appeal. In both instances, circumstances beyond the veteran's control may prevent timely amendment of tax returns. An exception to the 3-year limitation is fully justified to correct this inequity. Indeed, the IBVSOs maintain that taxes should not be withheld from disability severance pay and that necessary changes should be made to the law to discontinue this unnecessarily burdensome practice. The IBVSOs urge Congress to enact legislation to remedy this problem.

Recommendation:

Congress should amend the law to provide for an exception to the 3-year limitation on amendment of tax returns in the case of erroneous taxation of disability severance pay or in the case of retroactive exemption of more than 3 years and should change the law to discontinue the withholding of taxes from disability severance pay.

Exclusion of Compensation as Countable Income for Federal Programs:

Disability compensation should not be counted as income for purposes of eligibility for assisted housing through the Department of Housing and Urban Development and other means-tested Federal programs.

Current policy at the Department of Housing and Urban Development (HUD) considers nontaxable service-connected disability compensation provided by VA to be countable income when determining a veteran's eligibility for HUD's Assisted Senior Housing Program. In some cases, particularly when income is limited to Social Security and VA disability compensation, our aging veterans are being denied access to this program because their VA compensation places them above an established income threshold. This compassionate program must be available to those veterans who have severely limited incomes. The principle that disability compensation should not be counted as income should extend to all Federal programs.

Recommendation:

Congress should enact legislation to exempt VA disability compensation from countable income for purposes eligibility for federally funded programs.

Service-Connection for Smoking-Related Disabilities:

Congress should reverse its action that took money from veterans' disability compensation to pay for over-budget spending on transportation programs.

In 1998, Congress changed the law to prohibit service-connection for disabilities related to smoking. Under the pretext of making an appropriate change in law for genuine public policy purposes, Congress enacted, in a transportation bill, a provision concocted to generate savings from the veterans' disability compensation program to pay for over-budget spending on politically popular transportation programs. This unprecedented raid on veterans' programs for the ignoble purpose of paying the cost of massive pork-barrel spending was a shameful injustice against veterans. At a cost of $217 billion, this transportation bill contained nearly 1,500 pork projects and exceeded by $26 billion the spending caps set in the balanced budget bill of the year before.

Compensation for smoking-related disabilities provided a convenient target for those with the motive of finding money to satisfy their appetite for big spending. The target was convenient because it was easy to get similarly inclined members to subscribe to the superficial arguments that veterans should not be compensated for disabilities that result from their personal choice to use an injurious product. It was made an attractive target for those who coveted the money for their own use by exaggeration of the costs of smoking-related compensation for the calculated purpose of artificially increasing the amount of spoils it would yield to those who would capture it as their prize. As a result, they obtained $15.5 billion to pay for increased spending of massive proportions on transportation programs.

It is easy to subscribe to the notion that veterans should not be compensated for illnesses that result from their personal choice to smoke cigarettes. However, the argument that this is merely a matter of personal choice or responsibility is more than a deceptive oversimplification: It is a misrepresentation. The question of whether these are disabilities that should be compensated cannot be answered so simply. Indeed, when the question is considered in the depth required to arrive at a fair, judicious conclusion, the injustice of the prohibition against service-connection is easily seen.

Cigarettes have been one of our country's major mass-marketed products since the 1920s. Citizens across all socioeconomic levels have used tobacco for pleasure or have been enticed by its glamorization and romanticization in books, motion pictures, advertising, and in our society in general. Only recently has there been a serious shift in public attitude about smoking and serious proposals to regulate tobacco for public health reasons.

Smoking has traditionally been even more prevalent among members of our Armed Forces. The DOD has been perhaps our Nation's largest distributor of cigarettes. The DOD has long been in the business of discounting tobacco products and subsidizing smoking among servicemembers. In past years, many of the images of soldiers included cigarettes dangling from their mouths. Cigarettes were an integral part of military life. Survey data compiled in connection with a study for VA showed that more than 70% of veterans, as compared to about 50% of the U.S. adult population, had a history of smoking. Findings from that study indicate that a significant proportion of veterans started smoking while on active duty. The higher incidence of smoking among veterans can be explained by a military environment and culture that encouraged and facilitated smoking.

Smoking was much more of a social activity in the military setting than it was in civilian life. Part of that was due to the inherent nature of the military environment, and part was due to the military's own use of tobacco as a small and relatively inexpensive but effective way to help servicemembers cope with that difficult environment.

During rigorous training and combat operations, smoking often provided the only opportunity for a brief distraction or escape from the stresses or drudgery of the moment. Smoking provided the only coping tool immediately accessible. Drill instructors and others in control of military units used smoking as the activity for occupying servicemembers during breaks. Servicemembers looked forward to those breaks as their only respite and pause from combat and the rigors of military training and duties. Smoking was also an ever-present part of

the restricted social activities available to servicemembers in isolated military settings.

Perhaps it was for these reasons that the military establishment became a partner with the tobacco companies in distributing cigarettes and promoting tobacco use among members of the military services. It is well established that the Armed Forces, under various legal authorities, provided rations of tobacco to servicemembers. Free cigarettes were provided to them during combat tours. Free cigarettes were included in C-rations, and, as noted, cigarettes were provided at substantially discounted prices in military exchanges. Thus, we can accurately state that smoking was not only fully approved of by the Armed Services, it was encouraged and facilitated by the military on a level probably unparalleled anywhere else in our society.

Like the recent groundswell of anti-tobacco sentiments, the Government's opposition to tobacco-related benefits for veterans is of recent advent and, within VA, represents an abrupt—and convenient—reversal of policy. Given the Government's complicity in tobacco use among veterans, VA's self-righteous hypocrisy and the Government's ulterior motive for enacting this legislation become all the more reprehensible.

Under the law, service-connection is awarded for any disability incident to service. Disabilities due to willful misconduct are an exception to that rule, however. "Willful misconduct" is "an act involving conscious wrongdoing or known prohibited action." It means a deliberate or intentional act with "knowledge of or wanton and reckless disregard" of its probable consequences. Tobacco use has never been a prohibited action. On the contrary, as noted previously, tobacco use was fully authorized and approved by the military. VA has held expressly that tobacco use is not willful misconduct. In 1964, Administrator's Decision No. 988 pointed out that smoking is not deemed willful misconduct by VA. The Omnibus Reconciliation Act of 1990 amended sections 105(a), 1110, and 1131 of title 38, United States Code, to include "abuse of alcohol or drugs" as disabilities for which service-connection is barred. However, smoking did not fall within the definition of drug abuse for VA purposes. In that application, "drug abuse" means use of illegal drugs, use of illegally or illicitly obtained prescription drugs, intentional use of prescription or nonprescription drugs for purposes other than their medically intended use, and use of substances to enjoy their intoxicating effects.

It would be the height of hypocrisy for Congress or VA to declare smoking misconduct when VA provided free tobacco to hospitalized veterans under authority of a statute enacted by Congress, a law that has not been repealed. To do so would suggest the Government abetted misconduct.

Congress's action to prohibit service-connection for smoking-related illnesses was inequitable and inconsistent with the Government's position on who is responsible for the adverse health effects of smoking. During decades of litigation, the cigarette manufacturers paid not even a single dollar in damages for the injurious effects of smoking. They successfully invoked the defense that smokers were personally responsible for the consequences of smoking because they "assumed the risk" by knowingly using a potentially harmful product. Those suing the tobacco companies persisted, nonetheless, and that defense is no longer recognized as viable because it has come to light that the tobacco companies concealed from consumers much about the injurious and addictive effects of tobacco use.

It is on the premise that the cigarette manufacturers, and not smokers, are responsible for the effects of smoking that the state governments and the Federal Government are recouping from the tobacco industry billions of dollars for costs of tobacco-related health care provided to government beneficiaries. Yet the Clinton Administration disingenuously invoked the very defense the Government rejected as an excuse for depriving veterans of compensation. Congress, seeing that this was the way to fund its own pork-barrel spending, seized upon the President's proposal.

While the Government's position in the litigation against tobacco companies rested on the premise that these consumers could not themselves be held responsible for their own tobacco use inasmuch as they were not undertaking a potentially harmful activity with full knowledge of its risks and probable consequences, the President's proposal to prohibit compensation for veterans rested on a contrary premise. The contrary premise was that veterans were somehow in a position of knowledge and understanding superior to that of all other consumers and thereby voluntarily exposed themselves to a known danger of which they appreciated the nature and

extent and thus must be held personally responsible and not entitled to compensation.

There was no proposal to prohibit other Government benefits on this basis. For example, disability and health-care benefits continue under other Federal programs even though smoking may have played a role in causing the illness and disability.

Accordingly, considering that smoking was encouraged by the Armed Forces with the result of a higher incidence of smoking among veterans, considering that veterans were no more aware of the inherent risks of smoking than the general public, and considering that no other Federal programs prohibit disability or medical benefits for conditions related to smoking, no rational basis exists for holding veterans to a different standard and singling them out for disparate and punitive treatment.

In its quest to get veterans' benefits to fund increased spending on transportation, Congress paid little attention to the merits of a prohibition against service-connection. The manner in which the provision was enacted demonstrates that it was the money and not the merits that provided the momentum behind this legislation.

Certainly it is arguable that anyone entering military service today should be deemed to have full knowledge of the risks of smoking. We would not oppose a prohibition of service-connection for disabilities shown by clear and convincing evidence to have been caused by smoking alone if the law applied to persons who enter military service on or after the date of enactment of the law. The current prohibition should be repealed, however.

Recommendation:

Congress should repeal its prohibition on service-connection for smoking-related disabilities.

Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

VA's disability rating schedule should provide a minimum 10% disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable evaluation for hearing loss at certain levels severe enough to require hearing aids. The minimum rating for any hearing loss warranting use of hearing aids should be 10%, however.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial restoration of hearing, hearing aids negatively affect the wearer's physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of disability compensation that ratings are not offset by the function artificially restored by prosthesis. For example, a veteran receives full compensation for amputation of a lower extremity though he or she may ambulate with a prosthetic limb. Providing a compensable rating would be consistent with minimum ratings provided elsewhere when a disability does not meet the rating formula requirements but requires continuous medication.

Recommendation:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10% disability evaluation for any hearing loss for which a hearing aid is medically indicated.

Temporary Total Compensation Awards:

Temporary awards of total disability compensation should be exempted from delayed payment dates.

An inequity exists in current law controlling the beginning date for payment of increased compensation based on periods of incapacity due to hospitalization or convalescence.

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating. This rating is effective the first day of hospitalization and continues to the last day of the month of hospital discharge. Similarly, where surgery for a service-connected disability necessitates at least 1 month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary total rating is awarded effective the date of hospital admission or outpatient visit.

While the effective date of the temporary total disability rating corresponds to the beginning date of hospitalization or treatment, under 38 U.S.C. § 5111 the effective date for payment purposes is delayed until the first day of the month following the effective date of the increased rating.

This provision deprives veterans of any increase in compensation to offset the total disability during the first month in which temporary total disability occurs. This deprivation and consequent delay in the payment of increased compensation often jeopardizes disabled veterans' financial security and unfairly causes them hardships.

Therefore, the IBVSOs urge Congress to enact legislation exempting these temporary total ratings, under 38 C.F.R. §§ 4.29, 4.30, from the provisions of 38 U.S.C. § 5111.

Recommendation:

Congress should amend the law to authorize increased compensation on the basis of a temporary total rating for hospitalization or convalescence to be effective, for payment purposes, on the date of admission to the hospital or the date of treatment, surgery, or other circumstances necessitating convalescence.

READJUSTMENT BENEFITS
Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

Servicemembers who in every respect are at least equally entitled to participate in the Montgomery GI Bill as servicemembers who first entered military service after June 30, 1985, are ineligible if they entered or had military service before that date.

Under current law, an active duty servicemember must have first become a member of the Armed Forces after June 30, 1985, to be eligible to participate in the Montgomery GI Bill. An active duty servicemember who entered the Armed Forces before that date and continues to serve cannot participate—unless he or she was enrolled in the prior educational assistance program and elected to convert to the Montgomery GI Bill. In this situation, servicemembers who have served longer and are arguably more deserving of educational benefits are treated less favorably than members who have served in the Armed Forces for shorter periods.

Any person who was serving in the Armed Forces on June 30, 1985, or any person who reentered service in the Armed Forces on or after that date, if otherwise eligible, should be allowed to participate in the Montgomery GI Bill under the same conditions as members who first entered military service after that date.

Recommendation:

Congress should amend the law to remove the restriction on eligibility to the Montgomery GI Bill to those who first entered military service after June 30, 1985.

Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

The Government should refund the contributions of individuals who become ineligible for the Montgomery GI Bill because of general discharges or discharges "under honorable conditions."

The Montgomery GI Bill–Active Duty program provides educational assistance to veterans who first entered active duty (including full-time National Guard duty) after June 30, 1985. To be eligible, servicemembers must have elected to participate in the program and made monthly contributions from their military pay. These contributions are not refundable.

Eligibility is also subject to an honorable discharge. Discharges characterized as "under honorable conditions" or "general" do not qualify. The IBVSOs believe that in the case of a discharge that involves a minor infraction or deficiency in the performance of duty the individual should at least be entitled to a refund of his or her contributions to the program.

Recommendation:

Congress should change the law to permit refund of an individual's Montgomery GI Bill contributions when his or her discharge was characterized as "general" or "under honorable conditions" because of minor infractions or inefficiency.

Housing Grants

Increase in Amount of Grants and Automatic Annual Adjustments for Inflation:

Housing grants and home adaptation grants for seriously disabled veterans need to be adjusted automatically each year to keep pace with the rise in the cost of living.

VA provides specially adapted housing grants of up to $50,000 to veterans with service-connected disabilities consisting of certain combinations of loss or loss of use of extremities and blindness or other organic diseases or injuries. Veterans with service-connected blindness alone, or with loss or loss of use of both upper extremities, may receive a home adaptation grant of up to $10,000.

Increases in housing and home adaptation grants have been infrequent, although real estate and construction costs rise continually. Unless the amounts of the grants are periodically adjusted, inflation erodes the value and effectiveness of these benefits, which are payable to a select few but among the most seriously disabled service-connected veterans. Congress should increase the grants this year and amend the law to provide for automatic adjustment annually.

Recommendation:

Congress should increase the specially adapted housing grants and provide for future automatic annual adjustments indexed to the rise in the cost-of-living.

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Grant for Adaptation of Second Home:

Grants should be available for special adaptations to homes that veterans purchase or build to replace initial specially adapted homes.

Like those of other families today, veterans' housing needs tend to change with time and new circumstances. An initial home may become too small when the family grows or become too large when children leave home. Changes in the nature of a veteran's disability may necessitate a home configured differently and changes in the special adaptations. These things merit a second grant to cover the costs of adaptations to a new home.

Recommendation:

Congress should establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.

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Adequate Fees for Compliance Inspectors:

The current limitation on fees for compliance inspectors makes it difficult to obtain the services of qualified inspectors in some instances.

VA assumes the responsibility to ensure that specially adapted housing is properly constructed in compliance with the construction contract and according to the needs of the disabled veteran. To ensure that specially adapted housing conforms to the pertinent specifications and standards, VA uses contract inspectors. Currently, VA pays a maximum of $65 for compliance inspections. This amount is not sufficient to allow for geographic differentials and the variety of technical backgrounds of inspectors to ensure that competent inspections are performed.

Recommendation:

Congress should amend chapter 21 of title 38, United States Code, to authorize payment of reasonable fees, including travel reimbursements, for compliance inspections on housing being constructed or adapted under the specially adapted housing program.

Automobile Grants and Adaptive Equipment

Increase in Amount of Grant and Automatic Annual Adjustments for Increased Costs:

The automobile and adaptive equipment grants need to be increased and automatically adjusted annually to cover increases in costs.

VA provides certain severely disabled veterans and servicemembers grants for the purchase of automobiles or other conveyances. This grant also provides for adaptive equipment necessary for safe operation of these vehicles. Veterans suffering from service-connected ankylosis of one or both knees or hips are eligible for only the adaptive equipment. This program also authorizes replacement or repair of adaptive equipment.

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. With subsequent cost-of-living increases in the grant, Congress sought to provide 85% of the average cost of a new automobile, and later 80%. Until the 2001 increase to $9,000, the amount of the grant had not been adjusted since 1988, when it was set at $5,500.

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85% of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles was $21,750, according the National Automobile Dealers Association. The 1997 average cost of an automobile was 1,155% of the 1946 cost, but the automobile allowance of $5,500 was only 343% of the 1946 award. Currently, the $11,000 automobile allowance represents only about 42% of the average cost of a new automobile, which is $26,163. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80% of the average new vehicle cost, would be $20,930.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the

nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80% of the average cost of a new automobile in 2003. To avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

Recommendation:

Congress should increase the automobile allowance to 80% of the average cost of a new automobile and provide for automatic annual adjustments in the future.

Home Loans

Increase in Amount of VA Guaranty:

Average housing costs in some areas have risen to amounts that make the maximum VA guaranty insufficient to allow veterans to purchase homes with VA-guaranteed mortgages.

To make home ownership easier for eligible veterans and others, the VA home loan guaranty program creates conditions in which private lenders extend credit under more favorable terms than would generally be extended in the commercial mortgage market. By guaranty of repayment, the VA protects lenders against loss. This VA obligation to ensure repayment allows lenders to make loans without borrower down payments and other safeguards that would generally be necessary under conventional lending practices. However, when the maximum amount of the VA guaranty does not keep pace with rising home costs, veterans who must rely on VA guaranties are frozen out of the home market or are limited in their ability to acquire suitable homes.

The maximum amount of the VA guaranty effectively limits the maximum loan that can be made without a down payment. When the total guaranty does not at least equal what the lender would require as a down payment on a loan not guaranteed (e.g., 25% of the total loan), the lender will not provide a VA-guaranteed loan unless the borrower can make up the difference with a down payment. With the current maximum guaranty of $60,000, and the general requirement that 25% of the loan be covered by the guaranty, persons wishing to purchase homes with VA-guaranteed mortgages are in effect limited to homes costing a maximum of $240,000.

Until 1999, the VA loan limit was always significantly higher than the Federal Housing Administration (FHA) home loan limit. Since 1999, when FHA loans were indexed to the Federal National Mortgage Association ("Fannie Mae") and Federal Home Loan Mortgage Corporation ("Freddie Mac") conforming mortgage loan limit—which is adjusted annually to reflect increases in housing costs—FHA loan ceilings have risen substantially higher than the maximum loans for veterans. The FHA limit is 87% of the conforming loan limit. Starting January 1, 2004, the new Fannie Mae–Freddie Mac single-family loan limit will increase from $322,700 to $333,700, and the FHA limit will therefore increase to $290,319.

Home loans for veterans should be more generous than those available to other citizens under the FHA. The IBVSOs recommend that the VA home loan guaranty be set to allow maximum loans at 90% of the Fannie Mae–Freddie Mac conforming loan limit, with automatic annual indexing to the conforming limit. For 2004 the amount of the maximum VA loan under

that formula would be $300,330, which would require an increase in the maximum VA guaranty to $75,082.50. The IBVSOs recommend that the maximum VA guaranty be increased to $75,085 for 2004.

Recommendation:

To keep pace with the rising costs of housing, Congress should increase the maximum VA home loan guaranty to $75,085 for 2004 and provide for automatic annual indexing to 90% of the Fannie Mae–Freddie Mac loan ceiling thereafter.

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No Increase in, and Eventual Repeal of, Funding Fees:

Funding fees are contrary to the principles underlying our benefit programs for veterans, and increased funding fees are negating the benefits and advantages of VA home loans.

Congress initially imposed funding fees upon VA guaranteed home loans under budget reconciliation provisions as a temporary deficit reduction measure. Now, loan fees are a regular feature of all VA home loans except those exempted. During its first session, the 108th Congress increased these loan fees. The purpose of the increases was to generate additional revenues to cover the costs of improvements and cost-of-living adjustments in other veterans' programs. In effect, this legislation requires one group of veterans (and especially our young active duty military), those subject to loan fees, to pay for the benefits of another group of veterans, those benefiting from the programs improved or adjusted for increases in the cost of living.

First and foremost, it is the position of *The Independent Budget* that veterans' benefits, provided to veterans by a grateful nation in return for their contributions and sacrifices through service in the Armed Forces, should be entirely free. In addition, *The Independent Budget* finds it entirely indefensible that Congress can only make improvements or adjustments in veterans' programs for inflation by shifting the costs onto the backs of other veterans. The Government, not veterans, should bear the costs of veterans' benefits. With these increased funding fees, the advantages of VA home loans for veterans are being negated. These fees are increasing the burdens upon veterans purchasing homes while the intent of VA's home loan program is to lessen the burdens.

Recommendation:

Congress should refrain from further increasing home loan funding fees and should, as soon as feasible, repeal these fees entirely.

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INSURANCE

Government Life Insurance

Value of Policies Excluded from Consideration as Income or Assets:

For purposes of other Government programs, the cash value of veterans' life insurance policies should not be considered assets, and dividends and proceeds should not be considered income.

For nursing home care under Medicaid, the Government forces veterans to surrender their Government life insurance polices and apply the amount received from the surrender for cash value toward nursing home care as a condition for Medicaid coverage of the related expenses of needy veterans. It is unconscionable to require veterans to surrender their life insurance to receive nursing home care. Similarly, dividends and proceeds from veterans' life insurance should be exempt from countable income for purposes of other Government programs.

Recommendation:

Congress should enact legislation to exempt the cash value of, and dividends and proceeds from, VA life insurance policies from consideration in determining entitlement under other Federal programs.

Service-Disabled Veterans' Insurance (SDVI)

Lower Premium Schedule to Reflect Improved Life Expectancy:

VA should be authorized to charge lower premiums for SDVI policies based on improved life expectancy under current mortality tables.

Because of service-connected disabilities, disabled veterans have difficulty getting, or are charged higher premiums for, life insurance on the commercial market. VA therefore offers disabled veterans life insurance at standard rates under the SDVI program. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. However, VA continues to base its rates on mortality tables from 1941. Consequently, SDVI premiums are no longer competitive with commercial insurance and therefore no longer provide the intended benefit for eligible veterans.

Recommendation:

Congress should enact legislation to authorize VA to revise its premium schedule for SDVI to reflect current mortality tables.

Increase in Maximum SDVI Coverage:

The current $10,000 maximum for life insurance under SDVI does not provide adequately for the needs of survivors.

When life insurance for veterans had its beginnings in the War Risk Insurance program, first made available to members of the Armed Forces in October 1917, coverage was limited to $10,000. At that time, the law authorized an annual salary of $5,000 for the Director of the Bureau of War Risk Insurance. Obviously, the average annual wages of servicemembers in 1917 was considerably less than $5,000. A $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917.

Today, some 87 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage well over three quarters of a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

In the May 2001 report from an SDVI program evaluation conducted for VA, it was recommended that basic SDVI coverage be increased to $50,000 maximum. The IBVSOs therefore recommend that the maximum protection available under SDVI be increased to at least $50,000.

Recommendation:

Congress should enact legislation to increase the maximum protection under base SDVI policies to at least $50,000.

Veterans' Mortgage Life Insurance (VMLI)

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under VMLI needs to be increased.

The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

Recommendation:

Congress should increase the maximum coverage under VMLI from $90,000 to $150,000.

OTHER SUGGESTED BENEFIT IMPROVEMENTS

Protection of Veterans' Benefits Against Claims of Third Parties

Restoration of Exemption from Court-Ordered Awards to Former Spouses:

Through interpretation of the law to suit their own ends, the courts have nullified plain statutory provisions protecting veterans' benefits against claims of former spouses in divorce actions.

Congress has enacted laws to ensure veterans' benefits serve their intended purposes by prohibiting their diversion to third parties. To shield these benefits from the clutch of others who might try to obtain them by a wide variety of devices or legal processes, Congress fashioned broad and sweeping statutory language. Pursuant to 38 U.S.C. § 5301(a), "[p]ayments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever, either before or after receipt by the beneficiary."

Thus, while as a general rule an individual's income and assets should rightfully be subject to legal claims of others, the special purposes and special status of veterans' benefits trump the rights of all others except liabilities to the United States Government. Veterans cannot voluntarily or involuntarily alienate their rights to veterans' benefits. The justification for this principle in public policy is one that can never obsolesce with the passage of time or changes in societal circumstances.

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless.

Various courts have shown no hesitation to force disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans' laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

We should never lose sight of the fact that it is the veteran who, in addition to a loss in earning power, suffers the pain, limitations in the routine activities of daily life, and the other social and lifestyle constraints that result from disability. The needs and well-being of the veteran should always be the primary, foremost, and overriding concern when considering claims against a veteran's disability compensation. Disability compensation is a personal entitlement of the veteran, without whom there could never be any secondary entitlement to compensation by dependent family members. Therefore Federal law should place strict limits on access to veterans' benefits by third parties to ensure compensation goes mainly to support veterans disabled in the service of their Country. Congress should enact legislation to override judicial interpretation and leave no doubt about the exempt status of veterans' benefits.

Recommendation:

Congress should amend 38 U.S.C. § 5301(a) to make its exemption of veterans' benefits from the claims of others applicable "notwithstanding any other provision of law" and to clarify that veterans' benefits shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever "for any purpose."

General Operating Expenses

The Department of Veterans Affairs (VA) administers veterans' benefit programs through its central office in Washington, DC, and a nationwide system of regional and benefit offices. Responsibility for the various benefit programs is divided among five different services within the Veterans Benefits Administration (VBA): Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. Under the direction and control of the Under Secretary for Benefits and various deputies, the program directors set policy and oversee their programs from VA's Central Office. The field offices receive benefit applications, determine entitlement, and authorize benefit payments and awards.

The Office of the Secretary of Veterans Affairs and the assistant secretaries provide departmental management and administrative support. These offices along with the Office of General Counsel and the Board of Veterans' Appeals are the major activities under the General Administration portion of the General Operating Expenses (GOE) appropriation. The GOE appropriation funds the benefits delivery system—VBA and its constituent line, staff, and support functions—and the functions under General Administration.

The IBSVOs make the following recommendations for improving VA performance and service to veterans.

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

VBA Management

Line Authority over Field Offices:

VA program directors should have line authority over benefits' administration in the field offices.

The Veterans Benefits Administration (VBA) has introduced several new initiatives to improve its claims processes. Besides fundamental reorganization of claims processing methods to achieve increased efficiencies, the initiatives include several measures to improve quality in claims decisions. Among these measures are better quality assurance and accountability for technically correct decisions.

VBA's current management structure presents a serious obstacle to enforcement of accountability, however, because program directors lack line authority over those who make claims decisions. Of VBA management, program directors have the most hands-on experience with, and intimate knowledge of, their benefit lines and have the most direct involvement in day-to-day monitoring of field office compliance. Program directors are therefore in the best position to enforce quality standards and program policies within their respective benefit programs. While higher level VBA managers are properly positioned to direct operational aspects of field offices, they are indirectly involved in the substantive elements of the benefit programs. To enforce accountability for technical accuracy and to ensure uniformity in claims decisions, program directors logically should have authority over the decision-making process and should be able to order remedial measures when variances are identified.

In its August 1997 report to Congress, the National Academy of Public Administration (NAPA) attributed much of VBA's problems to unclear lines of accountability. NAPA found that a sense of powerlessness to take action permeates the VBA. In turn, field personnel perceived VBA's Central Office staff as incapable of taking firm action. NAPA said that a number of executives interviewed by its study team indicated VBA executives have difficulty giving each other bad news or disciplining one another. NAPA concluded that until the VBA is willing to deal with this conflict and modify its decentralized management style it will not be able to effectively analyze the variations in performance and operations existing among its regional offices. Neither will it be able to achieve a more uniform level of performance. Regarding Compensation and Pension Service (C&P) especially, NAPA concluded that the C&P director's lack of influence or authority over its field office employees would greatly hamper any efforts to implement reforms and real accountability. NAPA recommended that the Under Secretary for Benefits strengthen C&P influence over field operations and close the gaps in accountability.

Recommendation:

To make the management structure in the VBA more effective for purposes of enforcing program standards and accountability for quality, VA's Under Secretary for Benefits should give VBA's program directors line authority over VA field office directors.

Departmental Policy for Veterans' Programs

Improvements in Rulemaking:

Today's Department of Veterans Affairs is misusing its rulemaking authority for self-serving purposes and to orchestrate an insidious erosion of veterans' rights.

From America's beginnings, our citizens recognized that our Nation's very existence and future depended on a strong army and navy. They appreciated the fundamental necessity and exceptional value of military service. On the principle that those who devote part of their youth and risk their lives and health to defend their Country deserve special treatment and advantages over those who do not, our people have, through Congress, accorded veterans special honors and provided for generous benefits. Consistent with our indebtedness to veterans and our deep appreciation for their contributions and sacrifices, our citizens have charged VA with providing veterans seeking benefits with the highest level of personal service and assistance in obtaining those benefits. Every effort is to be made to help veterans apply for, and establish entitlement to, the benefits they claim; within the law, VA must endeavor to grant them the benefits they seek. For VA to create procedural impediments or substantive rules to limit veterans' rights offends the very essence and spirit of benefits for veterans and is antithetical to the intent of our grateful nation as expressed in the laws of Congress.

Congress has repeatedly stated its intent that the ultimate goal of VA's unique process is to ensure veterans receive every benefit to which they are entitled. That goal overrides agency convenience and expedience, and toward that end, the VA system must afford veterans advantages not afforded to claimants in other agencies. When enacting legislation to improve the process, Congress has frequently sought to preempt any misinterpretation of its intent that would formalize or make VA claims procedures burdensome for veterans. On these occasions, Congress has gone to great lengths to emphasize and reaffirm its intent to preserve the "pro-claimant bias," informality, and helpful nature of the process. Congress expressly stated it intends that no changes be made to the existing system except to further the goals, informality, accuracy, and fairness.

The Federal Courts have reaffirmed on many occasions the principle that laws governing veterans' benefits are to be liberally construed in favor of veterans. It is a well-settled rule of statutory construction that ambiguities in such statutes are to be resolved in favor of veterans.

Historically, VA's regulations were drafted to reflect these benevolent goals and the special treatment and considerations to be accorded veterans seeking benefits. For example, a longstanding VA regulation begins with this declaration: "It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation." 38 C.F.R § 3.102 (2003). In another regulation, the essence of VA policy is articulated with this statement: "Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government." 38 C.F.R. § 3.103 (2003).

Regrettably, with its decisions immune to judicial review and VA operating in what has been described as a state of "splendid isolation" for most of the 20th century, VA adjudicators often ignored the liberal provisions of VA regulations. With the advent of judicial review, the courts began enforcing the letter and spirit of the law and these regulations. In reaction, VA began to construe the statutes as narrowly as possible to limit veterans' entitlements, and it began to rewrite its rules in ways designed to diminish veterans' rights, to make the process more burdensome and formal, and to serve for VA's own advantage, convenience, and purposes rather than to serve the interests of veterans.

Although VA's Special Regulations Rewrite Task Force has initially shown signs of adhering to VA's pro-veteran mission in its rewrite of part 3 of title 38 C.F.R.—and we hope the final product will reveal good intentions—generally, when VA writes new regulations, they no longer have the traditional pro-veteran tone. They often have a negative, restrictive focus. They appear calculated to give VA the upper hand against claimants and to impair veterans' due process

rights or access to an open claims process and benefits. Today's VA regulations are too often self-serving: They are designed for VA expedience and to incorporate VA's resistance to liberalizing legislation. Sometimes, their apparent aim is to inhibit what VA cannot prohibit. VA exploits opportunities to reinterpret statutory provisions to remove from its longstanding regulations provisions that are favorable to veterans. With aloofness, VA pays little real attention to public comments and offers flimsy rationales for brushing them aside. VA's justifications in response to public comments sometimes suggest pretext and are tenuous, specious, shallow, or as arbitrary as the text of the rules themselves. VA vigorously defends narrow or restrictive judicial interpretations of its regulations that are adverse to veterans but actively seeks to overturn judicial constructions that are more favorable to veterans than VA desires.

Outraged veterans' organizations have begun to challenge more frequently VA's regulations, but, consistent with courts' tendency to indulge Federal agencies, the results have been mixed, despite special canons of statutory construction intended to favor veterans. While veterans' organizations have had some successes in getting the most objectionable regulations invalidated, the courts have sometimes strained to defer to VA rules, and veterans' organizations have sometimes not prevailed even in exceptionally meritorious challenges. As one court noted, this practice of judicial deference "all too often is taken to mean simply that administrative agencies win any dispute involving statutory construction." ***Mid-America Care Foundation v. National Labor Relations Board***, 148 F.3d 638, 642 (6th Cir. 1998). VA's awareness of these circumstances appears to embolden it in its arbitrary rulemaking.

In matters of veterans' rights, this type of agency behavior must not be tolerated. If the Secretary of Veterans Affairs is unwilling to rein in those who write his regulations and if the courts continue to permit such behavior, Congress should act to impose special constraints and requirements upon VA's rulemaking to ensure VA carries out the will of the people to treat veterans as a special class; to ensure that VA does not deal with veterans grudgingly, indifferently, or at arm's length as if they were ordinary litigants or claimants for Federal benefits; and certainly to ensure that VA does not treat veterans like adversaries.

As has often been observed, veterans have unique needs, the nation has an extraordinary obligation to meet those needs, and the VA system is therefore a unique system with an extraordinary mission. The procedures, rules, and remedies of other forums or agencies are frequently improperly suited or inadequate for the administration of veterans' programs. In view of the hardening of VA's regulations and its departure from the benevolent role assigned to it by Congress, specially tailored laws may become necessary to bring VA's rulemaking back in line with its unique mission as the nation's patron and benefactor for veterans.

Recommendations:

The Secretary of Veterans Affairs should act decisively to put an end to VA's self-serving rulemaking; if the Secretary does not, Congress should

(1) scrutinize VA's rulemaking more closely as part of its oversight role,

(2) intervene to override VA rules that run counter to Congressional intent, and

(3) enact special provisions to control VA rulemaking if the Secretary of Veterans Affairs fails to bring VA's rulemaking back in line with Congressional intent and VA's benevolent mission.

Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To reduce the error rate and to avoid unacceptably large case backlogs and protracted processing times in veterans' compensation and pension claims, the Veterans Benefits Administration (VBA) must address the root causes of its quality problems.

The inability of the VBA to process and decide veterans' compensation and pension (C&P) claims accurately and timely is widely recognized as one of the most serious and persisting problems affecting VA and veterans. This problem has seriously degraded VA's ability to fulfill its mission of assistance to veterans and its corresponding responsibilities to them under the law. It has prevented disabled veterans from receiving, within a reasonable time, the compensation or pension they often urgently need to relieve the economic effects of disability. Although this problem plagued VA for several years, VA's various initiatives and plans have failed to solve the problem. Rather, while the number of C&P claims decreased substantially over the past decade, the claims backlog continued to grow larger because production declined and because high error rates necessitated rework of large numbers of cases, thereby adding to the workload of an already overburdened system.

The historical dynamics of this intolerable situation include flawed policies. In a climate of immunity from outside review over several decades, a culture and mind-set developed within VA whereby adjudicators began making decisions based on their own personal beliefs, attitudes, and predilections. Unwritten rules evolved, and arbitrary practices became ingrained. The decisions were based more on these unwritten rules and practices than the law. As a result, angry veterans demanded, and eventually received, the right to have judicial review of VA decisions.

The courts found fundamental departure from the law in numerous areas. For a while VA attempted to resist the precedents of courts. Then VA found that its adjudicators were poorly equipped to interpret and apply case law. Other factors, such as budget reductions and inadequate resources, intervened to compound the predicament. Rather than address the problems directly, VA management went through a period of denial and blamed its problems on judicial review.

The claims backlog grew. VA management began to press for increased production. VA further compromised quality for quantity. Alarming claims backlogs, and consequent pressure from Congress and the veterans community, eventually forced VA to devote more meaningful attention to this serious problem. By that time, poor quality pervaded the claims processing system and the backlog was enormous. VA's own internal study revealed poor quality as the major cause of its inefficiency, but the poor quality was rooted in other factors, such as inadequate training and resources. Poor quality was a precipitating cause of the backlog and then, with the focus on production, also became an effect of the backlog.

To break this vicious cycle, VA needed a technically sound strategy and effective implementation. In its business process reengineering (BPR) plan, it had a well-designed and technically sound strategy to address the root causes, but VA management failed to take the decisive action necessary to implement the plan. In addition, while the BPR plan correctly identified the root causes in process and set out appropriate remedies, it did not address the paramount need to change the negative institutional culture and strengthen management within VA. These flaws seriously hindered progress in implementing the plan's reforms. Today, VA still struggles with the same enormous problem.

Studies by various panels, commissions, and other bodies have failed to produce effective solutions because they have either recommended reducing veterans' rights and benefits to reduce VA's workload and thus accommodate its inefficiency or they have lost focus and strayed away from the root causes to various incidental and contributing factors. Reducing veterans' rights and benefits to allow VA to remain inefficient is indefensible, and any viable and effective solution will necessarily require that VA first address the root causes.

In its October 2001 report, the VA Claims Processing Task Force made beneficial recommendations, but implementation of these recommendations has not resulted in the kind of systemwide and sustained improvements necessary to overcome the problem. Although VA has gained ground in reducing its large backlog of pending claims for disability benefits, these gains appear more the result of targeting of resources and stop-gap measures than systematic improvements in quality and accountability for accuracy. Indeed, in 2001, despite large numbers of inexperienced adjudicators and complex new procedural requirements in the Veterans Claims Assistance Act of 2000, which would be expected to both slow claims dispositions and result in increased errors, VA shifted its emphasis to increased production to meet goals of reducing the claims backlog. Under this emphasis on production, VA regional office directors became accountable for production targets; some were required to develop plans to increase production but not quality; and performance awards were based primarily on production. VA awarded bonuses for production to some regional offices that had not met VA accuracy standards. Quality again took a back seat to quantity. During fiscal year 2002, VA increased its number of claims decisions by two-thirds. Thus, there were three factors that each would be expected to have a negative effect on accuracy: increased production with a corresponding lack of emphasis on quality, inexperienced staff, and new complex procedural requirements. Together, these three factors could be expected to have a compounding effect. According to the United States General Accounting Office (GAO) in its September 2003 report, *Veterans' Benefits: Improvements Needed in the Reporting and Use of Data on the Accuracy of Disability Claims Decisions*, GAO-03-1045, VA's accuracy in compensation and pension claims decisions declined from 89% to 81% during fiscal years 2001 to 2002. The GAO also found that VA has not made the best use of the accuracy data it collects to evaluate regional office performance, to correct errors, to identify needed training, and to hold regional offices accountable for accuracy.

At the end of fiscal year 2003, VA had reduced its pending caseload to 253,000 claims, coming close to meeting its goal of reducing pending disability claims to 250,000. VA reported that it had increased its monthly claims decisions by more than 70% above its 2001 level, despite an inexperienced workforce and increased procedural burdens on VA. VA also surprisingly reported that its accuracy improved to 85% in fiscal year 2003. With its continued net decline in accuracy over the past 3 years, the number of claims needing additional work to correct errors is likely to rise. Accordingly, while the unmanageable claims backlog would appear on the surface to have been largely overcome for the present, the true amount of claims work awaiting VA may be greater than indicated by the inventory of currently pending claims. The backlog of pending claims may very well again begin to quickly grow, repeating the familiar vicious cycle in which poor quality necessitates rework and results in increased workloads, increased backlogs, decline in timeliness, and greater pressure to increase production at the expense of quality. Gains on the claims backlog through increased production at the expense of quality are merely cosmetic and temporary. The only way to break this vicious cycle is quality first. This requires management discipline and dogged persistence in improving quality even if timeliness and VA's pending claims statistics suffer in the short term. VA must focus primarily on the root cause of this problem to overcome it.

Clearly, VA's adjudicators make erroneous decisions because they are poorly trained in the law, they operate in a culture of indifference to the law, and they are not accountable for their poor proficiency and performance. 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 accountable. With its primary focus on these fundamental defects, VA should intensify its efforts to make other essential process improvements, such as better disability examinations and data exchange between the VBA and its health-care facilities. With well-informed, well-reasoned claims decisions will come fairness and efficiency. Stable reductions in claims backlogs and consistent timeliness will eventually follow.

Recommendations:

To improve quality in VA claims decisions and stabilize the inventory of pending claims to avoid the return of an enormous claims backlog and consequent long delays in the delivery of compensation and pension benefits, VA must address the root causes of the problem by:

1) improving the substance, implementation, and measurement of the effectiveness of its training for compensation and pension adjudicators;

(2) taking decisive and immediate steps to change its negative institutional culture to instill in its decisionmakers and line management more positive attitudes and fidelity to the law; and

(3) imposing from top to bottom real accountability for proficiency and a quality product.

In addition to these root causes of inefficiency, VA must address other substantial contributing problems, such as the inadequacy of VA disability examinations and its technology for information exchange between the VBA and its medical facilities.

Sufficient Staffing Levels:

To process and decide additional claims not anticipated and not considered in previous plans to reduce staffing, VA must maintain its staffing in FY 2005 at FY 2003 levels.

VA had projected that its workload would allow it to draw down its full-time employees (FTE) in FY 2005 by approximately 268 below its staffing of 7,757 FTE at the end of FY 2003. However, those projections did not take into account an additional 391,000 claims and an additional 52,869 appellate case load over the next 5 years, which VA now expects incident to legislation expanding eligibility for combat-related special compensation. Neither did it take into account workload incident to authorizing concurrent receipt of military retired pay and disability compensation for veterans with service-connected disabilities rated 50% or higher in degree. In addition, VA projects that it will have to rework approximately 48,000 claims to meet the requirements of the decision of the Court of Appeals for the Federal Circuit in *PVA v. Secretary of Veterans Affairs*. While most of that work will be done during FY 2004, it will likely delay work of some of C&P's inventory and carry some extra caseload over into FY 2005. This additional workload requires that VA maintain its staffing levels of 7,757 FTE for C&P Service in FY 2005.

Recommendation:

Congress should authorize 7,757 FTE for C&P service in FY 2005.

Improved Claims Processing with Information Technology:

To meet its workload demands, VA must develop integrated systems to electronically transfer veterans' medical records from their source to the claims processing database and to aid adjudicators in evaluating that evidence according to the pertinent law and regulations.

To meet its workload demands, VA must take full advantage of automated information systems. These systems can facilitate case management, claims processing, and decision making in ways that increase accuracy and efficiency. To determine and implement its optimum performance in record development, disability examinations, and claims disposition, VA is undertaking a review of its claims process with the goal of developing an integrated electronic format to aid in uniform and correct application of procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims database. Known as the C&P Evaluation Redesign (CAPER) initiative, this project is being undertaken by a CAPER team, working with outside experts.

VA began work on this initiative in 2001 with a goal of nationwide deployment by April 2005. VA now hopes to have this system fully in place by September 2006. To achieve that goal, VA needs approximately $3.5 million in FY 2005 to continue development of this system.

Recommendation:

Congress should provide $3.5 million to fund VA's Compensation and Pension Evaluation Redesign initiative.

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Improved Claims Processing with Electronic Files:

To improve its business processes through reliance on more efficient modern information technology, VA needs to acquire, store, and process claims data in electronic files.

VA is moving toward more modern and efficient methods of compensation and pension claims processing by replacing its paper-based claims system with electronic imaging. VA's project, known as "Virtual VA," has been deployed at VA's pension maintenance centers and is undergoing evaluation and assessment based on experience at these three sites. With eventual full implementation, all VBA regional offices will have document-imaging capabilities, and VA medical centers will have electronic access to veterans' claims folders for review in connection with disability examinations. VA expects better timeliness and accuracy in claims decisions once the system is fully deployed.

To continue document preparation and scanning at the pension maintenance centers and development of the system for use nationwide, VA needs $8 million in FY 2005.

Recommendation:

Congress should provide $8 million to support continuing use of VA's Virtual VA electronic file system at its pension maintenance centers and to continue developing the system for eventual installation in all VBA regional offices.

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Education Service

Adequate Staffing:

To sustain services at current levels and meet added workload demands consequent to liberalizations in education programs, the Education Service needs to retain its FY 2003 staffing.

As it is with its other benefit programs, VA is striving to provide more timely and efficient service to its claimants for education benefits. The Education Service has made gains in these areas during FY 2003. To continue on that course and to meet the added workload demands expected from recent expansion of training to qualify for educational benefits, VA must at least maintain its FY 2003 direct program staffing of 708 FTE (excludes information technology and management and support FTE) in its Education Service.

Recommendation:

Congress should authorize 708 direct program FTE for VA's Education Service.

Vocational Rehabilitation and Employment

Adequate Staffing Levels:

To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's VR&E Task Team, VR&E needs to increase its staffing.

At the end of FY 2003, VR&E had 931 direct program FTE (excludes information technology and management and support FTE). To sustain current levels of performance with its projected workload, VR&E needs to maintain that level of staffing. In addition, the Secretary's VR&E Task Team has made a number of recommendations to improve vocational rehabilitation and employment services for veterans. It is projected that approximately 200 additional FTE will be needed to implement these substantial reforms in the VR&E program, its organization, and its work processes.

Recommendation:

Congress should authorize 1,131 direct program FTE for the Vocational Rehabilitation and Employment Service for FY 2005.

GENERAL ADMINISTRATION
Board of Veterans' Appeals

Amendment of 38 C.F.R. § 19.5:

VA has declined to amend 38 C.F.R. § 19.5 to remove its erroneous provision that the BVA is not bound by VA manuals, circulars, and other VA directives.

In a 1995 study titled *Veterans Benefits: Effective Interaction Needed Within VA to Address Appeals Backlog*, the GAO cited as a factor contributing to the backlog of appeals the lack of uniformity between the BVA and VA's field offices in the interpretation and application of the law. The GAO noted that while both are bound by the same laws and regulations, they issue independent policy and procedural guidance and sometimes interpret legal requirements differently. Observing that "hundreds of individuals within these organizations interpret and apply laws, regulations, and guidance in adjudicating claims," the GAO said: "This legal and organizational structure makes consistent interpretation of VA's responsibilities essential to fair and efficient adjudication but difficult to achieve." The GAO noted that although "at least four studies have made recommendations" that VA coordinate its decision making to avoid these types of problems, "we found evidence that existing mechanisms do not always identify or are slow to resolve" such problems with adjudication. Assessing the effect of the lack of uniformity in interpretation and application of the law, the GAO said: "These types of differences not only contribute to inefficient adjudication, but also inhibit VA's ability to clearly define its responsibilities and the resources necessary to carry them out."

Despite good reason to do so, VA has inexplicably declined to correct § 19.5, which erroneously provides: "The Board is not bound by Department manuals, circulars, or administrative issues." Section 19.5 thus provides that the BVA will not operate under the same rules as VA field offices and therefore subjects claims decisions to different interpretations and applications of law. This provision is contrary to statute and a well-established line of case law, which holds that VA, like other Government agencies, is bound by its own internal procedures and rules.

In 38 U.S.C. § 501, Congress delegated to the Secretary the authority to prescribe rules and regulations, and issue "guidelines, or other published interpretation[s] or order[s]" on the nature, extent, and methods of submission of proof; application forms; methods of medical examinations; and manner and form of adjudication and awards. VA manuals are official Department instructions, which are binding on adjudicators under 38 C.F.R. § 3.100 and under provisions of the manuals themselves. Many of VA's actions, such as claims decisions and other official acts, are performed by the Secretary's subordinates and do not carry the Secretary's personal signature. They are nonetheless the Secretary's acts for purposes of law. Under 38 U.S.C. § 512, Congress authorized the Secretary to subdelegate the authority it delegated to him. Under that section, the Secretary may assign functions and duties to officers and employees, and "all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Secretary." The issuance of manuals as binding instructions must be an authorized and proper act and must be deemed instructions of the Secretary. Otherwise, they would not be legal and valid. Under 38 U.S.C. § 7104(c), the Board "shall be bound in its decisions by the regulations of the Department, instructions of the Secretary, and the precedent opinions of the chief legal officer of the Department."

Another point makes it clear that the BVA is bound by law to follow VA manuals and circulars. Regulations and instructions of the Secretary have the force and effect of law. Because VA field offices are clearly bound by VA manuals and circulars, the failure of a field office adjudicator to follow them would constitute an error in law. Under 38 U.S.C. § 7104(a), the BVA is charged with, and legally obligated to, correct errors in law. When the BVA refuses to follow, enforce, or apply a manual provision to correct its omission by a field office, it commits legal error. This has required veterans to appeal to the Court of Appeals for Veterans Claims to obtain enforcement of rules in manuals in some cases.

VA's refusal to amend § 19.5 to require the BVA to follow and enforce VA manuals and other departmental instructions is indefensible.

Recommendation:

VA should amend 38 C.F.R. § 19.5 to remove its unlawful provision exempting the BVA from VA manuals, circulars, and other Department directives, and absent timely action by VA, Congress should intervene to ensure this counterproductive problem is corrected.

Judicial Review in Veterans' Benefits

Although the Department of Veterans Affairs (VA) has the sole authority to adjudicate claims for veterans' benefits, VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established what is now the United States Court of Appeals for Veterans Claims (CAVC or the court) to review appeals from VA's Board of Veterans' Appeals (BVA), it added another beneficial element to appellate review. It created oversight of VA decision making by an independent, impartial tribunal from a different branch of Government.

For the most part, judicial review of the claims decisions of VA has lived up to positive expectations of its proponents. To some extent it has also brought about some of the adverse consequences foreseen by its opponents. Based on past recommendations in *The Independent Budget*, Congress made some important adjustments to correct some of the unintended effects of the judicial review process. In its initial decisions construing these changes, the CAVC has not given the effect intended by Congress to ensure that veterans have meaningful judicial review in all aspects of their appeals. More precise adjustments are still needed to conform CAVC review to Congressional intent.

In addition, most of VA's rulemaking is subject to judicial review. Here again, changes are needed to bring the positive effects of judicial review to all of VA's rulemaking.

Accordingly, *The Independent Budget* veterans service organizations make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

To achieve its intent that the court enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court's scope of review.

The Court upholds VA's factual findings unless they are clearly erroneous. Clearly erroneous is the standard for appellate Court reversal of a district court's findings. When there is a "plausible basis" for a factual finding, it is not clearly erroneous under the case law from other courts, which the CAVC has applied to BVA findings.

Under the statutory "benefit-of-the-doubt" standard, the BVA is required to find in the veteran's favor when the veteran's evidence is at least of equal weight as that against him or her, or stated differently, when there is not a preponderance of the evidence against the veteran. Yet, the court has been affirming any BVA finding of fact when the record contains the minimal evidence necessary to show a plausible basis for such finding. This rendered the statutory benefit-of-the-doubt rule meaningless because veterans' claims can be denied and the denial upheld when supported by far less than a preponderance of evidence against the veteran.

To correct this situation, Congress amended the law to expressly require the CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. With this statutory requirement, the CAVC can no longer properly uphold a BVA finding of fact solely because it has a plausible basis inasmuch as that would clearly contradict the requirement that the CAVC's decision must take into account whether the factual finding adheres to the benefit-of-the-doubt rule. The court can no longer end its inquiry after merely searching for and finding a plausible basis for a factual determination. Congress intended for the CAVC to afford a meaningful review of both factual and legal determinations presented in an appeal before the court. Congress also amended the law to specify that the CAVC should, as a general rule, reverse erroneous factual findings rather than set them aside and allow the BVA to decide the question anew on remand.

While Congress chose not to replace the clearly erroneous standard of review, it did foreclose the application of this standard in ways inconsistent with the benefit-of-the-doubt rule. Also, Congress made it clear that the CAVC is not to routinely remand cases for new BVA fact-finding when the findings of fact before the court did not have sufficient support in the record and the current record supports a conclusion opposite of that reached by the BVA. However, the CAVC has construed these amendments, intended to require a more searching appellate review of BVA fact-finding and to enforce the benefit-of-the-doubt rule, as making no substantive change. The court's precedent decisions now make it clear that it will continue to defer to and uphold BVA fact-finding without regard to whether it is consistent with the statutory benefit-of-the-doubt rule as long as the court's scope of review retains the clearly erroneous standard. To ensure the CAVC enforces the benefit-of-the doubt rule, Congress should replace the clearly erroneous standard with a requirement that the court will reverse a factual finding adverse to a claimant when it determines such finding is not reasonably supported by a preponderance of the evidence.

Recommendation:

Congress should amend section 7261 of title 38 United States Code to provide that the court will hold unlawful and set aside any finding of material fact that is not reasonably supported by a preponderance of the evidence.

Preservation of Informalities of VA Claims Process

"Exhaustion" Requirement Has No Place in Veterans Benefits Claims:

By refusing to consider points not specifically argued to BVA, the CAVC has, contrary to Congressional intent and the law, imposed formal pleading requirements upon VA's informal administrative claims process.

When Congress authorized judicial review of veterans' claims, one of its foremost concerns and intents was preservation of the informality of VA's administrative claims process under conditions in which the BVA's decisions would be subject to review by a court. Congress was very much aware of the dangers that the courts might attempt to impose their own formal rules of adversarial proceedings upon VA's informal claims process and therefore sought to prevent this adverse consequence. By imposing an exhaustion requirement upon veterans, the CAVC has, for its own expedience, largely ignored Congressional intent, the law, and the unique nature and purposes of veterans' programs by doing the very thing Congress so carefully and clearly acted to forestall.

In its broader sense, the purpose of the doctrine of exhaustion of administrative remedies is to prevent parties from bypassing the available administrative processes to take their claims directly to the courts. It has been recognized that the exhaustion doctrine has four primary goals:

(1) discourage flouting of the administrative processes created by Congress;

(2) allow the administrative agency to apply its expertise, to exercise its discretion, and to correct its own errors;

(3) aid judicial review by allowing the parties and the agency to develop the facts of the case in the administrative proceeding; and

(4) promote judicial economy by avoiding needless duplication of actions and perhaps by avoiding the necessity for any judicial involvement.

Clearly, the law does not allow a veteran to bypass the BVA and appeal an agency of original jurisdiction decision directly to the CAVC. As provided in 38 U.S.C. § 7261, under an appeal properly before it, the court "shall," "to the extent necessary to its decision and when presented," "decide all relevant questions of law, interpret constitutional, statutory, and regulatory provisions, and determine the meaning or applicability of the terms of an action by the Secretary"; "hold unlawful and set aside decisions, findings...conclusions, rules, and regulations issued or adopted by the Secretary, the Board of Veterans' Appeals, or the Chairman of the Board." Contrary to this statutory provision, the CAVC refuses to address "all" relevant questions of law, etc., "presented" to it unless the veteran expressly raised and argued these points to the BVA. In requiring that the veteran have first raised a precise legal point or argument to the BVA, the court is not only violating § 7261, it is ignoring Congressional intent and improperly shifting VA's obligations under the law to veterans.

Unlike judicial or more formal administrative proceedings where it is the responsibility of the parties to raise and plead all legal arguments and discover and present all material evidence, veterans are not expected to know and plead the legal technicalities of veterans' benefits. Veterans file simple claims forms with basic information, not detailed legal pleadings. Congress repeatedly stated its intent to preserve and maintain this informal process throughout the legislative history of its legislation to authorize judicial review. It is VA's legal obligation to assist the veteran in filing the claim and developing the evidence and to consider all relevant legal authorities and potential bases of entitlement regardless of whether they are expressly raised by the veteran. When a veteran appeals to the BVA and receives an unfavorable decision, the veteran has exhausted his or her administrative remedies. Any failure to fully develop the record, to fully explore all avenues of entitlement, or to apply all pertinent law is an error of omission by the BVA that the CAVC should address in its appellate review, irrespective of whether the veteran knew of or raised the specific point before the BVA. Yet, for its own purposes, the CAVC refuses to consider points of argument that were not specifically raised before the BVA. By requiring veterans to know and expressly raise and argue all the complex legal points relevant to a claim, the CAVC shifts the Government's obligations to veterans, imposes unnecessary formalities upon VA's administra-

tive claims process, and fundamentally alters the nonadversarial, pro-veteran nature of VA proceedings. The court seems unable or unwilling to grasp the simple fact that in considering veterans' appeals it reviews a claims record, not a litigation record.

Congressional intervention is necessary to restore veterans' basic rights under the VA claims process. Congress should amend 38 U.S.C. § 7261. The phrase "without regard to any theory of issue preclusion or exhaustion" should be added between the words "presented," and "shall" at the end of section (a). This change would not disfavor VA because the CAVC provides the agency an opportunity to respond to any legal argument presented by a claimant before it rules.

Recommendation:

Congress should amend 38 U.S.C. § 7261 to preclude judicial imposition of formal pleading requirements upon the VA claims process.

Court Facilities

Courthouse and Adjunct Offices:

The court should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 15 years since the court was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA General Counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The court should have its own home, located in a dignified setting with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States.

Construction of a courthouse and justice center requires an appropriate site, authorizing legislation, and funding.

Recommendation:

Congress should enact legislation and provide the funding necessary to construct a courthouse and justice center for the CAVC.

COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to VA Schedule for Rating Disabilities:

The exemption of VA changes to the rating schedule from judicial review leaves no remedy for arbitrary and capricious rating criteria.

Under 38 U.S.C. § 502, the Federal Circuit may directly review challenges to VA's rulemaking. Section 502 exempts from judicial review actions relating to the adoption or revision of the VA *Schedule for Rating Disabilities*, however.

Formulation of criteria for evaluating reductions in earning capacity from various injuries and diseases requires expertise not generally available in Congress. Similarly, unlike other matters of law, this is an area outside the expertise of the courts. Unfortunately, without any constraints or oversight whatsoever, VA is free to promulgate rules for rating disabilities that do not have as their basis reduction in earning capacity. The coauthors of *The Independent Budget* have become alarmed by the arbitrary nature of recent proposals to adopt or revise criteria for evaluating disabilities. If it so desired, VA could issue a rule that a totally paralyzed veteran, for example, would only be compensated as 10% disabled. VA should not be empowered to issue rules that are clearly arbitrary and capricious. Therefore, the Court of Appeals for the Federal Circuit (CAFC) should have jurisdiction to review and set aside VA changes or additions to the rating schedule when they are shown to be arbitrary and capricious or clearly violate basic statutory provisions.

Recommendation:

Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

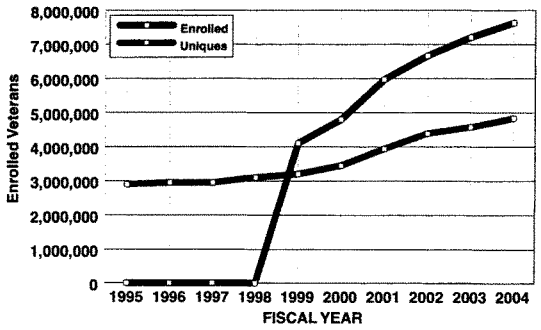
Medical Care

Medical Programs

As the largest direct provider of health-care services in the Nation, the Veterans Health Administration (VHA) provides the most extensive training environment for health professionals and the Nation's most clinically focused setting for medical and prosthetics research. The VHA is the Nation's primary backup to the Department of Defense in time of war or domestic emergency.

Of the 7.2 million enrolled veterans in fiscal year 2003, the VHA provided health care to more than 4.5 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any system in the United States or worldwide. The Institute of Medicine has cited the VHA as the Nation's leader in tracking and minimizing medical errors. The VHA was a recipient of the 2002 Pinnacle Award, in recognition by the American Pharmaceutical Association Foundation for its leading-edge technology in bar coding of pharmaceuticals, thereby dramatically reducing errors.

CHART 1. UNIQUE VHA PATIENTS & ENROLLED VETERANS



Even though the Secretary of Veterans Affairs placed a moratorium on the enrollment of priority 8 veterans during FY 2003, chart 1 shows the trend toward increasing numbers of patients treated in VHA facilities and the dramatic increase of veterans enrolled for care. ***NOTE:*** *Figures for FY 2004 are projections based on VHA data.*

Although the VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health-care systems, it is the most efficient and cost-effective health-care system in the nation. The VHA sets the standards for quality and efficiency, and it does so at or below Medicare rates, while serving a population of veterans that is older, sicker, and has a higher prevalence of mental and behavioral health problems.

Year after year the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past year, the IBVSOs are concerned about the methodology used in producing statistics reflecting this reduction in the backlog. As stated above, the Secretary placed a moratorium on the enrollment of priority 8 veterans in FY 2003. Additionally, the IBVSOs are receiving reports that VA hospital directors are no longer advertising VA services to veterans and in many cases openly discourage veterans from enrolling.

The annual shortfall in the VA Medical Care budget translates directly into higher national health-care expenditures. When veterans cannot get needed health-care services from VA, they go elsewhere, and the cost of care is shifted to Medicare or the safety net hospitals. In any case, society pays more while the veteran suffers. A method to ensure VA receives adequate funding annually to continue providing timely, quality health care to all enrolled veterans must be put in place.

During the 5-year period between 1996 and 2000, the VA Medical Care appropriation was virtually flatlined with an overall net increase over the 5 years of slightly more than 2%.

During the 4-year period between 2000 and 2003, the number of veterans enrolled and served by VA has increased significantly. However, the VA-appropriated budget has not kept pace. The number of enrolled veterans in the VA system increased approximately 50% over the 4-year period with the number of unique veterans increasing about 33%. Although the VA-appropriated medical care budget has increased approximately 24%, the buying power over the 4-year period has increased only 7%.

As U.S. military involvement in Iraq and Afghanistan continue, the number of veterans eligible for VA health care will continue to escalate. As of December 2003, more than 9,700 new veterans due to injuries received in Iraq or Afghanistan were being treated by VA. As of January 2004 there are almost one-quarter million Reserve and National Guard members on active duty. Within the year, all of these Reserve and National Guard members will be eligible for veteran status having served more than 180 days on active duty. At the very least, they will be eligible for VA benefits during the 2-year window following release from active duty. This is in addition to the many new regular veterans that will be rotating out of regular active duty ranks, currently staffed at approximately 1.5 million.

VA is the second biggest financial supporter of education for medical professionals, after Medicare, and the Nation's most extensive training environment for health professionals. As academic medical centers are under increasing financial pressures to reduce health-care professional training, VA has mitigated this gap by maintaining existing programs that train for VA and the Nation. VA has academic affiliations with 107 medical schools, 55 dental schools, and more than 1,200 other schools across the country. Each year, more than 81,000 health professionals are trained in VA medical centers. In addition to their value in developing the Nation's health-care workforce, the affiliations bring first-rate health-care providers to the service of America's veterans. The opportunity to teach attracts the best practitioners from academic medicine and brings state-of-the-art medical science to VA. Veterans get excellent care, society gets doctors and nurses, and the taxpayer pays a fraction of the market value for the expertise the academic affiliates bring to VA.

Programs initiated at VA have led to the development of new medical specialties, such as geriatrics, which focuses on care of the elderly. VA-based training, along with psychiatry, pain management, and spinal cord injury medicine, are addressing the needs of the Nation as well as the needs of our veterans. VA is developing new programs using teams of health-care providers that provide specialized services to veterans, such as palliative care teams that provide care to patients at the end of life. VA trains health-care professionals in the total care of the patient because VA health care provides total care to eligible veterans.

The largest integrated medical care system in the world has a unique capability to translate progress in medical science to improvements in clinical care and the health of the population. VA research is clinically focused: 80% of VA researchers see patients. The patient focus keeps VA research relevant and provides the incentive to translate research findings into evidence-based medical practice. More effectively than any other Federal research funding sector, the VHA provides a mechanism for the clinical application of research findings.

VA leverages the taxpayers' investment via a nationwide array of synergistic partnerships with the National Institutes of Health, other Federal research funding entities, the for-profit sector, and academic affiliates. This extraordinarily productive enterprise demonstrates the best in public-private cooperation.

VA medical and prosthetic research is a national asset that is a magnet for attracting high-caliber clinicians to practice medicine in VA health-care facilities. The resulting atmosphere of medical excellence and ingenuity, developed in conjunction with collaborating medical schools and universities, benefits every veteran receiving care at VA and ultimately benefits all Americans.

MEDICAL CARE ACCOUNT

The VA medical care account supports VHA medical facilities, including hospitals, nursing homes, outpatient clinics, and VA-financed contract and state home care. *The Independent Budget (IB)* recommends a "current services" budget of $28.2 billion for VA medical care in FY 2005. The FY 2005 *Independent Budget* current services recommendation is based on the FY 2004 *Independent Budget* recommended appropriation with commonly accepted assumptions about staffing and inflation. With increased staffing and services recommended by the *IB,* the IBVSOs recommend that Congress fund the Medical Care Account at the level of $29.8 billion for FY 2005.

Recommended FY 2005 Independent Budget Medical Care Account Initiatives:

	MILLIONS
Funding the Fourth Mission	$383.0
Increased workload, including priority 8	$400.0
Fully meet prosthetics needs for all veterans	$160.7
Fully fund long-term care	$600.0

MEDICAL CARE ISSUES
Financing Issues

Mandatory Health-Care Funding for VA Health Care

Congress should make funding for VA health-care mandatory to ensure service-connected disabled veterans, and all other enrolled veterans, have timely access to VA health care.

The Independent Budget Veterans Service Organizations (IBVSOs) are especially concerned about maintaining a stable and viable health-care system to meet the unique medical needs of our Nation's sick and disabled veterans. The effectiveness of all veterans' programs, including VA health-care services, is dependent upon sufficient funding for available benefits, services, and resources adequate to allow for their timely delivery.

We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. Yet veterans' health care remains a discretionary program, and each year funding levels must be determined through an annual appropriations bill. This creates an inherent conflict between open enrollment and constrained resources—a problem neither Congress nor the Administration has been willing to resolve. Year after year, the IBVSOs have fought for sufficient funding for VA health care and a budget that is reflective of the rising cost of health-care and increasing need for medical services. Despite our continued efforts, the cumulative effects of insufficient health-care funding have now resulted in the rationing of medical care. We believe mandatory funding for VA health care is a reasonable long-term solution to VA's funding crisis.

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). The task force was charged to identify ways to improve health-care delivery to VA and Department of Defense (DOD) beneficiaries. Most important to the IBVSOs is the PTF's recognition of a "growing dilemma" concerning VA health care. The PTF noted in its *Final Report*, "...it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care." As a solution to this complex problem, the PTF recommended the Government provide full funding for VA health care for priority groups 1–7 by using a mandatory funding mechanism, or by some other changes in the process that would achieve the desired goal of ensuring enrolled veterans are provided the current comprehensive benefits package, in accordance with VA's established access standards. The PTF also suggested the Government address the present uncertain access status and funding of priority group 8 veterans.

The PTF's final report noted that the discretionary appropriations process has been a major contributor to the historic mismatch between available funding and demand for health-care services. We agree that to improve timely access to health care for our nation's sick and disabled veterans, the Federal budget and appropriations process must be modified to ensure full funding for the veterans' health-care system. The long-term solution must factor in how much it will cost to care for each veteran enrolled in the system and guarantee that the full amount determined will be available to VA to meet that need. Including priority group 8 veterans under a guaranteed funding mechanism is essential to ensuring viability of the system for its core users, preserving VA's specialized programs, and maintaining cost effectiveness.

Even though over the past two budget cycles Congress has increased discretionary appropriations for veterans' health care, the funding levels have simply not kept pace with inflation or the significant increase in demand for services. Additionally, VA began the last two budget cycles without having the benefit of an enacted increased spending level. Although VA requested an increase for veterans' health care for fiscal year 2003, it fell far short of what VA's Under Secretary for Health testified would be necessary—a 13%–14% increase—just to maintain current services. We believe VA has an obligation to provide veterans timely top quality health care and that Congress has an obligation to ensure that VA is provided sufficient funding to carry out that mission. We agree that the real problem, as the PTF aptly states in its report, is that "the Federal government has been more ambitious in authorizing veteran access to health care than it has been in providing the funding necessary to match declared intentions."

During the 108th Congress, mandatory funding bills have been introduced in both chambers. The Assured Funding for Veterans Health Care Act of 2003 has been introduced in the House of Representatives as H.R. 2318 by House Veterans' Affairs Committee Ranking Member Lane Evans (D-IL) and in the Senate as S. 50 by Senator Tim Johnson (D-SD). This mandatory health-care funding measure aims to guarantee adequate annual funding for health care for all sick and disabled veterans eligible to receive medical care from the VA. If veterans' health care were a mandatory program, sufficient funding to treat all veterans who fell under its mandatory provisions would be guaranteed for as long as the authorizing law remained in effect. Veterans would not have to fight for sufficient funding in the budget process every year as they now do.

Making veterans' health-care funding mandatory would also eliminate the year-to-year uncertainty about funding levels that have prevented VA from being able to adequately plan for and meet the constantly growing number of veterans seeking treatment. For several months in fiscal year 2004, VA had to operate under a continuing resolution funded at the fiscal year 2003 level. This further complicates VA's budget problems and prevents VA from being able to provide the health-care services veterans need. Mandatory funding would prevent the adverse consequences resulting from such action when an appropriations bill is not enacted. It is disingenuous for our Government to promise health care to veterans, especially service-connected disabled veterans and then make it unattainable because of inadequate funding. Rationed health care is no way to honor America's obligation to the brave men and women who have so honorably served our Nation and who continue to carry the physical and mental scars of that service.

Mandatory health-care funding would not create an individual entitlement to health care nor change VA's current mission. We do not propose to change the existing eligibility criteria for priority groups 1–8 or the medical benefits package defined in current regulations, only the way the funds are provided for VA health care. Having a sufficient number of veterans in the health-care system is critical to maintaining the viability of the system and sustaining it. By including all veterans currently eligible and enrolled for care, we protect the system and the specialized programs VA has developed to improve the health and well-being of our Nation's sick and disabled veterans.

Providing timely quality health-care services for veterans disabled as a result of military service should be a top priority for this Congress, this Administration, and the American people. In a time when more veterans are turning to VA for care, it is unconscionable that VA is forced to reduce services, close enrollment, and severely ration care due to insufficient funding. But the discretionary appropriations process continues to unfairly subject disabled veterans to the annual funding competition for limited discretionary resources. Now is the perfect opportunity for this Administration and Congress to move forward on the recommendations of the PTF, charged with improving health-care delivery for our Nation's veterans, and to support solutions that will permanently resolve this untenable situation.

A young American wounded in Afghanistan, Iraq, or in the war on terror today will still need the VA health-care system in the year 2060. He or she will still need VA disability compensation and other benefits. Congress and the Administration have an obligation to ensure that these veterans have access to a stable, thriving health-care system, dedicated to their needs, now and in the future. Equally important is Congress's support for those who have previously served this Nation. Too many elderly veterans who have sacrificed their health, their limbs, and mental well-being on our Nation's behalf are being told they must wait—in some cases years—for care. Something must be done now to ensure VA is guaranteed sufficient resources to deliver the specialized high-quality health care to those who need it most.

The IBVSOs believe mandatory funding for VA health care provides a comprehensive solution to the current funding problem. This would ensure the viability of the veterans' health-care system and meet the needs of current and future users of the system. Therefore, it is imperative that funding for the veterans' health-care system be made mandatory to ensure access to and timely delivery of high-quality health services for veterans.

Recommendation:

Congress should make funding for VA health care mandatory so that all enrolled veterans have access to high-quality health-care services.

Homeland Security/Funding for the Fourth Mission:

The VHA is playing a major role in homeland security and bioterrorism prevention without additional funding to support this vital statutory fourth mission.

VA has four critical health-care missions. The primary mission is the provision of health care to veterans. The Department's second mission is to provide education and training for health-care personnel. Indeed, VA:

> ...manages the largest medical education and health professions training program in the United States, training 85,000 health professionals annually in its medical facilities that are affiliated with almost 1,400 medical and other schools.[1]

The third mission of VA is to conduct medical research, while its fourth is:

> During and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the armed forces in armed conflict, the Secretary may furnish hospital care, nursing home care, and medical services to members of the armed forces on active duty. The Secretary may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Department with the exception of veterans with service-connected disabilities.[2]

The National Disaster Medical System (NDMS) consists of, among others, the Departments of Defense (DOD), Health and Human Services (HHS), and VA, along with the Federal Emergency Management Agency (FEMA).[3] This mission would require that the Secretary of Homeland Defense, when necessary, activate the NDMS to:

> provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of a public health emergency... (and) be present at locations, and for limited periods of time, specified by the Secretary (of Homeland Security) on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified.[4]

Public Law 107-188 also provides that the NDMS carry out needed ongoing preparedness functions.

The Independent Budget is concerned that VA not only lacks the resources to meet its responsibilities under 38 USC 8811A and PL 107-188 but will actually lose resources before undertaking its fourth mission.

The fourth mission, as previously described, does not require, but allows the Secretary of Veterans Affairs to furnish medical care to active duty military personnel. However, there is a caveat: The Secretary may not allow the military to receive a higher priority for medical treatment than that of service-connected disabled veterans. Unfortunately, if the fourth mission must be utilized, a large number of VHA medical professionals will not be available as they will, quite probably, have been mobilized as members of the reserve components, including the National Guard, of the Armed Forces. These may include 482 physicians, 172 dentists, 2,209 RNs, 3,259 in other medical fields, and 7,144 men and women in support roles.[5] If these 13,266 VHA employees are, in fact, called up with reserve forces, how does VHA support its fourth mission?

> The Secretary of Veterans Affairs shall take appropriate actions to enhance the readiness of Department of Veterans Affairs medical centers to protect the patients and staff of such centers from chemical or biological attack or otherwise to respond to such an attack and so as to enable such centers to fulfill their obligations as part of the Federal response to public health emergencies... (To) include (A) the

[1]Homeland Security: Need to Consider VA's Role in Strengthening Federal Preparedness, GAO-02-145T, October 15, 2001.
[2]38 U.S.C. § 8111A(a)(1).
[3]Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188; 116 Stat. 594, 632.
[4]*Ibid.*, 116 Stat. 594, 600.
[5]E-mail from Under Secretary Roswell dated 27 October 2003.

> provision of decontamination equipment and personal protection equipment at Department medical centers; and (B) the provision of training in the use of such equipment to staff of such centers.[6]

The Secretary of Veterans Affairs must also ensure that not only the staff, but the patients, are protected in event of an emergency, to include chemical or biological attack or another type of terrorist attack. Additionally, there are security and pharmacology issues addressed by P.L. 107-188, as well as training issues under the cognizance of the Public Health Service Act (title 42 United States Code), that need to be addressed. Although P.L. 107-188 authorized the appropriation of a total of $133 million for VA to fulfill the added responsibilities in FY 2002, for the next four fiscal years VA has been authorized to have appropriated *"...such sums as may be necessary."*[7]

Additionally, the successful implementation and performance of the fourth mission requires the VA to have the proper facilities.

In 1986 the Assistant Secretary of Defense for Health Affairs testified before the House Committee on Armed Services that *"VA was directed to serve as the primary backup to the DOD in the event of a war or national emergency. The two Departments have made great strides in designing a VA backup system to our contingency system at DOD. Today the system stands ready to provide 32,506 contingency beds for use by DOD in the event of a war or a national crisis."*

However, the Congressional General Accounting Office (GAO) reported on October 15, 2001, that:

> VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualties within 72 hours of notification...VA's plans would provide up to 7,574 beds within 30 days of notification.[8]

This is a decrease of 77% of available beds in the intervening 15 years. Looking through the Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan submitted by the VA Under Secretary for Health, it appears that the VHA may be giving up an additional 4,441 beds, of which 666 would come out of the DOD Contingency Plan; thus, we have a total loss, since 1986, of an estimated 79% of the DOD contingency beds.

It is readily apparent that the VHA:

- has had a decrease of approximately 25,680 contingency beds;
- has 13,266 VHA employees serving in the Ready Reserve and the National Guard;
- has had an increase in service-connected and nonservice-connected patient workload; and
- has insufficient funding for veterans' health care.

The IBVSOs are deeply concerned that the VHA is ill-equipped and ill-prepared to adequately perform its role in the fourth mission.

Recommendations:

Congress should appropriate $250 million in the VHA's FY 2005 appropriation to fund the VHA's fourth mission. (We have included this in the Medical Care appropriation.)

Congress should include the funding the fourth mission as separate line item in the Medical Care Account.

Congress should appropriate $133 million to fund the four emergency preparedness centers created by P.L. 107-287. (We have included this in the Medical Care appropriation.)

Congress should, with the assistance of the Secretaries of Defense and Veterans Affairs and the Director of the Selective Service Administration, incorporate methodology in title 10 U.S.C. to preclude a major active duty call of reservists employed by the VHA or modify title 50 U.S.C. to authorize compulsory service for medical professionals in VA, the DOD, and HHS.

Congress should relocate portions of PL 107-188, pertaining to Veterans Affairs, to title 38 U.S.C.

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[6] *Supra*, 116 Stat. 594, 631.
[7] *Ibid.*, 116 Stat. 594, 632.
[8] GAO Report, *supra*.

Inappropriate Billing:

Service-connected veterans and their insurers are constantly frustrated by inaccurate and inappropriate billing for services related to conditions secondary to their service-connected disability.

The VHA continues to bill veterans and their insurers for care provided for conditions directly related to service-connected disabilities. Reports of veterans with service-connected amputations being billed for the treatment of associated pain and of veterans with service-related spinal cord injuries being billed for treatment of urinary tract infections or decubitus ulcers continue to surface. Inappropriate billing for secondary conditions forces veterans to seek readjudication of claims for the original service-connected rating. This process is an unnecessary burden to both veterans and an already backlogged claims system.

Additionally, veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record and the lack of timely and/or complete information exchange about service-connected conditions between the VBA and the VHA.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with the VHA, particularly information about service-connected conditions that exceed the six stored in the C&PBDN. According to VA, difficulties in the development and implementation of the first two steps have delayed the action plan for improving VBA/VHA sharing of information about veterans' service-connected conditions. Furthermore, VA acknowledges that not all these cases with more than six service-connected conditions have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

Recommendations:

The Under Secretary for Health should firmly establish and enforce policies that prevent veterans from being billed for service-connected conditions and secondary symptoms or conditions that relate to an original service-connected disability rating.

The Under Secretary for Health should establish specific deadlines for the action plan to develop methods to improve the electronic exchange of information about service-connected conditions that exceed the maximum of six currently captured in the C&PBDN master record.

Appropriations, not MCCF:

Third-party payments should augment, not offset, the VA medical care appropriation.

The FY 2005 *Independent Budget* calls for an adequate medical care budget fully funded by appropriations. Therefore, we strongly oppose the budget maneuver that Congress and the Administration have used since 1997 to offset appropriations by the estimated amount that VA might collect from veterans and their third-party insurers. Many VA beneficiaries, especially priority 7 and 8 veterans, are Medicare-eligible. However, the Centers for Medicare and Medicaid Services (CMS) is prohibited by law from reimbursing VA.

VA is pursuing additional revenue sources and improved collections, and more revenue from these sources could improve access to care within VA. Potential sources of increased VA revenue are:

(1) improved collections from first-and third-party payers;

(2) enhanced sharing with appropriate civilian community providers;

(3) enhance-use leases (for buildings or land where Federal-civilian partnering can occur); and

(4) reimbursement from other agencies when veterans are eligible for services from such agencies.

Developing additional revenue sources, whether from TRICARE reimbursements or Medicare subvention, will not help VA's overall funding situation if the additional revenues are simply applied as an offset to the Department's budget request VA could have a strong incentive to earn and collect additional revenues if it could retain these additional revenues without an offset to its appropriated budget.

The IBVSOs believe it is the responsibility of the Federal Government to fund the cost of veterans' care. Therefore, we have not included any cost projections for the Medical Cost Collection Fund (MCCF) in our budget development. VA's historical inability to meet its collection goals has eroded our confidence in VHA estimates. We also object to funding the absurdly high cost of collections out of the veterans' medical care account. The IBVSOs believe the cost of implementing effective billing practices and systems will absorb any net income generated by MCCF.

Recommendation:

The Administration and Congress must base the VA medical care budget on the principle that third-party collections are to supplement, not substitute for, appropriations.

Copayments:

Veterans should not be charged copayments for health-care services and medications.

Through extraordinary sacrifices and contributions, veterans have earned the rights to certain benefits. As the beneficiaries of veterans' service and sacrifice, the citizens of a grateful nation want our Government to fully honor our moral obligation to care for veterans and generously provide benefits and health care free of charge. Asking veterans to pay for part of the benefit is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans. Copayments are a feature of health-care systems in which some costs are shared by the insurer in a commercial relationship between the patient and the for-profit company or of Government health care programs in which the beneficiary has not earned the right to have the costs of health care fully borne by the taxpayers.

Copayments were only imposed upon veterans under urgent circumstances and as a temporary necessity to contribute to reduction of the Federal budget deficit. In an effort to help our nation get its fiscal house in order, veterans acquiesced in the imposition of copayments as a "temporary" deficit-reduction measure, even though the concept fully contradicts the spirit and purpose of veterans' benefits.

Unfortunately, Congress has not only made copayments a regular feature of some veterans' health-care services by extending the sunset date of this "temporary" measure, but also has introduced legislation encroaching down the "slippery slope" toward higher copayments and annual enrollment fees. With such brazen attempts to capitalize on the generous and selfless nature of veterans to serve their country when in need, Congress has forgotten its traditional philosophy of providing free benefits to veterans as repayment for protecting our freedoms.

The Administration and Congress seem unwilling to restore veterans to their prior status once either has impaired, reduced, or eliminated a benefit purportedly on a temporary basis. *The Independent Budget* strongly objects to such insidious erosion of veterans' benefits.

In the past, copayments were targeted as a source of funding for other veterans' benefits. Such schemes, in effect, require one group of veterans to pay for the benefits of another group of veterans. For example, if copayments were used to pay for increases in the Montgomery GI bill, this would mean requiring sick and disabled veterans to pay for a cost of national defense.

That is unconscionable. Copayments and user fees are actually taxes on veterans' benefits. The IBVSOs urge Congress to eliminate the copayment measure.

Recommendation:

Congress should eliminate copayments charged to veterans for medication or health-care services.

Access Issues

While the VHA has made commendable improvements in quality and efficiency, veterans' access to their health-care system is severely limited. Excessive waits and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

Access is the primary problem in veterans' health care. The significant backlog of delayed appointments, which is caused by severe funding shortfalls, is the immediate cause of veterans' limited access. Many VA facilities and clinics have reached capacity and have had to limit enrollment. Due to perennially inadequate health-care budgets, the VA health-care system can no longer meet the needs of our Nation's sick and disabled veterans. Without funding for increased clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services.

A July 2002 survey by the VHA revealed more than 310,000 veterans waiting for medical appointments, half of whom must wait 6 months or more for care and the other half having no scheduled appointment. As of October 15, 2003, the VHA reported the national total of veterans who will likely wait 6 months or more for nonemergent clinic visit has been reduced to 43,217, of which 17,496 veterans are waiting for their first clinic appointment to be scheduled. VA also reported 25,775 veterans waiting for a follow-up appointment. Even veterans with appointments are waiting more than 6 months.

Last year the situation became so critical that the Secretary of Veterans Affairs instituted regulations to allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though caring for veterans with service-connected disabilities is a core commitment for VA, this does not provide timely access to quality heath care for all eligible veterans authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans, and all other enrolled veterans, have access to the system in a timely manner, it is imperative that our Government provide an adequate health-care budget to enable VA to serve the needs of disabled veterans nationwide.

The Advanced Clinic Access Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing health-care demand, has shown promise in addressing the issue of wait times. The goal is to build a system in which veterans can see their health-care providers when they need to. Through the work of a few leaders, this program reduced waiting times and significantly improved veterans' access to their health-care system.

Under the Advanced Clinic Access Initiative, the average waiting time measurement at primary care clinics was reduced from 28.2 days for the next available appointment in FY 2002 to 23.7 days in FY 2003. The average waiting time at specialty clinics was reduced from 36.3 days to the next available appointment in FY 2002 to 29.02 days in FY 2003.

Despite improvements in wait times for needed appointments, continued disparities exist in the implementation of the Advanced Clinic Access Initiative nationwide. Currently, only one dedicated full-time employee and two volunteer employees manage the Advanced Clinic Access Initiative. With a dedicated staff of six, VA could fully implement this initiative across the country to improve the health-care experiences of millions of veterans. A fully staffed and supported Advanced Clinic Access initiative could develop better ways to measure real waiting times, link performance measures to improvements in waiting times, and compare VHA patients' waiting times with those of private sector patients.

Both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access to VA health-care services.

Recommendations:

The VHA should fully develop the Advanced Clinic Access Initiative to measurably improve waiting times.

The VHA should include improvements in waiting times as part of an administrator's performance measures.

The Administration should establish a physician-led program within VHA National Headquarters and provide six full-time staff to the Advanced Clinic Access Initiative.

Community-Based Outpatient Clinics:

Many community-based outpatient clinics do not comply with the Americans with Disabilities Act and lack staff and equipment to serve the specialized needs of veterans.

As of August 2003, the VHA operated 677 community-based outpatient clinics (CBOCs).

Proposed under the currently ongoing CARES process is establishment of 262 additional CBOCs. The IBVSOs commend the VHA's efforts to expand access to needed primary care services. The presence of CBOCs reduces the travel required of many veterans who live long distances from VA medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult. CBOCs also improve veterans' access to timely attention for medical problems; reduce hospital stays; and improve access to, and shorten waiting times for, follow-up care.

While the IBVSOs support establishment of CBOCs, we are concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for the general veteran population or those with service-connected mental illness. Too often CBOC staff lack the requisite knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, VSOs caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care program.

Inadequately trained providers are less likely to render appropriate primary or preventive care and accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with section 504 of the Rehabilitation Act regarding physical accessibility to medical facilities. Veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the accomplishment of the VHA's mission of providing health services to veterans with specialized needs. These individuals also require primary and preventive care, which, in many cases, can be appropriately provided in CBOCs. It is essential,

however, that CBOCs use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

To ensure the integrity of the VA medical system, it is essential that Congress and the Administration appreciate the indispensable role of VAMCs in providing both acute and primary care. Valuable resources must not be siphoned away from the infrastructure of VA hospitals as more CBOCs are established. Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VHA care.

Recommendations:

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting the special health-care needs of veterans wherever those needs justify specialized resources.

The VHA must develop clinically specific referral protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at the facility at which the need exists.

The VHA must ensure all CBOCs fully meet the accessibility standards set forth in section 504 of the Rehabilitation Act.

VHA-DOD Sharing:

The Independent Budget *encourages collaboration of VA-DOD health systems and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.*

The President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF) delivered its final report in May 2003. The PTF was charged with three tasks:

(1) identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;

(2) review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and

(3) identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure.

Interest in VA-DOD health systems' collaboration is supported by enactment of sharing initiatives in the FY 2003 National Defense Authorization Act and other legislation.

The Independent Budget VSOs continue to support the careful expansion of VHA/DOD sharing agreements. We agree, however, with PTF Cochairman Dr. Gail Wilensky's testimony before the House Veterans' Affairs Committee (June 2003) that true sharing will not be possible until Congress addresses the underlying mismatch between demand for VA services and appropriated resources. Further, we do not believe that joint activities demonstrate the need to integrate the management of the two systems. Complementary business systems can offer benefits to users of both systems, but these benefits do not mean that a total integration of the two systems is practical or necessary.

Leadership and Reporting

The recently authorized VA-DOD Joint Executive Council should report annually to the Armed Services and Veterans' Affairs Committees on collaborative activities, including development of tools to measure the "health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing, and desired outcomes." *The Independent Budget* VSOs believe there has been insufficient transparency in the work of various VA-DOD executive planning forums—stakeholders need information on the likely impact of sharing initiatives on veterans.

Seamless Transition

The IBVSOs note that some veterans returning from Iraq and Afghanistan are not seamlessly referred or transferred between the DOD and VA health-care systems. We strongly support early development of servicemember medical records that are "interoperable, bi-directional, and standards-based."

Joint Venture Sites

The DOD and VA have identified 60 sharing initiatives at the facility level, and the DOD has labeled 20 of these as "priority" initiatives. In addition, VA and the DOD announced in October 2003 a series of demonstrations required by the fiscal year 2003 National Defense Authorization Act to test improving business collaboration between VA and DOD health facilities. The two departments will use the demonstration projects at eight sites to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. The *IB* does not object to these joint ventures in themselves, but we have serious concerns about their interaction with the VA CARES and DOD health facilities planning processes.

VA and DOD Access Standards

VA has had access standards since 1995 but has not been required to meet them. Conversely, the DOD has mandatory access standards and is required by law to meet them. The DOD's access standards drive funding levels to meet demand in the military health-care system, TRICARE. In examining the "mismatch between demand and funding," the PTF report concluded that the VA health-care system should be funded "in accordance with VA's established access standards."

Fully Fund Enrolled Veterans

The PTF recommended that the Government should provide "full funding" for all veterans enrolled in VA health care in priority groups 1–7. The PTF suggested that this objective could be achieved either by a "mandatory funding mechanism," through "modification to the current budget and appropriations process," or by some other method. It is clear that the PTF recommended that the gap between demand and resources must be closed by increasing and sustaining VA health-care funding. As outlined elsewhere in *The Independent Budget*, we strongly recommend mandatory funding for all enrolled veterans VA has agreed to care for. The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

Recommendations:

Congress should provide necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions.

Congress should provide sufficient resources for the DOD and VA to enhance information management/information technology interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in title 38 United States Code.

Enrollment Priority 4 Not Fully Activated:

Many catastrophically disabled veterans are incorrectly classified as enrollment priorities 5, 6, 7, and 8.

Six years ago Congress enacted Public Law 104-262, which specifies that veterans who are receiving increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4.

Prior to VA curtailing enrollment of priority group 8 veterans, all enrolled veterans that were entitled to be but were not classified as enrollment priority 4 have been denied VA health care. In the future it is possible that inadequate appropriations may force the Secretary to change enrollment policy with regard to priority 7 veterans. If that were the case, thousands of misclassified veterans could be affected.

The VHA has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them as priority group 4. Reports from national service officers attempting to help veterans obtain appropriate reclassification to priority group 4 indicate that many times they are met with resistance and at times refusal from VA hospital staff.

There is no logical reason for the VHA to delay implementation of this law. Appropriate classification of eligible veterans to priority group 4 must be accomplished without further delay.

Recommendations:

The VHA should expedite the proper identification and classification of enrollment priority 4 veterans.

Congress should require the VHA to report on numbers of enrolled priority 4 veterans.

Emergency Services:

Many enrolled veterans may be excluded from non-VA emergency medical services.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance. An eligible veteran who receives such care is not required to pay a fee to the private facility. However, eligibility criteria prohibit many veterans from receiving emergency treatment at private facilities.

To qualify under this provision, veterans not only must be enrolled in the VA health-care system, they also must have been seen by a VA health-care professional within the previous 24 months. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The IBVSOs object to eligibility limitations on enrolled veterans. We believe all enrolled veterans should be eligible for emergency medical services at any medical facility.

A related concern is the frequency with which VA denies payment for the emergency care to veterans, who, as a result, are charged by the private facilities. At times VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to, and emergency care at, a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., esophogitis, instead of the admitting diagnosis, e.g., chest pain. It is ludicrous to penalize a veteran for seeking emergency care when he or she is experiencing symptoms that manifest a life-threatening condition.

Recommendations:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care

professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish, and enforce, a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a medical emergency.

VA should establish a policy allowing all enrolled veterans to be eligible for emergency medical services at any medical facility.

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Despite significant improvement in many areas, problems in the VA prosthetics and sensory aids arena continue to exist. As a result, veterans who require prosthetic and sensory aids continue to encounter obstacles in receiving timely and appropriate services and equipment. The program enhancements developed to eliminate or minimize these obstacles have not been fully implemented throughout the VA health-care system.

The IBVSOs are pleased to report that on a national level veterans have continued to benefit significantly through the continuation of the centralized prosthetics budget. The protection of these funds from being used for unintended purposes has had a major positive impact on disabled veterans. The IBVSOs applaud VHA's senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetic needs of veterans with disabilities.

The IBVSOs also commend the decision to distribute FY 2004 prosthetic funds to the VISNs based on prosthetics fund expenditures and utilization reporting. This decision has greatly improved the budget reporting process. For example, prior to implementing FY 2002 prosthetics budget, the VISN network directors were informed, in no uncertain terms, that the variance between obligations for prosthetics budget object codes and the National Prosthetics Patients Database (NPPD) would be no greater than 5%. In FY 2001, a total of $634.7 million was obligated against prosthetics, yet VHA field stations only documented $492.2 million through the NPPD, resulting in a variance of 22.4% at the national level. Among the 22 networks, the variance ranged from a best of 13.2% to a worst of 52.6%. Additionally, the network directors were instructed to ensure that VA purchase cards (credit cards) will be utilized to purchase at least 90% of all prosthetics devices at the facility level. It was believed this requirement would increase accountability for the funds obligated and expended and facilitate NPPD entry. Of the VISNs, 5 of the 22 failed to comply with this method of accounting. This resulted in VHA senior officials withholding a total of $12 million (combined) from the five VISNs. After each of the VISNs complied with the required accounting procedures to demonstrate the actual need for their budget, an appropriate portion of the $12 million reserve was disbursed to the five VISNs. The end result of VISN compliance was increased communication and documentation between prosthetics and fiscal officers. As a result, for FY 2003 all 21 VISNs fell within the 5% variance between expenditures versus obligations.

Detractors of a centralized prosthetics budget continue to argue that when prosthetics funds are diminished, the facility or VISN is required to replenish the prosthetics account by utilizing the general operating funds. Many facility and fiscal managers who manage the general operating funds believe that because they are responsible for the general operating funds, they should also control the prosthetic funds. But historical evidence has strongly proven that this practice results in funds being diverted from the prosthetics budget to

other areas of the VHA facility. Conversely, the historical evidence also shows that centralization and protection of prosthetic dollars has resulted in improved services to disabled veterans.

The IBVSOs believe the requirement for increased managerial accountability through extensive oversight of the expenditures of centralized prosthetic funds through data entry and collection, validation, and assessment has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetic budget expenditures at all levels, primarily utilizing data generated from the NPPD. As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs applaud the senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2004. The allocated budget for prosthetics was approximately $846 million, up from $752.7 million in FY 2003. Funding allocations for FY 2004 were primarily based on FY 2003 NPPD expenditure data, coupled with Denver Distribution Center billings and an overall 12.5% increase. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

Because of the increased compliance rate between prosthetics obligations and NPPD expenditure data, most VHA facilities received FY 2004 budget allocations at their requested levels. However, prosthetics requested approximately $917 million to cover the actual anticipated FY 2004 prosthetics budget. The $71 million that was not funded is needed to cover the Home Oxygen Program, which currently is not reflected in the prosthetics budget, in addition to recent enhancements in the prosthetics package, including technological advancements, and service dogs. The advancements in prosthetics technology bring with them a high price. For example, a single prosthetic limb, the C-leg, has an anticipated cost of $30,000, a single IBOT wheelchair $25,000, and a single service dog $20,000.

In FY 2005, the IBVSOs anticipate that the prosthetics budget will need to be increased to approximately $951.7 million. If the prosthetics budget were to reflect the Home Oxygen Program, for which prosthetics is responsible, an additional $55 million is needed. Part of these funds must be used to allocate the latest technological advances in prosthetics and sensory aids. Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Recommendations:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetic and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetic expenditures and trends.

The VHA should continue to allocate prosthetic funds based on prosthetic expenditure data derived from the NPPD.

VHA's senior leadership should continue to hold its field managers accountable for failing ensure that data is properly entered into the NPPD.

Consistent Application of National VHA Prosthetic Policies and Procedures:

Prosthetics services (e.g., the provision of hearing aids and eyeglasses, wheelchairs, artificial limbs, etc.) are still not provided uniformly across the Nation to veterans who are enrolled and eligible for VA care and treatment.

It is clear that senior leadership in the VHA recognizes that this problem exists. For example, Prosthetics and Sensory Aids receives repeated requests to clarify instructions to its VISN prosthetics representatives concerning the uniform application of the provisions on the issuance of medically needed automotive adaptive equipment (ingress/egress items). This had to be done even though the policy for issuance of this equipment was clearly listed in VHA's prosthetics handbook (VHA Handbook 1173). In fact, the prosthetics handbook contains key language that addresses the problem of inconsistent application of prosthetic policies and provisions. The handbook indicates that the VHA is striving to provide a uniform level of services on a national level. Every section of the handbook specifically indicates that the policies contained therein are intended to set uniform and consistent national procedures for providing prosthetics and sensory aids and services to veteran beneficiaries. We believe national VHA officials need to be diligent to ensure that national prosthetic policies are properly followed as this handbook is translated in VISN and facility-level operating guidelines.

As we noted above, policy enforcement and individual accountability is needed to effect positive change in local practices. In addition, the Chief Consultant for Prosthetics and Sensory Aids must work with all the VISNs to develop VISN-wide training initiatives that provide emphasis on ensuring that the interpretation of these national VHA policies and procedures on the issuance of prosthetic devices is consistent and appropriate, regardless of facility.

Recommendations:

The VHA must ensure that national prosthetic policies and procedures are followed uniformly at all VHA facilities.

All 21 VISN prosthetic representatives, in cooperation with the Chief Consultant for Prosthetics and Sensory Aids, need to develop, conduct, and/or continue appropriate prosthetic training programs for their VISN prosthetic personnel.

Assessment and Development of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

Single-source national contracts for specific prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

In the past, the IBVSOs cautiously supported VHA efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetic prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our continued concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used, as part of the PCMP process, to award single-source national contracts for specific prosthetic devices. Mainly, our concern lies with the high rates that are contained in the national contracts. The typical compliance rate, or performance goals, in the national contracts awarded so far as a result of the PCMP have been 95%. This means that for every 100 of the devices purchased by the VHA, 95 of the devices are expected to be of the make and model covered by the national contract. The remaining 5% consist of similar devices that are purchased "off-contract" (this could include devices on Federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that

inappropriate pressure may be placed on clinicians to meet these goals due to a counter productive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe that national contract awards should be multiple-source. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA's standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

The following is a synopsis of a statement made by a paralyzed veteran who is active on a PCMP workgroup:

> We do not live in a one-size-fits-all world, and when you spend 15-plus hours a day sitting down, the manner in which you do it is very personal and intimate. I would be a fool to think that, as a wheelchair user, I fully understand the factors that other wheelers need to consider in their selection of specific types or models of wheelchair. Disabled veterans who require a wheelchair for ambulating must be able to participate in the selection process and maintain their freedom of choice to help maximize their independence and facilitate their lifestyles. I understand that new users, or those with changing medical needs, require a lot of help in selecting the right chair from specialists. Experienced users have a better feel for their needs and limits and play a larger role or even a solo role in the selection process.
>
> I cringe at the thought that someone may point to the work of this workgroup and say, "Sorry, but you can't have that wheelchair. A VA workgroup has already decided what is best for you." I'm working hard to prevent a scenario like this from occurring. And I see from your thoughts that you understand my concerns, and I appreciate your efforts as a clinician and those of the other workgroup members, to address those concerns for the benefit of all disabled veterans who depend on these wonderful devices. Saving dollars at the expense of the disabled veteran would be a tragedy, not a victory.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA will routinely purchase threatens future advances. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market. Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs, stair climbing, and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible.

Another problem with the issuance of prosthetic items concerns surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device (LVAD), coronary stents, cochlear implants), the surgical costs associated with implanting the devices come from the local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are "limiting the number of surgeries" due to the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

Recommendations:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to

inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient need—not cost—and must be permitted to prescribe devices that are "off-contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.

Restructuring of Prosthetic Programs:

Not all VISNs have taken necessary action to ensure that their respective prosthetic programs have been appropriately restructured, despite the passing of nearly 5 years.

The IBVSOs continue to support the restructuring efforts that are occurring at the VISN level as a result of the prosthetics program reinvention project completed in March 1999. To ensure an acceptable degree of consistency nationwide, the IBVSOs believe that VHA headquarters must provide more specific information to the VISNs on the restructuring of their prosthetics programs, as it is now obvious that some VISNs will not commit to restructuring on their own initiative. As we have stated for the past 4 years, VHA headquarters ***must*** direct VISN directors to:

- Designate a qualified VISN prosthetics representative to whom the prosthetics service at each VA facility is accountable (the position should be graded at the approved GS-14 or GS-15 level).
- Ensure that VISN prosthetic representatives have line authority over all prosthetics full-time employee equivalents at local facilities who are organized under the consolidated prosthetics program or product line.
- Ensure that VISN prosthetics representatives do not have collateral duties as a prosthetics representative for a local VA facility within their VISN.
- Hold each VISN prosthetic representative responsible for ensuring implementation and compliance with national prosthetic and sensory aids goals, objectives, policies, and guidelines.
- Provide a single VISN budget for prosthetics and ensure that the VISN prosthetics representative has control of and responsibility for that budget.

Recommendation:

The VHA must require all VISNs to adopt the consistent operational parameters and authorities for reorganizing prosthetics services and hold individual VISN directors responsible for failing to do so.

Failure to Develop Future Prosthetic Managers:

There continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions.

The VHA has developed and requested 12 training billets for the National Prosthetics Representative Training Program. VHA's National Leadership Board has approved the re-implementation of this vital program. This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. Because of the lack of this training program, there continues to be a serious shortage in the number of qualified prosthetic representatives who are available to fill current or future vacant positions. This has led to many inappropriate prosthetic personnel selections around the country.

On a positive note, the IBVSOs are aware that prosthetics has been allocated 12 billets for trainees in the Prosthetics Representative Training Program for fiscal years 2003, 2004, and 2005. However, additional trainee billets may be necessary based on the future anticipated vacancy rates.

As we have reported previously, some VISNs have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetics representative positions. The IBVSOs believe that the future strength and viability of VA's prosthetics programs depends on the selection of high caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients or the creation of prosthetics gatekeepers—individuals whose primary mission would be to save dollars at the expense of the veteran.

Continuing education and certification for field prosthetic staff, especially VISN prosthetics representatives who are responsible for ensuring compliance with national policy, is also essential to improving the prosthetics program. The IBVSOs strongly encourage the VHA to continue to conduct quarterly VISN prosthetics representative training meetings and its prosthetics chiefs national training conferences, which are held normally in conjunction with other rehabilitation services (e.g., blind rehabilitation, spinal cord injury, traumatic brain injuries, etc.).

In addition, appropriate prosthetic procurement personnel need to become certified as assistive technology suppliers, and orthrotists/prosthetists need to be certified in their respective fields.

Recommendations:

The VHA must fully fund and implement its National Prosthetics Representative Training program, with responsibility and accountability assigned to the Chief Consultant for Prosthetics and Sensory Aids, and continually allocate sufficient training funds and FTEE to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that their selected candidates for vacant VISN prosthetics representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that Prosthetics and Sensory Aids departments are staffed by appropriately qualified and trained personnel.

Mental Health Services:

Congress must ensure that mental health care becomes a greater programmatic and funding priority for VA.

Congress and the Administration must make VA mental health care a much greater priority; must improve access to specialized services for veterans with mental illness, post-traumatic stress disorder (PTSD), and substance abuse disorders commensurate with their needs; and must make recovery from mental illness a guiding component of VA health-care programming. For too long, mental health care has *not* been a priority for VA, as evidenced again only last year by the VHA's development of a CARES plan, which employed a badly flawed planning model that underestimated veterans' future needs for mental health services.

Despite very substantial current and future veteran need for mental health care, recent years have seen erosion in VA mental health service capacity. Virtually every entity with oversight of VA mental health-care programs, including Congressional oversight committees, the GAO, VA's Committee on Care of Veterans with Serious Mental Illness, and *The Independent Budget,* have documented both the extensive closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These glaring gaps highlight VA's ongoing failure to meet a statutory requirement to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs.

In all, during the transformation of its health-care system beginning in 1996, VA has allowed mental health spending to decline by 25%. That spending reduction cannot be attributed to "efficiencies gained in shifting from inpatient to outpatient care" as has been suggested. To the contrary, as documented by VA's statutorily mandated Committee on Care of Veterans with Serious Mental Illness, the Department has not adequately developed, nationwide, the community-based services needed to replace lost inpatient and other services. Although the *IB* has long called for the VHA to maintain equitable access to a full continuum of mental health services, veterans' access to mental health services is highly variable, without a common commitment among VA's networks to making mental health and substance use services a priority.

In reinforcing and strengthening the capacity law through the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135), Congress has unmistakably directed VA to substantially expand the number and scope of specialized mental health and substance abuse programs so as to improve veterans' access to needed specialized care and services. The law now makes clear that VA's obligation is not simply to report to Congress, but to make systemic changes network by network to reverse the erosion of that specialized capacity. To ensure that real change occurs, Congress has made very clear that the criteria by which the "maintain capacity" obligation is to be met are not vague "outcome" data, but hard, measurable indicators that apply not only nationally but to each of VA's veterans integrated service networks.

With wide disparity in the availability of needed services across the system, the *IB* continues to find that ***veterans with mental illnesses can have no assurance that any given VA facility, or network of facilities, will meet their mental health needs.*** To appreciate the profound implications of this failure, one must consider the impact of mental illness on our veterans and the magnitude of the obligation this Country owes them:

- More than 460,000 veterans are service-connected for mental disorders.
- Nearly 117,000 of these veterans are service-connected for psychosis.
- More than 180,000 are service-connected for PTSD, a disorder most often directly related to combat duty.
- During fiscal year 2002, more than 750,000 veterans, or 17%, received mental health services from VA; during that same period, VA provided care to more than 206,000 veterans with psychoses, 97% of whom were high priority patients due to service-connection or low-income status.

The prevalence of mental illness and substance-use problems among our veterans, and the significant need for mental health services among VA's patients—particularly among those with the highest priority for care—is at odds with the still relatively limited specialized programming available to them. Even veterans residing in reasonable proximity to VA health-care facilities often do not have access to a needed continuum of mental health services. Resources freed up in prior years by hospital ward closures were not retained in and dedicated to mental health programming. Rather than reinvesting dollars to meet veterans' mental health needs, these savings were used to establish and operate an array of new community-based outpatient clinics (CBOCs), which to this day still do not have mental health staffing in most locations. Efforts to provide such staffing, moreover, are still no substitute for the specialized services needed to support veterans with serious mental illness.

The problem of unmet need is not one that faces only veterans with a chronic, serious mental illness. As VA's special committee on PTSD has reported, there are not enough specialized PTSD programs to meet veterans' needs, and access is a problem in many areas. Veterans with substance-use disorders may be even more underserved. The dramatic decline in VA substance-abuse beds has robbed clinicians of the means of providing veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illness or co-occurring substance-use problems is also markedly short of the needs in that population. Despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

Given the high proportion of VA patients who need treatment for mental health problems and the long-documented need to restore VA's specialized mental health service capacity, it is very troubling that VA mental health-care spending has declined by 8% over the past 7 years, and by 25% when adjusted for inflation. The *IB* estimates that simply to restore lost funding support, VA should be devoting an additional $478 million to mental health-care spending. This projection would still fall short, however, of what is needed to fully fund a comprehensive continuum of care for veterans with serious mental illness, PTSD, and substance-use disorders, an altogether reasonable target identified at a 2002 Senate Veterans' Affairs Committee hearing. Meeting that very compelling need would exceed $4 billion annually, almost double VA's current mental health budget.

In addition to the gaps attributable to an erosion in services for mental health care since 1996, the *IB* is concerned that VA mental health service delivery needed to provide veterans state-of-the-art care has not kept pace with advances in the field. The 2003 report of the President's New Freedom Commission on Mental Health Care has particular relevance in this regard in highlighting that recovery is a realizable goal for people with mental illness. VA can, and should be, a model for recovery-based mental health care. Such care requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help veterans recover from a mental illness. VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available through VA. But it is not. At most, it can be said that some VA facilities have the capability to provide some limited number of these services to a fraction of those who need them. ***But what is clear is that the professionally recognized standard of care that should be available to any person suffering from serious mental illness is not available through VA, even to the many veterans who are service-connected for a serious mental illness.***

As the *IB* noted last year, VA's compensated work therapy (CWT) program illustrates the extent to which VA mental health care has failed many of those most in need. This rehabilitation program helps veterans learn social and work skills as part of a recovery process and has successfully placed many participating patients in competitive employment. Yet only minute numbers of veterans who have a severe mental illness and who have been found to be employable with sufficient supports have participated in this program. The *IB* commends Congress for passing legislation to enable VA to provide supported employment services to these veterans and thereby taking an important first step toward moving VA from simply managing the symptoms of mental illness to providing the needed supports to make possible recovery from mental illness and return to productive life in the community. VA can

go much further, however, and should follow the call of the Committee on Care of Veterans with Serious Mental Illness to expand the arsenal of support that can help veterans on a path toward recovery. The *IB* strongly urges VA to utilize peer-support services, which have been shown to have both clinical and cost effectiveness in building independence, self-esteem, and skills that foster recovery.

The *IB* has identified a broad array of mental health funding needs, covering such areas as intensive community case management programs, psychosocial rehabilitation services and other recovery supports, geriatric psychiatry, increases in supported housing and residential treatment capacity, additional mental health services available through more community-based outpatient clinics, and additional inpatient beds. Compelling considerations, including the outright needs of veterans who rely on VA, professional state-of-the-art treatment standards, and Congressional mandates, dictate that FY 2005 funding provide for restoring both lost program capacity in, and increased support for, veterans' mental health care and recovery.

The *IB* recognizes that the development of these needed programs must be approached with deliberation and care and recommends that funding be augmented steadily over a 5-year period.

Recommendations:

Congress must incrementally augment funding for specialized treatment and support for veterans who have mental illness, PTSD, or substance-use disorders by $500 million each year from FY 2005 through FY 2009.

The VHA must invest resources in programs to develop a continuum of care that includes intensive case management, psychosocial rehabilitation, peer support, integrated treatment of mental illness and substance-use disorder, housing alternatives, work therapy and supported employment, and other support services for veterans with serious mental illnesses.

In light of the flawed methodology regarding veterans' mental health needs used in the CARES process, VA (and Congress in its oversight capacity) must give priority to ensuring that the Department's strategic planning relating to mental health care and support is based exclusively on data and assumptions that have been validated by VA mental health experts. Accordingly, the Under Secretary for Health must ensure that erroneous CARES mental health projections are expunged from VA planning databases.

With the failure of many VA networks to maintain specialized mental health and substance abuse treatment capacity, and restore such lost capacity, and with the resultant lack of access to needed mental health and substance abuse care, VA must institute a mechanism to "fence" funding of monies for these programs for those networks whose mental health or substance use funding levels are markedly out of line with inflation-adjusted 1996 funding.

The VHA, its networks, and facilities should partner with mental-health advocacy organizations, such as the National Mental Health Association, the National Alliance for the Mentally Ill, and veterans service organizations to provide support services, such as outreach, educational programs, peer and family support services, and self-help resources.

Specialized Services Issues

Blinded Veterans:

The VHA needs provide a full continuum of vision rehabilitation services.

The VA Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our Nation's blinded and severely visually impaired veterans. VA currently operates 10 comprehensive residential Blind Rehabilitation Centers (BRCs) across the Country. Historically, the residential BRC program has been the only option for severely visually impaired and blinded veterans to receive services.

As the VHA made the transition to a managed primary care system of health-care delivery, the BRS failed to make the same transition for rehabilitation services for blinded veterans. *The Independent Budget* believes it is imperative that the VA BRS expand its capacity to provide blind rehabilitation services on an outpatient basis when appropriate. More than 2,600 blinded veterans are waiting entrance into 1 of the 10 VA BRCs. Many of these blinded veterans do not require a residential program. If a veteran cannot or will not attend a residential BRC, he or she does not receive any type of rehabilitation.

The Independent Budget encourages funding for additional research into alternative models of service delivery to identify more cost-efficient methods of providing essential blind rehabilitation services. Alternative methods of delivering rehabilitative services must be identified, tested, refined, and validated before the existing comprehensive residential BRC programs are dismantled. Innovative programs like the outpatient 9-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) at the VAMC Lebanon, Pennsylvania, must be encouraged and replicated. VISOR offers skills training, orientation and mobility, and low-vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery.

Congressionally mandated capacity must be maintained. The BRS continues to suffer losses in critical FTEEs, compromising its capacity to provide comprehensive residential blind rehabilitation services. Many of the blind rehabilitation centers are unable to operate all of their beds because of the reduction in staffing levels. Other critical BRS positions, such as full-time Visual Impairment Services Team (VIST) coordinators and blind rehabilitation outpatient specialists (BROS), have been frozen, postponed indefinitely, or eliminated. Currently, there are only 22 BROS positions. In addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, BROS provide blind rehabilitation training in veterans' homes. This service is particularly important for blinded veterans who cannot be admitted to a residential blind rehabilitation center.

Recommendations:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of P.L. 104-262.

The VHA must rededicate itself to the excellence of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

The VHA headquarters must undertake aggressive oversight to ensure appropriate staffing levels for blind rehabilitation specialists.

The VHA must increase the number of blind rehabilitation outpatient specialist (BROS) positions.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the Director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff. When disputes over such selections cannot be resolved between the BRS director and local management, they must be elevated to the Under Secretary for Health for resolution.

Spinal Cord Dysfunction:

VA continues to have a shortage of bedside nursing staff, which adversely affects the quality of care for spinal cord dysfunction patients.

A system of classifying patients according to the amount of bedside nursing care needed has been established by VA. Five categories of patients were developed, which took into account significant differences in nursing care hours for each category, on each shift, and in determined segments of time such as a 24-hour period, shift by shift, and the number of FTEEs needed for continuous coverage. This could be converted in nursing needs over a week, quarter, or even a year. It was also adjusted for net hours of work for annual, sick, holiday, and administrative leave.

The emphasis of this acuity system is on *bedside care nursing* and does not include administrative nursing or light-duty nurses who either do not or are not able to provide full-time, labor-intensive bedside care for the spinal cord injured/dysfunctional (SCI/D) patient. According to the *California Nurses Association's Safe Staffing Law* about California registered nurse (RN)-to-patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing was delineated in VHA Handbook 1176.1 and VHA Directive 2000-022. It was derived on 71 FTEEs per 50 staffed beds based on the average of category III patients. Currently nurse staffing numbers do not reflect an accurate picture of bedside care being provided because administrative nurses and light-duty nurses were counted in with bedside nurses as the total number of nurses caring for SCI/D patients.

VHA Directive 2000-022 requires 1,347.6 bedside nurses to provide minimal nursing care for 85% of the available beds at 23 SCI centers. Bedside nurses are comprised of RNs, licensed vocational/practical nurses, nursing assistants, and health technicians. The regulation is that the nursing staff mix should approximate 50% RNs. Not all SCI centers are in full compliance with this regulation. At the end of fiscal year 2003, nurse staffing was 1,266.4. Of the 1,266.4, 79 nurses were administrative and 45 were light-duty nurses. This left only 1,142.4 nurses for bedside care, which is 205.2 below the required 1,347.6. This represents a *15% decrease* of available bedside nursing care.

SCI facilities are using minimal staffing levels as their maximum recruiting levels. And, as shown above, when the minimal staffing levels contain numbers of administrative nurses and light-duty nurses, nursing care is severely compromised. It is well documented in professional medical publications that patient morbidity and mortality following complications are affected by nurse staffing. For every additional patient in the average nurse's workload, the odds of death increase by 7%.

The IBVSOs continue to believe that basic salaries of bedside nurses is too low to be competitive with community hospital nurses, causing many of the nursing staff to leave VA or accept a job at one of the community hospitals.

Recruitment and retention bonuses have been instituted at several VA SCI Centers to assist in increasing morale and to comply with staffing requirements. However, these efforts have been variable and inconsistent systemwide. SCI center staff find themselves with a complete lack of flexibility in their work schedules and in many cases have to work mandatory overtime. This has also contributed to low morale.

Recommendations:

The VHA needs to count only those nurses who provide direct bedside care and use those numbers for assessing compliance with VHA Directive 2000-022 and VHA Handbook 1176.1.

The VHA needs to hire more nurses.

The VHA needs to centralize their policies systemwide for recruitment and retention bonuses.

Salaries as well as recruitment and retention bonuses need to be set at an amount that is competitive with community health-care facilities.

Congress should appropriate the funds necessary to provide competitive salaries and bonuses for SCI/D nurses.

Gulf War Veterans:

Gulf War veterans still suffer from undiagnosed illness related to their service.

Heightened controversy over "Gulf War Syndrome" still exists more than a decade after the start of the Gulf War. Sick Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain. Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf Theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf veterans suffer from real illnesses, there is no single disease or medical condition affecting them.

In the 12 years since the Persian Gulf War (PGW), both the DOD and VA have had many service members and veterans with concerns regarding undiagnosed illnesses and Gulf War Syndrome. Although some headway has been made in diagnosis, treatment, and payment of disability compensation, further research by both Departments is needed. Moreover, we are now confronted by an additional issue. The international War on terrorism has put our troops on the ground in Iraq and Afghanistan. Many of these young men and women have fought, are fighting, and are living in the same areas as did our PGW veterans. The IBVSOs, therefore, expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses from which the veterans of the PGW have suffered.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled due to their military service in the Gulf War. Unfortunately, veterans returning from all of our Nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service-connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. P.L. 105-277 requires that VA and the National Academy of Sciences (NAS) determine which hazardous toxins members of the Armed Forces may have been exposed to while serving in the Persian Gulf. Upon identification of those toxins, NAS will identify the illnesses likely to result from such exposure, for which a presumption of service-connection is or will be authorized. Accordingly, the IBVSOs urge that Congress extend the provision of Public Law 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Persian Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation times" in which conditions associated with Gulf War service will manifest.

Many Gulf War veterans are frustrated over VA medical treatment and denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. In this connection, VA uses clinical practice guidelines (CPGs) for chronic pain and fatigue. VA has not yet, however, developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle their cases in a traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

On a more positive note, recently enacted legislation includes poorly defined illnesses, such as fibromyalgia and chronic fatigue syndrome, under the "undiagnosed illness" provision. Previously, many Gulf War veterans received diagnoses of these conditions, yet were denied compensation simply because they were diagnosed. Because of passage of Public Law 107-103, which became effective March 1, 2002, Gulf War veterans diagnosed with chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome now qualify for VA compensation for those conditions. Additionally, the Secretary has granted presumption for service-connection to those Gulf War veterans diagnosed with ALS

(Lou Gehrig's Disease). The Secretary should reexamine VA regulations for disabilities due to undiagnosed illnesses, with a focus on the intent of Congress in Public Law 106-446 to ensure Gulf War veterans are fairly and properly compensated for their disabilities.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War–related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support vigorously significant increases in the effort, and funds, devoted to such research by both the Federal Government and private entities.

Recommendations:

VA should continue to foster and maintain a close working relationship with the NAS in the effort to ascertain which toxins Gulf War veterans were exposed to and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

Congress must reject the recommendation of the Commission on Service Members and Veterans Transition Assistance to declare February 28, 1993, as the ending date of the 1991 Persian Gulf War.

Women Veterans:

VA should evaluate which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure quality health care is provided at all VA facilities.

According to the United States Census 2000, in contrast to the overall declining veteran population, the female veteran population of the United States is increasing. Of the 26.4 million veterans, 1.6 million are women.

Today more than 212,000 women serve on active military duty and represent nearly 15% of the active force. Another 149,000 women serve in the National Guard and Reserve. As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services.

Enrollment of women veterans into the VA health-care system increased 10.8% from 275,316 in FY 2001 to 304,989 in FY 2002. The projection for FY 2003 for women veteran enrollees is 378,559, representing an estimated 24.1% increase between FY 2002 and FY 2003. Between FY 2000 and FY 2002, the number of women veteran patients receiving VA health-care services increased from 154,256 to 182,434 with a projected increase of 14.9% between FY 2002 and FY 2003. Women veterans make up approximately 5% of all users of VA health-care services, and within the next decade this figure is expected to double. With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is equipped to meet their specific health-care needs.

VA is obligated to deliver health-care services to female veterans that are equal to those provided to male veterans.

According to the VA Veterans Health Administration (VHA) Handbook 1330.1, *VHA Services for Women Veterans:*

> It is a VHA mandate that each facility, independent clinic, mobile clinic, and Community-Based Outpatient Clinic (CBOC) ensure that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions that is equal in quality to that provided to male veterans.

The Independent Budget is concerned that although VA has markedly improved the way health care is being provided to women veterans, privacy and other deficiencies still exist at some facilities. VA needs to enforce, at the VISN and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities. The VHA has an excellent handbook for providing services for women veterans. Unfortunately, these guidelines and directives are not always followed at the VISN or local levels. VA needs to evaluate its clinical guidelines, best practice models, and performance and quality improvement measures to determine which health-care delivery model demonstrates the best clinical outcomes for women veterans. More than 50% of women seeking VA care are younger than 45, compared to only 15% of men. VA must be responsive to the unique demographics of this veterans' population and adjust programs and services as needed to meet their changing health-care needs.

According to VHA Handbook 1330.1, *VHA Services for Women Veterans:*

> Clinicians caring for women veterans in any setting must be knowledgeable about women's health-care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. VA has a very limited number of comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. Most facilities provide care to women in integrated primary care settings and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based to an outpatient preventative medicine health-care delivery model. The *IB* is seriously concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report *The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services* stated, in part:

> VA women's clinics were established because, unlike the private sector, where women make up 50 to 60% of a primary care practitioner's clientele, women veterans comprise less than 5% of VA's total population. As a result, VA clinicians are generally less familiar with women's health issues, less skilled in routine gender specific care, and often hesitant to perform exams essential to assessing a woman's complete health status. With the advent of primary care in VA, many women's clinics are being dismantled and women veterans are assigned to the remaining primary care teams on a rotating basis. This practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. In cases where there are relatively low numbers of women being treated at a given facility under this scenario, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health.

The IBVSOs are also concerned about the availability of quality mental health services for women veterans, especially women veterans who have experienced sexual trauma during military service. Only 43% of VAMCs have one or more designated women's health providers in outpatient mental health clinics to accommodate women veterans' special needs.

The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, "... it is essential that VA staff recognize the

importance of the environment in which care is delivered to women veterans, and that VA clinicians possess the knowledge, skill and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

Women Veterans Program Managers (WVPMs) are another key component to addressing the specialized health-care needs of women veterans. These program directors are instrumental to the development, management, and coordination of women's health services at all VA facilities.

According to VHA Handbook 1330.1, *VHA Services for Women Veterans:*

> Each VHA facility must have an appointed WVPM. (The WVPM appointed by the medical center Director should be) a health care professional...who provides health-care services to women as a part of their regular responsibilities. The WVPM will be a member of the Women Veterans Primary Health Care Team [and must participate] in the regular review of the physical environment, to include the review of all plans for construction, for the identification of potential privacy deficiencies, as well as availability and accessibility of appropriate equipment for the medical care of women.

Given the importance of this position, the *IB* is concerned about the actual amount of time WVPMs are able to dedicate to women veterans' issues. VA staff members assigned to these positions frequently complain that their duties as coordinators are collateral or "secondary" to their overall responsibilities, and that they generally do not have sufficient time to devote to women veterans' issues. WVPMs must have adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to women veterans is necessary because female veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often smaller programs, such as women veterans' programs, are endangered. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to increase the priority given to women veterans' programs to ensure that quality health care is provided in all VA facilities and that specialized services are equally available to women veterans as men veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers such as exists between women and men in VA facilities. The health-care environment directly affects the quality of care provided to women veterans and significantly impacts the patient's comfort and feeling of safety and sense of welcome. Finally, the *IB* recommends VA focus its women's health research on finding which health-care delivery model demonstrates the best clinical outcomes for women veterans to ensure they have equal access to high-quality health care at all VA facilities.

Recommendations:

VA must ensure laws, regulations, and policies pertaining to women veterans' health care are enforced at VISN and local levels.

VA needs to increase the priority given to women veterans' programs and evaluate which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans because female veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs in such areas as post traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to female veterans as male veterans.

Long-Term Care Issues

VA Long-Term Care

VA has failed to meet its statutory obligation to maintain its capacity to provide extended (long-term) care services to America's aging veterans as mandated by 38 U.S.C. § 1710B.

Since 1998, VA's average daily census (ADC) for VA nursing homes has continued to decline and VA has failed to provide comprehensive coverage for its noninstitutional long-term care services.

VA Nursing Home Care:
VA's Veteran Population (VetPop) data adjusted to the Census of 2000 reveals aging trends that will certainly increase veteran demand for both VA's institutional and noninstitutional (home and community-based) long-term care services. For example, the number of veterans in the 85–89 age groups is expected to rise from 547,735 as of September 30, 2002, to 966,669 (almost double) by September 30, 2010. Additionally, the number of veterans in the 90–94 age groups is expected to increase from 107,695 in 2002 to 314,167 (almost triple) in 2010. These aging demographics will place a tremendous strain on existing VA long-term care resources within the next 10 years.

Despite an aging veteran population VA's ADC for VA nursing homes continues to decline from the 1998 baseline number of 13,391 as required by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117 of 1999 (Mill Bill). According to VA's workload data, included in its 2004 budget submission the ADC for VA nursing homes, was 11,969 in 2002, 9,900 in 2003, and is projected to be 8,500 for 2004. Also, VA's ADC for Community Nursing Homes showed 3,834 in 2002, 4,929 in 2003, and a projected drop to 3,072 in 2004.

Yet despite this clear picture of increasing long-term care demand, VA has failed to meet its statutory obligations as mandated in 38 U.S.C. § 1710B to maintain its nursing home capacity at 1998 levels. Section 1710B states, "The Secretary shall ensure that the staffing and level of extended care services provided by the Secretary nationally in facilities of the Department during any fiscal year is not less than the staffing and level of such services provided nationally in facilities of the Department during fiscal year 1998."

VA Noninstitutional Care (Home and Community-Based Services):
In addition to a decline in VA nursing home capacity, VA has done a poor job of correcting service gaps and facility restrictions that limit veterans' access to noninstitutional long-term care services provided under the Mill Bill.

In May of 2003, the GAO issued a report (GAO-03-487) titled *Service Gaps and Facility Restrictions Limit Veterans' Access to Non-institutional Care.* The report addresses service gaps for six noninstitutional VA services mandated by the Mill Bill. The GAO found that of the 139 VA facilities it reviewed, 126 do not offer all six of these services. The services were adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Of these six services, veterans have least access to respite care.

The GAO also reported that veterans' access to noninstitutional services is even more limited than the numbers suggest because even when facilities offer these services they often do so in only part of the geographic area they serve. The report also states that at least nine facilities limit veterans' eligibility to receive these services based on their level of disability related to military service, which conflicts with VA's own eligibility standards. These restrictions have resulted in waiting lists at 57 of VA's 139 facilities.

The GAO said that "VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care." The GAO went on to say, "Without emphasis from VA headquarters on the provision of noninstitutional services, field officials faced with competing priorities have chosen to use available resources to address other priorities."

The GAO issued two recommendations to correct VA's access barriers to noninstitutional care:

- VA should ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.
- VA should refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.

VA Long-Term Care Workload:

The following data is taken from VA's FY 2004 budget submission and is expressed in Average Daily Census (ADC) numbers.

INSTITUTIONAL CARE:	2002	2003	2004	INCREASE/ DECREASE
VA Domiciliary	5,484	5,577	5,672	+ 95
State Home Domiciliary	3,772	4,323	4,389	+ 66
VA Nursing	11,969	9,900	8,500	- 1400
Community Nursing Home	3,384	4,929	3,072	- 1,857
State Home Nursing	15,833	17,600	18,409	+ 809
Subacute Care	1,122	956	860	- 96
Psychiatric				
Residential Rehabilitation	1,349	1,429	1,508	+ 79
Institutional Total	43,363	44,714	42,410	- 2,304

NONINSTITUTIONAL CARE	2002	2003	2004	INCREASE/ DECREASE
Home-Based Primary Care	8,081	10,024	13,024	+ 3,000
Contract Home Health Care	3,845	3,959	4,070	+ 111
VA Adult Day Care	427	442	458	+ 16
Contract Adult Day Care	932	1,352	1,962	+ 610
Homemaker/Home Health Aide	4,180	4,247	4,315	+ 68
Community Residential Care	6,661	6,821	6,821	0
Home Respite	0	1,284	1,552	+ 268
Home Hospice	0	0	492	+ 492
Noninstitutional Care Total	24,126	28,129	32,694	+ 4,565
Long-Term Care Total	67,489	72,843	75,104	+ 2,261

These VA workload numbers show a clear decline in VA nursing home care and contract community nursing home care and an overall decline in capacity for VA institutional care services. While VA noninstitutional care reflects a modest increase in ADC, the projected increase in 2004 services remains to be seen.

Over the next 10 years an aging veteran population will have an increased demand for VA long-term care services. Despite mandating legislation, VA has failed to meet legislative requirements requiring it to maintain long-term care capacity at 1998 levels and provide noninstitutional long-term care services systemwide. VA's capacity to provide VA nursing home care continues to decline despite increased appropriations from Congress. In 2003 the GAO reported that VA has failed to provide these noninstitutional long-term care services in a comprehensive manner. It is clear that VA must do more to meet the increasing demand for VA long-term care services.

VA has attempted to amend Congressional language mandating VA long-term care capacity at 1998 levels by allowing VA to count nursing home care furnished by private providers and state veterans' nursing homes. The IBVSOs are adamantly opposed to this suggestion and continue to believe the only true measure of VA capacity is one that counts only the services provided directly by VA.

Sadly, it appears that VA would prefer to off-load America's aging veterans who require nursing home care to the private sector or other Federal payers. It also appears that VA is allowing its facilities to provide noninstitutional long-term care as they see fit instead of providing these services as mandated by Congress. Noninstitutional long-term care services can be a great benefit to America's veterans and in some cases can reduce the timing and need for nursing home care. But the availability of these services must be nationwide and unrestricted by the manipulation of eligibility standards.

The IBVSOs believe VA must move to embrace its aging veteran population by improving its mind-set and current culture, which seems to see this veteran population as a financial burden rather than a national treasure.

Recommendations:

Congress must provide the necessary resources to enable VA to meet its legislative mandate to maintain its long-term care services at the 1998 levels and meet increasing demand for these services. VA requires up to $600 million dollars to correct this long-term care bed deficit and provide required increased number of home- and community-based services.

VA must meet its statutory obligation to provide long-term care services in its facilities.

VA must work to identify and incorporate additional noninstitutional services and programs that can improve and bolster VA's ability to meet increasing demand as required by law.

VA must ensure that its facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services.

VA must refine current performance measures to help ensure that all facilities provide veterans with access to required noninstitutional services.

Assisted Living:

Assisted living can be a cost-effective alternative to nursing home care for many of America's veterans. The IB also believes that an expansion of the assisted living pilot project to additional VISNs will benefit veterans and provide useful information to VA regarding other assisted living markets.

Assisted living (AL) is a special combination of individualized services, which include housing, meals, health care, recreation, and personal assistance, designed to respond to the individual needs of those who require assistance, with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). A key feature is the delivery of services in a home-like setting. Assisted living can range from renovated homes serving 10 to 15 individuals or high-rise apartment complexes accommodating 100 people or more. The philosophy of AL emphasizes independence, dignity, and individual rights.

Therefore, AL can be a viable alternative to nursing home care for many of America's aging veterans who require ADL or IADL assistance and can no longer live at home. However, there are some AL regulatory barriers that must be overcome before AL will be open to many disabled veterans. Currently, AL is an industry that is regulated by state law, and many states have regulations that are not friendly to disabled veterans or other people with disabilities. Before VA becomes an AL provider or establishes relationships with private AL providers, solutions to these regulatory barriers

must be found to enable full participation in any VA or private AL program.

VA has argued that it should not become an AL provider because it is not in the business of providing housing to its veterans. However, VA has long been in the business of providing housing for veterans who use VA domiciliary programs, VA nursing homes, and VA contract nursing homes. VA could easily harness its vast long-term care expertise and building resources to become an efficient provider of AL services. AL could be provided through an expanded VA domiciliary care program if modifications were made to serve this population.

VA medical centers have already looked into public-private partnerships to provide AL on VA property through VA's enhanced-use leasing authority. Under this program, VA leases unused land to private AL providers in exchange for services to veterans at a negotiated rate. Additionally, VA's CARES initiative has called for the broad use of AL in its Draft National CARES Plan.

Public Law 106-117, "The Veterans Millennium Health Care and Benefits Act," authorized VA to establish a pilot program to determine the "feasibility and practicability of enabling eligible veterans to secure needed assisted living services as an alternative to nursing home care." VA's Northwest Veterans Integrated Service Network, VISN 20, is implementing the Assisted Living Pilot Program (ALPP) in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon, and Roseburg, Oregon; and Spokane, Washington, and the Puget Sound Health-Care System (serving the Seattle and American Lake, Washington, and White City, Oregon).

Following are highlights that reflect a preliminary review of the implementation of the program and the first year of program operation through December 2002. The final report, as mandated by law, will be provided to Congress in October of 2004. VA findings thus far include:

- The implementation of the ALPP has been successful: Despite significant challenges, the ALPP has negotiated contracts with a total of 89 vendors. All sites are actively recruiting and enrolling veterans for the program. From January 29, 2002, through December 31, 2002, a total of 181 veterans were placed in ALPP facilities.
- A new computerized database is allowing efficient recruitment, processing of payments, high-quality data collection, and data analysis for ongoing management feedback and evaluation.
- The average ALPP veteran is a 69-year-old unmarried white male who is not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.
- ALPP veterans show significant functional impairment and a wide variety of physical and mental health conditions.
- 36 adult family homes, 39 assisted-living facilities, and 14 residential care facilities have been contracted with to date. The average vendor has 25 rooms/apartments, ranging from 2 to 208.
- Preliminary data on the cost of ALPP placements are available. Initial findings suggest the mean cost per day for the first 160 enrolled veterans (not including bed hold days) is $75.10.
- The ALPP's implementation will allow VA to obtain an accurate picture of the feasibility of these services in VA based on high-quality managerial and clinical staff with commitment to the goals of evaluation, the new data base, and a wide variety of important issues arising from a multisite demonstration.

Recommendations:

VA must expand and broaden the ALPP authorized by P.L. 106-117.

VA must investigate and eliminate state regulatory barriers that prevent disabled veterans from enrollment and full participation in any VA ALPP, VA AL program, or any other AL arrangement or contract for private AL services utilizing VA property.

VA should aggressively pursue development of AL capacity within existing VA programs that are adaptable to AL and through enhanced-use lease opportunities with private-sector providers and partnerships.

Congress must pass permanent legislation and provide funding to allow VA to provide AL.

Veterans' Access to Noninstitutional Long-Term Care Services:

Veterans' access to noninstitutional long-term care programs is limited by the lack of services available through VA and restrictions imposed by local VA facilities.

Changes in VA eligibility have resulted in an increase in the number of veterans eligible for VA health care, including noninstitutional, long-term care services. The demand for these services is likely to increase significantly during the next decade due to the increasing age of our Korean- and Vietnam-era veteran population. VA estimates the number of veterans age 85 and older—those most in need of long-term care—will more than double by year 2012.

In response to this demand, Congress passed the Veterans Millennium Health Care and Benefits Act of 1999, P.L. 106-117, requiring VA to provide enrolled veterans equal access to three noninstitutional, long-term programs: adult day health care, geriatric evaluations, and respite care. VA is also required to provide home-based primary care, skilled home health care, and homemaker/home health aide as part of its standard benefits package.

Unfortunately, veterans' access to these six noninstitutional long-term care programs is limited by the lack of services available through VA and restrictions imposed by local VA facilities. Many facilities restrict access to a small portion of the respective geographic areas for which they are responsible; impose their own eligibility requirements, e.g., service-connected veterans only; or limit the number of veterans allowed to participate in the various programs, resulting in veterans being placed on waiting lists for noninstitutional services they need now. These restrictions conflict with VA eligibility standards and cause an inequity in access for all enrolled veterans.

Recommendations:

The IBVSOs recommend that VA specify in Department policy (and enforce) the requirement that all eligible veterans be afforded equal and timely access to noninstitutional, long-term care programs.

VA should promulgate performance standards and provide adequate program guidance to ensure nationwide compliance with this policy.

VA MEDICAL AND PROSTHETICS RESEARCH

Funding for Medical and Prosthetic Research:

Funding for VA medical and prosthetics research is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade, and replace aging research facilities.

The Department of Veterans Affairs (VA) medical and prosthetic research is a national asset that helps to attract high-caliber clinicians to practice medicine and conduct research in VA health-care facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

Focused entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population, VA research is patient oriented: 60% of VA researchers treat veterans. As a result, the VHA, which is the largest integrated medical care system in the world, has a unique ability to translate progress in medical science to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other Federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment

to steady and sustainable growth in the annual research and development (R&D) appropriation is necessary for maximum productivity.

The annual appropriation for the Medical and Prosthetics Research Program, which makes this leverage and synergy possible, relies on an outdated funding system. A thorough review of VHA research funding methodology is needed to ensure adequate funds for both the direct and indirect costs of this world-class research program. The Office of Research and Development allocates R&D funding for the direct costs of projects, while indirect costs and physicians' and nurses' salaries are covered by the medical care appropriation, with no centralized means to ensure that each facility research program receives adequate support. As demands on medical center resources increase, physicians have difficulty finding time to fulfill their clinical, administrative, and training responsibilities **and** to conduct research. Also, funds to staff the necessary oversight committees—Research and Development, Institutional Review Boards, Animal Safety, Biosafety, etc.—are scarce.

VA-funded programs are barely one-third (37%) of the total VA research enterprise, yet VA has failed to secure equitable reimbursement for its indirect costs from all of its research partners, particularly other Federal agencies. VA investigators are to be applauded for their success in obtaining extramural grants, but the medical care appropriation should not bear the entire cost of the necessary infrastructure.

For decades, VA has failed to request, and Congress has failed to mandate, construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor construction funding amounting to more than $4 million and $29 million for major construction. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements, as well as at least one major research construction project per year, until the backlog is addressed.

VA medical and prosthetics research is highly productive and has a direct impact on the quality of care provided to veterans.

Medical and Prosthetic Research Account:

VA cannot continue to achieve break-through applications in health-care delivery without adequate growth in the annual R&D appropriation.

Recent VA research achievements include findings that flu shots may also protect the elderly from pneumonia, heart attacks, and strokes; a combination of drugs results in decreased suffering and shorter hospital stays for schizophrenia patients; and believing that tumors spread when exposed to air, African Americans are more likely to decline lifesaving surgery to treat lung cancer. These and many more VA research breakthroughs have direct applications to health-care delivery for veterans as well as the Nation as a whole. However, a commitment to steady and sustainable growth in the annual R&D appropriation is necessary for VA to continue its long record of achievement.

Recommendation:

The IBVSOs recommend an FY 2005 appropriation of $460 million to offset the higher costs of research resulting from biomedical inflation and wage increases as well as opportunities for new breakthroughs.

Medical and Prosthetic Research Issues

A New Vision for VA Research

The VA research program is in need of a thorough review and long-term planning involving external stakeholders.

During 2003, significant changes in the VA research program were implemented without prior public debate or input from stakeholders. Despite the resulting turmoil, VA researchers added to their remarkable record of achievement, and the IBVSOs are confident that VA research has much to offer in advancing diagnosis and treatment of disease and disability. However, there is a need to build a new foundation of broad consensus about the purpose and scope of the VA research program.

Recommendation:

VA should convene a consensus committee involving VA personnel and external stakeholders to conduct a thorough review of the VA research program. The committee should propose to the Secretary and Congress a clear vision for the future with recommendations on complex policy matters in need of resolution.

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Restructuring the Research Funding Methodology

More study is needed before deciding whether to assign to the Office of Research and Development (ORD) responsibility for administering the Veterans Equitable Resource Allocation (VERA) research support funds.

Ensuring adequate, accountable funding for both the direct and indirect costs of research is an essential factor in the success of any research enterprise. Currently, ORD allocates R&D funding for the direct costs of projects, while the indirect costs, and physicians' and nurses' salaries are covered by the medical care appropriation. As a result, there is no centralized means to ensure that each facility's research program receives adequate support. At the same time, the flexibility of the current methodology at the local level is essential to meet the variable needs of research, academic, and clinical cycles.

Recommendations:

The IBVSOs do not support assigning to ORD administration of the FY 2005 VERA research support dollars. Prior to consideration of this possibility, VA must demonstrate that it has a workable plan for implementation that provides accountability while preserving the local flexibility of the current methodology. At a minimum, such a plan should be pilot-tested at three sites before contemplating national implementation.

Congress must ensure adequate resources for both the direct and indirect costs of advancing medical diagnosis and treatment.

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Research Infrastructure:

VA research infrastructure is in need of repair and improvement.

The IBVSOs applaud Congress and VA for beginning to address in the FY 2004 budget the critical need for minor construction funding to maintain, upgrade, and replace VA's aging research facilities. However, a backlog of high priority research sites in need of minor construction funding amounting to more than $45 million still remains. Additionally, some research facilities are beyond repair, and $290 million is needed for construction to begin replacing outdated buildings.

Recommendation:

Congress and VA must work together to ensure sufficient funding for research facility maintenance and improvements as well as at least one major research construction project per year until the backlog is addressed.

Paralysis Research, Education, and Clinical Care Center and Quality Enhancement Research Initiatives for Paralysis:

Congress and VA should support the Christopher Reeve Paralysis Act of 2003, which would address needs of the paralyzed veteran community through research, rehabilitation, and quality of life programs.

VA through the Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical, and rehabilitative care to veterans. Among VHA developments are research, education, and clinical centers (RECCs), which focus on specific conditions common in veterans. RECCs are designed around the idea of translational research, and they develop educational and training initiatives to implement best practices into the clinical settings of VA.

VA research opportunities attract first-rate clinicians to practice medicine and conduct research in VA healthcare facilities, thereby keeping veterans' health care at the cutting-edge of modern medicine. By promoting consortia-style research, research conducted in conjunction with the Nation's leading medical schools, VA promotes an environment of medical excellence and ingenuity that benefits every veteran receiving VA care and, ultimately, all Americans.

VA's Quality Enhancement Research Initiative (QUERI) is designed to translate research discoveries and innovations into better patient care and systems improvements. QUERI focuses on eight high-risk and/or highly prevalent diseases or conditions among veterans: chronic heart failure, diabetes, HIV/AIDS, ischemic heart disease, mental health, spinal cord injury, stroke, and substance abuse.

VA could expand and coordinate the activities of the VHA to develop a paralysis research, education, and clinical care center, as well as establish a Quality Enhancement Research Initiative for Paralysis. Together, the programs would encourage collaborative research, identify best practices, define existing practice patterns and outcome measurements, and improve patient outcomes associated with improved health-related quality of life through rehabilitation research.

Recommendations:

Congress should enact the Christopher Reeve Paralysis Act of 2003 (S. 1010, H.R. 1998), which would establish a paralysis RECC and consortia and QUERIs for paralysis.

The VHA should establish a paralysis RECC and consortia to focus on basic biomedical research on paralysis; rehabilitation research on paralysis; health services and clinical trials for paralysis that results from central nervous system, trauma, or stroke; dissemination of clinical and scientific findings; and replication

of the findings of the centers for scientific and translational purposes. The formation of centers into consortia provide for the linkage and coordination of information among the centers to ensure regular communication between members.

The VHA should establish QUERIs for paralysis, which translate clinical findings and recommendations into practices within the VHA; identify best practices; define existing practice patterns and outcome measurements; improve patient outcomes associated with improved health-related quality of life; and evaluate a quality enhancement intervention program for the translation of clinical research findings into routine clinical practice.

Adminstative Issues

Critical Need for a Strong Nursing Workforce:

VA needs a committed, satisfied, and well-educated nursing workforce to sustain the high-quality care our veterans deserve.

VA has the largest nursing workforce in the country, with more than 55,000 registered nurses, licensed practical nurses, and other nursing personnel. The Country and VA are facing an unprecedented nursing shortage, a shortage that could potentially have a profound impact on the care given to our Nation's veterans. VA nurses are an essential component in delivering high-quality, compassionate care to veterans, and VA must be able to retain and recruit well-qualified nurses in order to continue that care.

VA is facing serious challenges in providing consistently *high* quality care. Compensation, benefits, and workplace issues affect VA's ability to retain and recruit nurses in today's highly competitive labor market. The average age of a VA registered nurse is 47.4 years, and only 17% are under 40 years of age. By the end of 2003, 35% of VA's registered nurses were eligible to retire.

The October 23/30, 2002, issue of the *Journal of the American Medical Association* reported job dissatisfaction among hospital nurses nationwide is four times greater than the average for all U.S. workers, and one in five hospital nurses reported an intention to leave his or her current job within a year. Overall, many VA nurses report wage scales and benefits are inadequate and are a major factor in their decision to maintain employment with VA.

An article in the September 24/30, 2003, issue of the *Journal of the American Medical Association* examined whether the proportion of hospital RNs educated at the baccalaureate level or higher is associated with mortality and failure to rescue (deaths in surgical patients with serious complications). The documentation revealed significantly better patient outcomes in hospitals with more highly educated RNs at the bedside. This article reinforces VA's commitment to the VA Nurse Qualification Standard and the expectation of a bachelor's of science degree in nursing for advancement beyond the entry level, as well as a commitment of economic support for associate degree nurses to pursue an advanced degree.

In the current nursing shortage, public policy discussion has centered on how to increase the supply of RNs. VA invests in two major educational pathways into nursing: practice-associate or bachelor's degree programs. However, little attention has been paid to considering how investments of VA funds in these programs will best serve the good of our veteran patients. The documentation of significantly better patient outcomes in hospitals with more highly educated RNs at the bedside underscores the importance of placing greater emphasis on policies to alter the educational composition of the future nurse workforce. VA funding should aim at shaping a workforce best prepared to meet the needs of our aging veteran

population and enhancing the quality of care they receive.

Unfortunately, the VA health-care budget has not kept up with rising health-care costs, and the situation grows more critical each fiscal year. Adequate funds must be appropriated for recruitment and retention programs for the nursing workforce.

VA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also causes diversions of veterans to private-sector facilities at great cost. This situation is complicated by the fact that VA has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier stays, and requires more skilled nursing care.

Inadequate funding has resulted in nationwide hiring freezes. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume nonnursing duties due to shortages of ward secretaries, building management, and other support personnel. These staffing deficiencies have an impact on both patient programs and VA's ability to retain an adequate nursing workforce.

VA nurses are a national treasure and are dedicated to the mission of caring for America's heroes. Establishing and support of the following recommendations as well as the structures that support the work of nursing will foster the environment necessary for a successful future. Our veterans deserve it.

Recommendations:

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

To meet this goal VA should:

- Establish recruitment programs that enable VA to remain competitive with private-sector marketing strategies;
- Reestablish the VA Professional Scholarship Program;
- Continue the Employee Debt Reduction Program to include all VA nursing personnel;
- Continue funding for the National Nursing Education Initiative;
- Implement youth outreach programs to foster selection of nursing as a career choice;
- Develop special programs between local VA facilities and community colleges/universities with a focus on preparing all levels of future VA nursing personnel;
- Increase support of career path development within nurses' qualification standards; and
- Ensure adequate nursing support personnel to achieve excellence in patient care and outcomes.

Volunteer Programs:

VHA's volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 534 million hours of volunteer service to America's veterans in VA health-care facilities. As the largest volunteer program in the Federal Government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee, composed of 63 major veteran, civic, and service organizations, which reports to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2003, VAVS volunteers contributed a total of 12,983,728 hours to VA health-care facilities. This represents 6,221 FTEE positions. These volunteer hours represent more than $215 million if VA had to staff these volunteer positions with FTEE employees.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated at $42 million in gifts and donations. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the Nation's veterans and to VA.

The need for volunteers continues to increase dramatically as more demands are being placed on VA staff. Health care is changing, which provides opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 287,000 volunteer hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our Nation.

Recommendations:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

The VHA should develop volunteer opportunities in community-based and home-health settings and recruit local volunteers.

The VHA should develop partnerships with local businesses and corporations for volunteer and program support.

The VHA should include VAVS volunteer productivity data in VHA facility productivity measurement systems and facility management performance standards to create incentives for facilities and managers to utilize VAVS volunteers effectively.

The VHA should initiate volunteer recruitment strategies for age groups 20–40 within each VISN.

VA should encourage all national cemeteries to expand volunteer programs.

Contract Care Coordination

VA does not ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private community-based providers at VA expense.

To ensure a full continuum of health-care services, VA spends approximately $1 billion a year for medical care outside the VA health-care system when privately contracted medical services are needed. Current legislation allows VA to contract for non-VA health care (fee basis) only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. Unfortunately, no consistent process exists in VA for veterans receiving contracted care services to ensure that:

(1) veterans are getting the appropriate, most cost-effective care delivered by certified or credentialed providers;

(2) continuity of care is properly monitored by VA and that veteran patients are directed back to the VA health-care system for follow-up care when possible;

(3) veterans' medical records are properly updated with any non-VA medical and pharmaceutical information;

(4) the process is part of a seamless continuum of care/services to facilitate improved health-care delivery and access to care.

Currently, the Preferred Pricing Program allows VA to reap savings when veterans who need contracted care select a physician within the established Preferred Provider Organization (PPO) network. Preferred pricing allows contracted VA medical facilities to save money when veterans need non-VA health-care services by using network discounts. However, VA's program for contracted care is *passive* and only allows for cost savings when veterans coincidentally *choose* to receive care from the contractor's provider network. VA currently has no system in place to direct veteran patients to the participating PPO providers so that VA can:

(1) receive a discounted rate for services rendered;

(2) use a mechanism to refer to credentialed, quality providers; and

(3) exchange clinical information with non-VA providers

Although preferred pricing is available to all VA medical centers (VAMCs), not all facilities take advantage of these cost savings. Therefore, in many cases VA is paying more for contracted medical care than necessary. Though preferred pricing was a significant improvement in purchasing care for the best value when it was introduced in 1999, and despite the significant savings achieved (more than $19 million), there are several major improvements that can be made to improve the access, quality, and cost of non-VA care.

By partnering with an experienced managed care contractor, VA can define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program would include:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks would address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor would require providers to meet specific requirements, such as the timely communication of clinical information to VA, electronic claims submission, meeting VA established access standards, and complying with directors' performance measures.
- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical condition, the care coordination contractor addresses appropriateness of care and continuity of care. The result for the veteran is an integrated episode of care.
- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.
- Best value health-care purchasing.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating PPO physicians at VA expense. Additionally, VA is not fully optimizing

its resources to improve timely access to medical care through coordination of private contracted community-based care. A care coordination contractor could be used to temporarily fill a gap or deal with unexpected backlogs. Prior to the implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan, it is important for VA to develop an effective care coordination model that achieves VA's health care and economic objectives. Doing so will improve patient care delivery, optimize the use of VA's limited resources, and prevent overpayment when utilizing community contracted care.

Recommendations:

VA should establish a phased-in contracted care coordination program that is based on principles of medical management.

Whenever possible, veterans who receive care outside VA, at VA expense, should be required to do so in the care coordination model.

VA should engage an experienced contractor willing to go at risk to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor would jointly develop identifiable and achievable metrics to assess program results and will report these results to stakeholders.

Components of a care coordination program should include claims processing, centralized appointment scheduling, and a call center or advice line for veterans who receive care outside the VA health-care system—and should be implemented at VA's expense.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES (MAMOE)

The Medical Administration and Miscellaneous Operating Expenses (MAMOE) appropriation enables supervision and administration in support of the goals and objective of the VHA's comprehensive and integrated health-care system. MAMOE functions include development and implementation of policies, plans, and broad program activities; assistance to the networks in attaining their objectives; and follow-up actions necessary to ensure complete accomplishment of goals. The Facilities Management Service Delivery Office, funded on a reimbursable basis by other VA components, supports project management; architectural engineering; real property acquisition; and disposition, construction, and renovation of facilities under the jurisdiction of, or used by, VA.

MAMOE Account

The Independent Budget VSOs recommend the MAMOE account be funded by the Congress at $86.7 million for FY 2005. The recommended amount is the minimum funding consistent with maintenance of current operations through all MAMOE departments.

MAMOE Recommended Budget Appropriation
(Dollars in Thousands)

FY 2005 IB RECOMMENDATION BY TYPE OF SERVICE	
Personnel Compensation	$71,408
Travel and Transportation of Persons	1,319
Rental Payments to GSA	6,160
Communications, Utilities, and Miscellaneous Charges	1,522
Other Services	3,698
Supplies and Materials	1,353
Equipment	1,229
IB Recommended FY 2005 Appropriation	$86,689

MAMOE Issues

Quality Assurance and Policy Guidance:

Funding shortfalls in the MAMOE account have left VA unable to implement adequate quality assurance efforts or to provide adequate policy guidance within the 21 VISNs.

Despite VHA headquarters' enormous oversight responsibility, large reductions in VHA National Headquarters' staff have caused serious degradation of VA's ability to manage quality of care, provide effective policy guidance, or ensure collection and management of essential information. MAMOE reductions have also adversely impacted VA's critical oversight function and made it difficult to gauge VA's compliance with Congressional mandates.

The work of VHA's Office of Quality and Performance is of the utmost importance, not only to the patient, but also to the Administration and to the Congress who are ultimately responsible for veterans' health policy. What data are available certainly support the contention that VA care is as good as or better than care rendered outside of the VA. However, a quality program must have adequate staff to successfully perform all its necessary functions and be fully accountable to its various constituencies. Additional quality management staff in VA headquarters would translate to more thorough collection, analysis, and reporting of information about health-care quality by network and across the system.

VHA National Headquarters has the critical role of ensuring VA fulfills its Congressional mandate to maintain the capacity for provision of specialized services. Although the VHA takes great pride in its efforts to aggregate patient data within the system, the agency must be equally capable of providing in-depth analyses of its collection in order to understand who is providing the highest quality care and how those analyses can be shared systemwide. The VHA is charged with establishing national policies and priorities, a responsibility whose successful execution further reductions to MAMOE will seriously jeopardize.

VA is the Federal Government's largest employer of physician assistants (PAs), with more than 1,290 FTEE positions. The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the VHA establish a physician assistant advisor position to the Office of the Under Secretary for Health. Congress strongly encouraged that the VHA ensure the PA advisor position is full-time and located in the VA Central Office or in a VA medical center in close proximity to Washington, DC; further, that sufficient funding be provided to support the

administrative and travel requirements associated with the position. Congress directed that VA report by March 3, 2003, on the progress made in this regard. As of this writing, the PA advisor position has not been established as full-time. Moreover, the minimal travel funds made available to the part-time incumbent in FY 2004 have been significantly decreased in the FY 2005 allocation. Indeed, the position is not assigned to the Office of the Under Secretary for Health, does not reside in or near the VA Central Office, and does not appear on the VHA organizational chart.

Health-care delivery and its management are extremely dynamic. Advances in information management/information technology (IM/IT) are even more so, and of ever-increasing importance. New technologies and concepts are both prerequisites to and great opportunities for health-care improvement. IM/IT is the key to many process improvements, evidence-based medicine, population-based research, and other health-care quality enhancements.

The Principi Commission recommended, and the IBVSOs endorse, joint acquisition of a clinical information system to replace the VA's legacy systems. In this connection, the GAO recommended strengthening the Government Computer-Based Patient Record (GCPR), since renamed the Federal Health Information Exchange (FHIE), because of the importance of VA/DOD interoperability.

Recommendations:

Congress and the Administration must provide adequate funding to the MAMOE account to support VHA National Headquarters' role relative to quality management; policy guidance; and information collection, analysis, and dissemination.

VHA National Headquarters must maintain hands-on oversight to meet Congressional mandates to monitor and maintain the capacity for specialized programs.

VHA must staff the PA advisor with one Congressionally approved FTEE position.

Congress should fund, and the VA should implement, new FHIE capability.

Construction Programs

The Department of Veterans Affairs construction budget includes major construction, minor construction, grants for construction of state extended care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund.

The Historical Appropriations for VA Major and Minor Construction chart listed on the next page clearly shows that since 1993 VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to the current low level. The FY 1993 combined total was $600 million; however, by FY 2003, the total had decreased to only about $300 million. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets.

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that VHA's investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2% and 4% of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is approximately $35 billion. The 2%–4% range would therefore equate to annual funding of $700 million to $1.4 billion

There continues to be major political resistance to fund an adequate construction budget before the Capital Asset Realignment for Enhanced Services (CARES) process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the "ES"—enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of systemwide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance, and renovations of VA facilities.

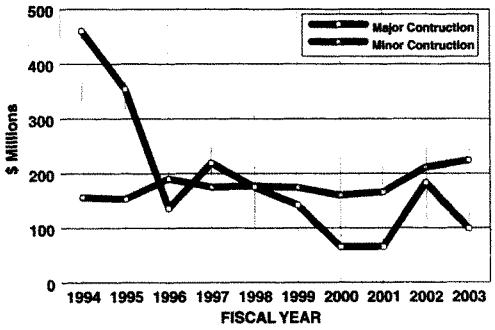
While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-

term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In additional, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The IBVSOs are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

CHART 2. HISTORICAL APPROPRIATIONS FOR VA MAJOR AND MINOR CONSTRUCTION



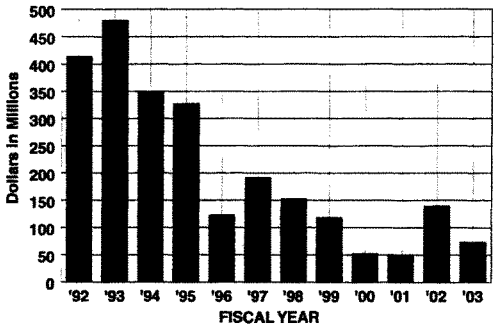
MAJOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate **$571 million** to the Major Construction Account for FY 2005. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Construction, Major Projects Recommended Appropriation
FY 2005 IB Recommendation by Type of Service
Medical Program (VHA)

Seismic Improvements	$285,000
Clinical Improvements	25,000
Patient Environment	10,000
Research Infrastructure Upgrade and Replacement	50,000
Advance Planning Fund	60,000
Asbestos Abatement	60,000
National Cemetery Administration	81,000
IB Recommended FY 2005 Appropriation	$571,000

CHART 3. MAJOR CONSTRUCTION BUYING POWER ADJUSTED FOR INFLATION



MINOR CONSTRUCTION ACCOUNT

The IBVSOs recommend that Congress appropriate **$545 million** to the Minor Construction Account for FY 2005. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, a staff office account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Construction, Minor Projects Recommended Appropriation
FY 2005 Recommended by Type of Service
Medical Program (VHA)

Inpatient Care Support	$130,000
Outpatient Care and Support	100,000
Infrastructure and Physical Plant	150,000
Historic Preservation Grant Program	25,000
Other	25,000
VBA Regional Office Program	35,000
National Cemetery Program	35,000
VA Research Facility Improvement and Renovation	45,000
IB Recommendation FY 2005 Appropriation	$545,000

CONSTRUCTION ISSUES

CORRECT SEISMIC DEFICIENCIES:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed at "significant" seismic risk and buildings that are at "exceptionally high risk" of catastrophic collapse or major damage. Currently, 890 of VA's 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

Four exceptionally high-risk seismic correction projects—Palo Alto, San Francisco, West Los Angeles, and Long Beach—were included in VA's recent budget submission; however, none of these seismic projects were funded. These four facilities have been classified as the most exceptionally high risk for catastrophic collapse or major damage.

The IBVSOs believe, as we have indicated in the past, that there is political resistance to fund any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope.

Also, consideration must be given to enhanced service recommendations provided for CARES. Due to the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time.

Recommendations:

Congress should appropriate $285 million to correct seismic deficiencies.

VA should schedule facility improvements projects and CARES recommendations concurrently with seismic corrections.

Inadequate Funding/Declining Capital Asset Value:

VA's health-care facility infrastructure is grossly undercapitalized.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In *The Independent Budget for Fiscal Year 2004,* we cited the recommendations of the interim report of the President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF). That report was made final in May 2003. To underscore the importance of this issue, we will cite the recommendation of the PTF again this year.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64% of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2% of plant replacement value for its entire facility infrastructure. A minimum of 5% to 8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the DOD adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

It was also recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF also indicated that "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF believes that VA must accomplish three key objectives:

(1) invest adequately in the necessary infrastructure to ensure safe, functional environments for health-care delivery;

(2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and

(3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

Additionally, it was recommended by the PTF report that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels." The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure.

The IBVSOs concur with the provisions contained in the PTF final report. If construction funding continues to be inadequate, it will become increasingly difficult for VA to provide high-quality services in old and inefficient patient care settings.

Recommendation:

Congress must ensure that there are adequate funds for the major and minor construction programs so that the VHA can undertake all urgently needed projects and correct the system's aging infrastructure.

Increase Spending on Nonrecurring Maintenance:

The deterioration of many VA properties calls for increased spending on nonrecurring maintenance.

The IBVSOs support the Price Waterhouse recommendation that VA spend at least 2% of the value of its buildings or $700 million annually on upkeep. The IBVSOs believe that $400 million should be appropriated in FY 2005 with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of VA properties is achieved.

Recommendations:

Congress should appropriate no less than $400 million for nonrecurring maintenance in FY 2005 to provide for adequate building maintenance.

VA should direct no less than $400 million for nonrecurring maintenance in FY 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

Empty or Underutilized Space at Medical Centers:

VA should avoid the temptation to reuse empty space inappropriately.

The suggestion has been made that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. Furthermore, it has been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical requirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a

space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger extensive "domino" impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics. Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the "shell" space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a "gut" renovation to accommodate medical functions usually costs approximately 85% of the cost of similar new construction. If the renovation plan is less efficient, or the "domino" impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall "modern" structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary structures. Many current VA medical centers are built around prototypical "Bradley buildings." These structures were rapidly constructed in the 1940s and 1950s for returning World War II veterans. Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The older hospital's wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital's central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics often make it unsuitable for modern medical functions.

VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate uses for its nonhistoric vacant properties.

Recommendation:

VA should develop a comprehensive plan for addressing excess space in nonhistoric properties that is not suitable for medical or support functions due to its permanent characteristics or location.

Preservation of VA's Historic Structures:

VA's extensive inventory of historic structures must be protected and preserved.

VA's historic structures provide direct physical evidence of America's proud heritage of veterans' care, and they enhance our understanding of the lives and sacrifices of the soldiers and sailors that fashioned our country. VA owns almost 2,000 historic structures. Many are suffering from neglect and deteriorate further every year. These structures must be stabilized, preserved, and protected. The first step in addressing this important legal and moral responsibility is for VA to develop a comprehensive national program for its historic properties. Because the majority of these structures are not suitable for modern patient care, the current CARES planning process will *not* produce a national strategy for the preservation of historic properties. A separate initiative must be undertaken immediately.

VA must inventory its historic structures and establish broad classifications regarding their current physical condition and their potential for adaptive reuse. This reuse may be either by VA medical centers or by local governments, nonprofit organizations, or private-sector businesses. In order to accomplish these initial objectives, we recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. This expertise should prove helpful in establishing this program. In addition, VA must expand its current staffing for this new task.

In conjunction with an adaptive reuse program, VA needs to develop legal models and strict administrative policies for protecting those historic structures that are leased or sold. VA's responsibilities, for example, could be addressed through legal easements on appropriate property elements, such as building exteriors, interiors, or grounds. The National Trust for Historic Preservation has successfully completed a cooperative agreement assisting the Department of Army with the management of its historic properties.

We propose a $25 million budget for FY 2005 in order to stabilize, preserve, and reuse the thousands of historic VA properties. The funds should also be used to maintain VA's artifacts and collections and to provide grants to local organizations for preservation activities related to veterans facilities. We support the proposed language in Section 8171 for the establishment of a fund and for its purpose.

The protection and preservation of VA's historic structures is an important responsibility that the Department has ignored for too long. Faced with scarce funding and competing patient care demands, VA management has delayed addressing this issue for decades. We therefore recommend that specific funding and detailed responsibilities are included in the FY 2004 budget for this purpose.

Recommendation:

Specific funds should be included in the FY 2005 budget to develop a comprehensive program for the preservation and protection of VA's inventory of historic properties.

CARES ISSUES

Establishing a Program for Medical Center Master Plans:

Each VA medical center needs to develop a detailed facility master plan.

CARES will *not* produce detailed facility master plans for each VISN medical center. Without these facility plans, the CARES recommendations cannot be efficiently implemented. Potential benefits of the lengthy and expensive CARES medical planning process will be jeopardized by hasty and ill-conceived construction planning. The construction budget should therefore include $100 million to fund master plans for the 167 VA medical centers. In order to implement this detailed facility planning, VA must immediately establish guidelines and formats for these master plans so that work can proceed. Since VISN 12 planning was completed in the CARES pilot phase, this network would be a good staring point for the master facility planning process.

Master plans for each medical center must be developed by contracted design professionals based on programmatic and operational decisions agreed to during CARES. Medical center master plans must be internally and externally coordinated. External coordination may prove to be the more complex undertaking. For example, where current programs are relocated to from one medical center to another medical center, new construction at the second facility must be completed *before* related actions can be undertaken at the first. This requires that the proposed changes be a part of *two* facility master plans, one for the donor facility and one for the acquiring facility.

Similarly, construction priorities must be coordinated between the medical centers. Construction of an expanded SCI facility may be a high priority for the gaining facility, but the loss of an existing program may be a low priority for the donor facility. If construction funds will be expended at both facilities, it may be a practical budget policy to fund the two actions together.

Even when program changes will take place on a single campus, master plans must be developed so that a series of projects can be prioritized, coordinated, and phased. Each project is a logical step in achieving the long-range CARES objectives in an efficient and effective manner with the minimum disruption to patient care.

Master planning will allow preparation of accurate construction cost estimates that include sufficient contingency expenses for operational phasing. When complete, cost estimates prepared during master planning will either validate or challenge the original CARES strategic decisions. For example, if CARES called for use of renovated space for a relocated program and a more comprehensive examination indicates that the selected option is impractical, different options must be considered to achieve the desired results.

Master planning will also provide the mechanism for VA to address the three critical programs that were omitted for the CARES study. For long-term care, severe mental illness, and domiciliary care VA will need to accomplish both program and facility planning. Because these are significant programs, the impact of their incorporation in the planning process will be substantial.

Two other components of facility management were omitted from CARES: planning for historic structures and planning for existing vacant space on VA campuses. These must be addressed in a timely manner.

Master planning must follow immediately after CARES in order to efficiently implement necessary construction, to prepare accurate budgets, and to validate the original strategic planning decisions. VA should already have developed a master planning program as recommended in *The Independent Budget for Fiscal Year 2004*. The consequences of electing to bypass this critical step are already evident in VISN 12, where Chicago Lakeside demolition is currently scheduled to precede, rather than follow, Westside construction. Facility master planning should be funded and implemented immediately.

Recommendations:

Congress must appropriate $100 million for medical center master plans in the FY 2005 construction budget.

The facility master plans should address the long-term care, severe mental illness, and domiciliary care programs that were inexplicably omitted from the CARES study. Facility master plans should also address historic properties and vacant space.

VA must quickly develop a format for these master plans so there is standardization throughout the system, even though the planning work will be performed in each VISN by local contractors. The format should be tested in a pilot project.

Each VA medical center should initiate their procurement process immediately so that they are ready to proceed after CARES is completed and adopted.

Coordinate Planning and Design Time Frames in Order to Efficiently Manage Construction:

VA must develop realistic and compatible time frames for use in CARES, facility master planning, and individual project development.

Based on historical data, the VA project development process for design and construction takes from 8 to 10 years, measured from design initiation to building occupancy. The length of the process cannot be ignored in evaluating current CARES planning initiatives. The inherent contradiction is that a rather short, 17-year long-range planning process is coupled to a long, 10-year implementation process. The current project timeline does not include the critical new master planning step. Furthermore, many CARES-generated projects will require more complex construction phasing and private-sector real estate transactions. Therefore implementation of CARES projects will take longer than current projects—even if funding were immediately available. This reality has ramifications for CARES planning because it impacts its implementation.

The medical center master planning process will add at least one year to the current project development process. Even if master planning were initiated for every medical center immediately after CARES was adopted, building occupancy of the first CARES project would be more than a decade later. As a practical matter, the assumption must be that the majority of the CARES projects will *not* be completed by 2020, the second CARES planning target date. Very few projects will be completed by 2012, the "bump" year and the first CARES target date.

Recognition of these time frames means that CARES plans must be viewed in a different light. For example, the higher demand for veterans' services that are projected for 2012 (the "bump") must be addressed by *nonconstruction* alternatives. There is simply not sufficient time to construct new facilities to meet the forecast need. VA should therefore begin to address this responsibility immediately by means of operational adjustments.

In order to efficiently manage its assets and construction, VA must develop realistic and coordinated cycles for medical planning, facility planning, and project design. Statistical data gathering, for example, should be conducted annually. Now that planning tools have been adopted for CARES, the same data should be evaluated and updated annually. This will allow VA to monitor previous planning projections. Was the CARES demand forecast for future services accurate? If not, why not? This analysis will also allow VA to conduct future long-range planning more easily, more inexpensively, and more accurately. Comprehensive medical planning (like CARES) should be conducted on a 10-year cycle but reviewed and updated annually.

Facility master planning should be conducted on the same cycle as comprehensive medical planning, but it should be updated every 3 years to reflect ongoing changes in demand for services and in philosophy of care. VA should make every effort to reduce the length of the design and construction process so that newly completed facilities reflect the most current planning data, the most advanced medical technologies, and the

newest models for patient care. Medical advances occur at much too swift a pace to be compatible with a long and inflexible design and construction process.

Recommendations:

VA must develop nonconstruction alternatives to enable it to meet the projected increased demand for veterans' health-care services in the year 2012.

VA should conduct both medical program and facility master planning on a regular cycle that is appropriate for each activity.

Congress must appropriate sufficient construction funding each year so that there is steady implementation of planning initiatives.

Uses for CARES Statistical Data in Facility Management and Budgeting:

VA and Congress should make full use of the data produced by the CARES initiative.

The CARES process has produced extensive new data that is potentially useful to Congress and VA, regardless of full acceptance or implementation of the entire study. Even if there is disagreement on the planning assumptions, one category of CARES data paints a clear picture of VA facilities as they exist today. This category is "existing space deficiencies."

CARES provides a statistical analysis of the VA system's current deficiencies in functional space that is available to support the medical services that are currently delivered. By the application of established planning algorithms, the current space requirements have been mathematically computed for every program except long-term care, severe mental illness, and domiciliary. This computation establishes an objective benchmark that is compared to existing space inventories. These inventories are available on a program-by-program basis for each medical center, for each VISN, and for the overall VA system. The mathematical difference between the benchmark and the inventory represents the deficiency. This deficiency is the current need for new facility construction in order to provide quality medical care to today's veterans. Using this CARES data, a specific medical center, for example, can be identified as the "most deficient" in the VA system. By extension, this facility is most in need of new construction. Specific medical programs can also be compared on a similar basis.

This data identifies the current need for new space and therefore establishes the magnitude of construction that is necessary to adequately address today's veterans' needs. This data will also allow prioritization of construction funding, based on a variety of different criteria, including geographic regions or medical programs. This data is based on completely objective measurements, not based on any assumptions regarding future needs.

The CARES data category that is based on assumptions is "projected space deficiencies." These projections are based on various planning assumptions regarding veteran eligibility, population demographics, and future military actions. Actuarial data is used to project these future demands for veterans' health-care services. Because of these fundamental assumptions and unforeseeable medical advances, these space projections are based on much less solid information than existing space deficiencies. These projections must be considered, however, because VA must plan to the best of their abilities for future needs. Long-range planning is particularly critical for an efficient construction program because the implementation process is so long. Future projections can also be used to project the future need for construction and as a basis for resource allocation.

The newly collected CARES data illustrate the scope of both the system's current and future construction needs. These data can be used to establish the magni-

tude of future construction budgets and provide a rational basis to allocate these resources. Allocations, for example, could be made to address the greatest current space deficiencies. Alternatively, funding could be prioritized to offset the greatest projected space needs. Funding could also be adjusted to emphasize one medical program over another. Data of this type should have been available for decades for both management and oversight purposes.

With the new CARES data, better systemwide facility and medical management will now be possible. CARES data should therefore be periodically updated in order to verify the accuracy of the underlying assumptions and make the necessary adjustments to the facility and operational plans. Similar statistical data should be generated and maintained for the three missing programs (long-term care, severe mental illness, and domiciliary).

Recommendations:

VA should generate similar statistical data for long-term care, severe mental illness, and domiciliary.

VA should use CARES data to establish the magnitude of construction that is required to address current space deficiencies.

VA should use CARES data to identify future space deficiencies and initiate construction now to meet future needs.

VA should use the deficiencies data to establish current and future construction budgets and to allocate these resources among the various medical centers and medical programs.

VA should periodically update the CARES data as an important tool for systemwide planning and management.

What Should Follow CARES?

VA must immediately undertake certain activities in order to secure the potential benefits of CARES.

The CARES long-range planning study has been completed, and it is certainly time to initiate a major construction program to enhance VA's medical facilities. The CARES study has attempted to project the future demand for services and identify what types of patient programs will be needed. In addition, CARES has proposed a realignment of existing assets to best meet these needs. During the past few years, construction funding has been virtually frozen pending the outcome of CARES. This severe funding reduction has been detrimental to the maintenance of VA's capital assets and has allowed atrophy in the construction management program. It is now time to ramp up construction in order to meet the system's current and future needs. This expanded construction program needs to be implemented in an efficient and deliberate manner.

In order to initiate a new era of expanded medical facility construction, VA must establish a national program of facility master planning that describes, in detail, the most efficient means of implementing the medical program planning that was agreed to in the CARES study. In addition, VA needs to establish an ongoing national planning program that collects, maintains, and evaluates critical statistical data. The new planning program should monitor CARES projections and adjust the conclusions, as necessary, as future events unfold. New statistical data for the three medical programs (long-term care, severe mental health, and domiciliary) that were omitted from CARES should be added as quickly as possible.

VA must coordinate its planning, construction, and management responsibilities. Appropriate cycles for planning activities need to be established and implemented. Management mechanisms need to be estab-

lished to collect and evaluate planning data. Inaccurate planning forecasts cannot be allowed to continue uncorrected, as was the case with MEDIPP in the late 1990s. Better long-range planning also needs to be coupled with shorter design and construction time frames in order to deliver a better product in a more efficient manner.

Several aspects of the facility inventory management were not addressed in CARES. These include the historic properties that VA owns and the vacant space that exists at many medical centers. Comprehensive solutions for these management issues need to be developed, approved, and implemented.

Recommendations:

VA construction should be expanded in order to meet the system's current and projected space needs.

VA must initiate new programs for facility master planning based on the CARES recommendations.

VA must maintain and analyze new planning data and streamline the current design and construction process.

VA must develop programs to address historic properties and vacant space.

Vocational Rehabilitation and Employment

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or re-entry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties in turn contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to eliminate licensing requirements and employment barriers. We are encouraged by the appointment of a new director and deputy director who have the opportunity to take Vocational Rehabilitation and Employment in a new direction.

Vocational Rehabilitation and Employment Issues

Services for Disabled Veterans Lacking:

Many disabled veterans are not receiving suitable vocational rehabilitation and employment services required to provide a smooth transition into the workforce.

On January 10, 2000, the Department of Veterans Affairs changed the name of the Vocational Rehabilitation and Counseling Service (VR&C) to Vocational Rehabilitation and Employment Service (VR&E). The purpose of the name change was to reenergize the focus of the organization's mission, preparing disabled veterans for suitable employment and providing independent living services to those veterans who are severely disabled and are unlikely to secure suitable employment at the time of their entry into independent living. We applaud the Veterans Benefits Administration's efforts and look forward to their continuing changes to improve delivery of meaningful services to disabled veterans. For too many years, and in spite of many individual successes, VR&E was the recipient of valid criticism. Many of these criticisms remain of concern, including the following:

- Inadequate and sometimes nonexistent case management;
- Outdated regulations, as well as policies and procedures manuals;
- Long delays in the time taken to process applications;
- Lack of accountability for poor decision making—there needs to be consistency with flexibility and accountability;
- Inadequate use of electronic information technology;
- Failure to explore entrepreneurial opportunities for severely disabled veterans and other disabled veterans who are unable to obtain or retain employment or are suitable for self-employment;
- Declaring veterans rehabilitated after training without ensuring that they achieve suitable employment;
- Case loads too large;
- VR&E's Case Management Information Management System (Corporate WINRS is in need of updating and implementation);
- Staff shortages;
- Need for collaboration with the Department of Labor and the Small Business Administration.

We encourage VR&E to continue with its efforts to improve its services and to involve and seek recommendations from the IBVSOs and other stakeholders.

Recommendations:

VBA must place a higher emphasis on complementing VR&E's staffing requirements and needs.

VR&E should continue its efforts to improve case management techniques and use state-of-the-art information technology.

VR&E should rewrite its operational policies and procedure manuals.

General Counsel should expedite the promulgation of new regulations for VR&E.

VR&E must place higher emphasis on academic training, employment services and independent living services to achieve the goal of rehabilitation of severely disabled veterans.

VR&E should develop plans and partnerships to enhance the availability of entrepreneurial opportunities for disabled veterans.

VR&E should develop plans to continue follow-up of rehabilitated veterans for at least 2 years to ensure that rehabilitation is successful.

Unpaid Work Experience:

For vocational rehabilitation clients, the unpaid work experience program should be expanded to include work in the private and nonprofit sector.

For many years disabled veteran clients under vocational rehabilitation could participate in a program of unpaid work experience as part of their rehabilitation program with Federal Government agencies. Several years ago that authority was expanded to include state and local governments but not private- or not-for-profit-sector employers.

In today's labor market it is beneficial for those seeking career employment not only to be trained properly but also to have some related work experience, either as an intern or volunteer or in some other capacity. The concept of unpaid work experience as part of a veteran's training program is significant and should result in a higher success rate of employment outcomes.

Recommendation:

Congress should extend the authority for unpaid work experience to private-sector and not-for-profit-sector employers who are willing to develop such unpaid work experience opportunities consistent with the veterans' training program.

Assistance Programs Inadequate:

The Transition Assistance Program and Disabled Transition Assistance Program do not adequately serve servicemembers.

For several years the Department of Defense (DOD), the Department of Labor (DOL), and VA have been providing transition assistance workshops to separating military personnel through the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP). These programs generally consist of a three-day briefing on employment and related subjects, as well as veterans' benefits.

DTAP, however, has been largely relegated to a session in which a representative from VA's Vocational Rehabilitation and Employment Service advises disabled veterans with potential eligibility about their rights and how the programs work. DTAP has been viewed as a "stand alone" program. Typically, a DTAP participant does not benefit from other transition services.

The number of military members being separated annually is still high (more than 200,000 as projected by the DOD) and could increase because of large numbers of soldiers leaving due to the current operational tempo. The IBVSOs believe that TAP must continue to provide its important services. The Commission on Servicemembers and Veterans Transition Assistance has recommended the continuation of TAP/DTAP.

The IBVSOs are concerned, as well, that too little is being done for transitioning disabled veterans.

Recommendations:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

The DOD should ensure that separating servicemembers with disabilities receive all of the services provided under TAP as well as the separate DTAP session by VR&E.

Congress has authorized the provision of TAP services to separating servicemembers 1 year prior to discharge and for military retirees up to 2 years prior to discharge. In the event that notification of separation or retirement occurs less than that authorized, transi-

tion services should begin as soon as possible following notification.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active duty, unless separation is due to a service-connected disability when these services are mandatory.

Certification and Licensing of Transitioning Military Personnel:

Civilian licensure and certification barriers facing transitioning military members must be reduced.

In recent years there has been an increased reliance on licensure and certification as a primary form of competency recognition. The public, professional associations, employers, and the Government have turned to credentialing to regulate entry into employment and to promote safety, professionalism, and career growth. Hundreds of professional and trade associations currently offer certification in their fields, and there has been an increase in occupational regulation by states and the Federal Government. The trends suggest that in the 21st century the interest in competency recognition will accelerate.

The emphasis on licensure and certification can present significant barriers for transitioning military personnel seeking employment in the civilian workforce. Credentialing standards, such as education, training, and experience requirements, are developed based on traditional methods for obtaining competency in the civilian workforce. As a result, many transitioning military personnel who have received their career preparation through military service find it difficult to meet certification and licensing requirements due to the lack of civilian recognition of military training and experience. For some, this inability to become credentialed bars entry into employment in their fields entirely. For others, the lack of credentials will make it difficult to compete with their civilian-sector peers for jobs. Those who are able to obtain employment in their fields without the applicable credentials may face decreased earnings and limited promotion potential.

Pilot programs have been initiated in some states to provide credentialing to servicemembers in a limited number of fields. The IBVSOs believe that there are a number of factors that have an impact on the ability of current and former military personnel to obtain civilian credentials. Many civilian credentialing boards do not have adequate knowledge of and do not give proper recognition to military training and experience. The lack of clarity regarding the procedures for exchange of transcripts between military and civilian credentialing boards creates undue barriers for military personnel.

The IBVSOs believe the DOD must assist members preparing to transition from active duty to civilian jobs through the proper dissemination of information. The DOD must maintain involvement with the certifying organizations and coordinate efforts among Federal agencies and private industry.

Recommendation:

Armed Forces training schools need to pay greater attention to the activities and requirements of civilian credentialing agencies.

Performance Standards:

Performance standards in the Veterans Employment and Training Service system are inconsistent and inadequate.

Within the Veterans Employment and Training Service (VETS) system there are currently no performance standards that can be used to compare one state to another or even office to office within a state. Even where such benchmarks have been produced, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. Given the limits of state civil service systems, some State Employment Security Agency (SESA) administrators have a similar difficulty in holding local managers accountable for performance. The only real tools VETS possesses is the staff members' own powers of moral suasion and personal relationships they may have developed.

The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. The power to declare a state out of compliance can be likened to the power to declare nuclear war: Everyone is afraid to use it because it might well destroy everything. For several years many have seen a need for some sort of standards for both Disabled Veterans' Outreach Program (DVOP)/Local Veterans' Employment Representative Program (LVER) staff and for the SESAs as an entity. The problem has always been both a technical one, how to develop national standards and for what purpose, and a political one, the states have viewed even the minimal standards of behavior currently in place as constituting intrusive interference from Washington. Current standards compare services to nonveterans and veterans—a state need only do a little better for veterans than for nonveterans. If it places 3% of its nonveteran applicants, the state need only place 4% of its veteran applicants to be in compliance.

This certainly conflicts with Congressional intent and purpose as expressed in title 38 U.S.C. § 4102:

> The Congress declares as its intent and purpose that there shall be an effective Job and Job Training Counseling Service Program, Employment Placement Service Program, and Job Training Placement Service Program for eligible veterans so as to provide such veterans and persons the maximum of employment and training opportunities.

Recommendations:

VETS must complete development of meaningful performance standards and reward states that exceed the standards by providing additional funding.

Public Law 107-288, the Jobs for Veterans Act, authorizes VETS, through its grants to states, to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly those with barriers to employment, find work. This recognition is only for individuals and not entities. Congress should amend this law so that such entities as Career One-Stops who do a good job for veterans can be recognized.

Congress should consider the feasibility and practicality of alternative means of delivering employment services for veterans, such as a competitive bidding process.

Training Institute Inadequately Funded:

The National Veterans Training Institute lacks adequate funding to properly administer its training programs, which are unavailable elsewhere.

The National Veterans Training Institute (NVTI) was established in 1986 and authorized in 1988 by P.L. 100-323. NVTI is administered by staff from the Department of Labor/VETS through a contract currently with the University of Colorado at Denver. NVTI trains Federal and state employees and managers who provide direct employment and training services to veterans and servicemembers. The NVTI curriculum offers courses for staff of the DVOP and LVER programs in core professional skills, marketing and accessing the media, case management, vocational rehabilitation and counseling program support, and facilitation of Transition Assistance Program (TAP) workshops.

Training offered to VETS staff includes a basic course on the Uniformed Services Employment and Reemployment Rights Act (USERRA), enacted in October 1994; a new investigative techniques course; a quality management course; and a grants management course.

NVTI offers DOD employees TAP management training, through reimbursable agreements under the Economy Act (at actual cost of training). NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans programs, projects, and activities.

Recommendation:

Congress must fund NVTI at an adequate level to ensure training is continued and expanded to state and Federal personnel who provide direct employment and training services to veterans and servicemembers in an ever-changing environment.

Program Reassessment:

Leadership is needed on a comprehensive reassessment of veterans' employment and training programs.

This reassessment must involve all veterans and other stakeholders, as well as congressional oversight. The Senate or House Veterans' Affairs Committee should take the lead to involve veterans service organizations; the National Association of State Workforce Agencies; veteran-based organizations, such as the National Coalition of Homeless Veterans (NCHV) and the Office of the Assistant Secretary for Veterans Employment and Training (OASVET); and possibly the International Association of Personnel Employment Services (IAPES) Veterans' Committee in discussing these matters of standards and accountability for veterans' employment programs. These issues include accountability at every level, backed up by:

- Significant incentives and reasonable sanctions, and
- The selective use of competition to ensure performance.

A meeting to discuss a more effective basis for delivering employment and training services to veterans should take place at an early date. The need is to secure the best ideas of veterans and the various stakeholders, solicit their support of general concepts, forge common ground for modifications to the law, and ensure early and effective compliance should such changes to the law be authorized and the funding appropriated. The de facto devolution of the SESAs is proceeding at an accelerating rate. The enactment of the Workforce Investment Act of 1998 is accentuating this trend.

Someone must take the lead, and the IBVSOs recommend it be the House or Senate Veterans' Affairs Committee. The progressive movement toward one-stops does not make the traditional way of delivering employment services to veterans a viable alternative.

Veterans continue to receive far less than a proportionate amount of the primary Job Training Partnership resources (Title IIA and Title III), and there are virtually no veteran-specific projects funded by this $2.3 billion resource at the state or local level.

Unless there is a paradigm shift, there will likely be reductions in force of DVOP specialists and LVERs and a further erosion of the buying power of each dollar appropriated for the programs administered through VETS. To do nothing is tantamount to waiting for the system operation to become increasingly problematic, contentious, and even less effective. Some have suggested that trying to keep everything the way it was is irresponsible in light of the dramatically changed realities.

Recommendations:

The House or Senate Veterans' Affairs Committees should conduct oversight to assure full implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills it purposes of:

- Raising employer awareness of the advantages of hiring separating servicemembers and recently separated veterans;
- Facilitating the employment of separating servicemembers and veterans through America's Career Kit, the national electronic labor exchange; and
- Directing and coordinating departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act, P.L. 103-353.

National Cemetery Administration

The National Cemetery Administration (NCA) has as its mission: "To honor veterans with a final resting place and lasting memorials that commemorate their service to our Nation."

Building on a proud and compassionate history beginning in the Civil War, the administration of NCA cemeteries continues to contribute every day to that mission.

Through a system of 120 national cemeteries in 39 states, the District of Columbia, and Puerto Rico, as well as 34 soldiers' lots and monument sites, The NCA maintains more than 2.6 million gravesites in approximately 14,000 acres of cemetery land while providing nearly 90,000 interments annually.

A new cemetery in Oklahoma, Fort Sill National Cemetery, was scheduled for completion and dedication in late 2003. Since November 2001, the facility has operated a fast-track section that permits interments, with dignity and reverence, prior to final completion of all construction activities. In addition, continued progress is anticipated on cemetery development in Atlanta, Miami, Pittsburgh, Detroit, and Sacramento.

In November 2003, the President signed into law H.R. 1516 (P.L. 108-109), the National Cemetery Expansion Act, to authorize the Department of Veterans Affairs to continue developing new cemeteries in areas not currently served by either a national veterans' cemetery or a state veterans' cemetery. These areas include development of six new national cemeteries in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida.

The development of these new national cemeteries will provide burial options for veterans, spouses, and dependents. Clearly, the rapid aging of the current veteran population has placed great demands on NCA operations and available burial space. Nearly 655,000 veteran deaths are estimated in 2005 with the death rate peaking at 690,000 in 2009; of these, it is expected that 109,000 will seek burial in a national cemetery. As veteran deaths accelerate, it is obvious the demand for veterans' burial benefits will increase.

It is important to note that the staffing needs of the NCA have become more critical as the volume and intensity of cemetery operations have increased. While the *The Independent Budget* veterans service organizations (IBVSOs) support efforts to increase efficiency of operations, it is essential to remind decisionmakers that much of the NCA work is labor-intensive, requiring a fully staffed and fully equipped workforce.

The increased burial rate with its resulting demand on support services necessitates an appropriate budgetary increase for the NCA. *The Independent Budget for Fiscal Year 2005* recommends an operations budget of $175 million for NCA to meet the increasing demands of interments, gravesite maintenance, and other areas of cemetery operations.

NCA ACCOUNT

Although the NCA has benefited from marginal increases to its appropriations over the past 3 years, prior years of successive restrained budgets have made it impossible to address long-term field management and operational needs of the system. Shortfalls have forced the system to address only the highest priority projects while backlogging important preventive maintenance and infrastructure repairs.

Resources must keep pace as the workload continues to grow due to increasing demands of interments, gravesite maintenance, repairs, upkeep, and related labor-intensive requirements of cemetery operations. In addition, VA is scheduled to open new cemeteries in Atlanta, Oklahoma City, Pittsburgh, Detroit, Miami, and Sacramento. Also, under P.L. 108-109, VA is directed to design and construct cemeteries at six new national locations in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida. These requirements combined with dramatic increases in the interment rate necessitate increases in funding if the NCA is to carry out its statutory mandates.

The report in *Volume 2* of the *Study on Improvements to Veterans Cemeteries,* submitted in 2002 by VA to Congress as directed under the Veterans Millennium Health Care and Benefits Act (P.L. 106-117), identifies more than 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery. A major contributing factor in these project repair recommendations is the accumulation of uncorrected past deficiencies.

As reported in *Volume 3* of the *Study on Improvements to Veterans Cemeteries,* many of the individual cemeteries within the system are steeped in history. The monuments, markers, grounds, and related memorial tributes represent the history and very foundation of our country. This volume serves as a planning presentation of the scope of work required to help set national standards to improve the appearance of NCA cemeteries and guide the application of future resources.

In this regard, the IBVSOs recommend that Congress fund the National Cemetery Administration operating account at $175 million for fiscal year 2005, $31 million more than last year's recommendation. The increase results mainly from a response to needs outlined in the *Study on Improvements to Veterans Cemeteries*, the growing costs of administrative expenses due to increased workload, addition of new cemeteries, general inflation, and wage increases.

Four years after Congress declared that national cemeteries should be awe-inspiring shrines to veterans, the NCA should be provided the funding necessary to remove decades of blemishes and scars from these honored grounds across the Country.

A fundamental part of the operations budget is the maintenance and enhancement of the grounds and memorials. Improving the appearance of our national cemeteries embraces the achievement of those interred. It allows visitors to see the evidence of our Nation's gratitude for those buried there and what they did. Problems and deficiencies in this regard are clearly identified in the *Study on Improvements to Veterans Cemeteries*, a comprehensive report about the conditions of each cemetery, submitted to Congress by VA in 2002.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service and the State Cemetery Grants Program (SCGP).

The Memorial Programs Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Law 107-103 and P.L. 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries, who died on or after September 11, 2001. Prior to this change the NCA could only provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

Under the Presidential Memorial Certificate program, the award of a certificate signed by the President is, in addition to the provision of the United States flag, furnished by VA to all veterans honorably discharged from military service or otherwise eligible for burial in a national cemetery.

The SCGP complements the NCA mission to establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100% of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries.

The SCGP makes burial options more available, more accessible and more convenient. Since 1973, VA has more than doubled acreage available and accommodated more than a 100% increase in burials.

To help provide reasonable access to burial options for veterans and their eligible family members, The IBVSOs recommend $37 million for the SCGP The availability of this funding will help the NCA help states establish, expand, and improve state-owned veterans' cemeteries.

IB Recommended NCA FY 2005 Appropriation
(Dollars in Thousands)

FY 2005 RECOMMENDED APPROPRIATION BY TYPE OF SERVICE	
Personnel Compensation	$97,690
Travel and Transportation of Persons	3,944
Rental Payments to GSA	1,100
Communications, Utilities, and Miscellaneous Charges	8,349
Other Services	42,313
Supplies and Materials	9,303
Equipment	12,301
IB Recommended FY 2005 Appropriation	**$175,000**

NCA ISSUES

The National Cemetery Administration is faced with a number of serious challenges. One of the most serious of these, described previously, is the provision of adequate funding to meet increasing demands of interments, gravesite maintenance, repairs, upkeep, and related labor-intensive requirements of cemetery operations. Another major challenge facing the NCA is to ensure that all national cemeteries are maintained in a manner appropriate to their status as national shires and memorials of reverence. In addition, the State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. Moreover, Congress faces the challenge of stemming the serious erosion in the value of burial allowance benefits. The IBVSOs have identified these issues as critical to ensuring world-class, quality service delivery from the NCA and integral to the memory of all veterans who have served their Country honorably and faithfully.

State Cemeteries Grant Program:

Heightened interest in the SCGP results in stronger state participation and increased demands on the program.

The SCGP provides funds to assist states in establishing, expanding, and improving state-owned cemeteries. The program has helped develop 52 operating cemeteries across the country, which accounted for 18,189 burials of veterans and their eligible family members in FY 2003, an increase of nearly 6% over the prior year.

With the enactment of the Veterans Benefits Improvements Act of 1998, the state SCGP became instantly more attractive to states by substantially increasing the Federal share to 100% of allowable costs, including design, construction, and purchase of equipment for new cemeteries.

In FY 2003 the State Cemetery Grants Program awarded $26.2 million. Over the past two years the program helped develop seven new cemeteries at Grand Junction, Colorado; Sierra Vista, Arizona; Fort Dodge, Kansas; Caribou, Maine; Bloomfield and Jacksonville, Missouri; and Fort Campbell (Hopkinsville), Kentucky. In addition, the program has on hand 32 preapplications for $138 million and 3 pending awards for $14.7 million.

During FY 2004 the IBVSOs anticipate fast-track openings at new cemeteries under construction: Boise, Idaho (the last state in the United States without a veterans cemetery); Wakeeney, Kansas (300 miles east of Denver and west of Kansas City, serving rural area in western Kansas); Winchendon, Massachusetts (serving the densely populated northern part of the state); and Suffolk, Virginia (serving 200,000 veterans in the Tidewater area).

The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the Veterans Benefits Improvements Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial Federal purchase of equipment. The program allows states, in concert with the NCA, to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

Recommendations:

Congress should fund the SCGP at a level of $37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

A PricewaterhouseCoopers study, submitted to VA in December 2000, indicates serious erosion in the value of burial allowance benefits. 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 the Federal Government first started paying burial benefits for our veterans.

In the 107th Congress, the plot allowance, limited to wartime veterans, was increased for the first time in more than 28 years to $300 from $150, approximately 6% of funeral costs. The IBVSOs recommend increasing the plot allowance from $300 to $725, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery not just those who served during wartime.

Also in the last Congress, the allowance for service-connected deaths was increased $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. The IBVSOs recommend increasing the service-connected benefit from $2,000 to $4,000, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6% of funeral costs. We recommend increasing the nonservice-connected benefit from $300 to $1,225, bringing it back up to the original 22% level.

Finally, the IBVSOs recognize the need to adjust burial benefits for inflation annually to maintain the value of these important benefits.

Recommendations:

Congress should increase plot allowance from $300 to $725 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,000.

Congress should increase the nonservice-connected benefit from $300 to $1,225.

Congress should enact legislation to adjust these burial benefits for inflation annually.

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Strategic Planning and Performance Goals

The strategic planning process for the National Cemetery Administration requires meeting the increasing demands for burials and maintaining existing cemeteries to high standards.

The Veterans Millennium Heath Care and Benefits Act (P.L. 106-117) required VA to contract for an assessment of the current and future burial needs of our Nation's veterans. An independent study, titled *An Independent Study on Improvements to Veterans Cemeteries,* was submitted to Congress in 2002. Three volumes comprise the study: *Future Burial Needs, National Shrine Commitment*, and *Cemetery Standards of Appearance*. In whole, the completed study would help form the platform for adopting further improvements to veterans cemeteries.

Volume 1: Future Burial Needs identifies those areas in the United States with the greatest concentration of veterans whose burial needs are not served by a national cemetery. According to the report, current and planned cemeteries under the NCA fiscal year 2000 strategic plan, which runs through 2006, will service

most large population centers. However, the report states that an additional 22 cemeteries will be required to ensure that 90% of veterans live within 75 miles of a national cemetery.

The IBVSOs encourage Congress and the Administration to carefully consider the report's findings in achieving burial service objectives. The analysis provides useful guidelines to continue a strong state grant program, to expand existing cemeteries wherever appropriate, and to build new national cemeteries at or near densely populated areas of veterans. 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.

Volume 2: National Shrine Commitment provides a systemwide comprehensive review of the conditions at 119 national cemeteries. *Volume 2* identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options, and maintenance programs. The total estimated cost of completing these projects is nearly $280 million, according to the study.

The IBVSOs agree with this assessment and believe that Congress needs to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. The operations budget and minor construction budget recommended by *The Independent Budget* contain funding to begin these projects based on the severity of the problems.

Volume 3: Cemetery Standards of Appearance is a careful presentation of the scope of work required to elevate existing national cemeteries as national shrines. *Volume 3* serves as a planning tool to review and refine overall operations in order to express the appreciation and respect of a grateful Nation for the service and sacrifice of military veterans.

Volume 3 describes one of the most important elements of veterans' cemeteries—namely, to honor the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report finds, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual."

The IBVSOs agree with this assessment. The purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history: The monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries...shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43).

In this vein, the IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the Nation's commitment to all veterans who have served their Country honorably and faithfully. The current and future needs of NCA require continued adequate funding to ensure that the NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

An Independent Study on Improvements to Veterans Cemeteries presents valuable information and tools for the development of a truly national veterans' cemetery system. We recommend Congress give it close examination because the suggestions it contains require Congressional and Administrative budgetary support.

As we look forward to funding decisions for fiscal year 2005, the IBVSOs await Congressional action on appropriating funds for construction of recommended cemeteries in areas already approved for new sites. Because the planning and construction horizons of new cemeteries can take up to 10 years or more, it is important that the system develop concrete plans to address the increased demand for burial benefits in subsequent fiscal years.

Recommendations:

Congress and the Administration should use *An Independent Study on Improvements to Veterans Cemeteries* to help form the platform for adopting improvements to veterans cemeteries and for setting the course to meet increasing burial demand.

Congress should make funds available to ensure the proper planning and fast-track construction of needed national cemeteries. Adequate funding must be assured to complete construction of additional national cemeteries in areas that remain unserved.

Congress and the Administration must find ways to expand the useful life of currently operating national cemeteries, build new cemeteries where appropriate, and encourage state grant program cemeteries as a means of providing service to veterans.

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Mr. FULLER. What we do in the interest of time and also so we don't repeat ourselves is that each organization takes a certain segment of *The Independent Budget* to testify on, and for the past 18 years, Paralyzed Veterans of America has worked on the health care portion. I will address my comments to that today.

The Administration's budget request for health care is a shocking one, providing once again a woefully inadequate funding level for sick and disabled veterans. Calling for only a $310 million increase in appropriated dollars is a mere 1.2 percent increase over fiscal year 2004. This is the smallest health care appropriation request of any Administration in nearly a decade.

Indeed, the VA Under Secretary for Health testified just last year that the VA requires a 13 to 14 percent increase just to keep its head above water each year. Once again, we are faced by a request that relies too heavily on budgetary gimmicks and accounting sleight-of-hand rather than on real dollars that veterans need.

The Administration is again resurrecting its user fee and increased copayment schemes, proposals that were soundly rejected before and we hope they will be rejected again. Once again, we see unrealistic management efficiencies utilized to mask how truly inadequate this budget is.

For fiscal year 2005, The Independent Budget recommends a medical amount of $29.8 billion. This amount represents an increase of $3.2 billion over the amount provided in 2004. For medical and prosthetic research, The Independent Budget is recommending $460 million. This represents a $54 million increase over the 2004 amount. Sadly, the Administration has proposed cutting research grants alone by approximately $21 million, which is absolutely unprecedented in recent history. Accepting this level of funding would set the research grant program back to fiscal year 1999 levels. This also needs to be corrected.

In closing, the VA health care system faces two chronic problems. The first is underfunding, which I have already outlined, and the second is a lack of consistent funding. The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only knowing how much money it is going to get, but more equally important, when it is going to get that money. No Secretary of Veterans' Affairs, no VA hospital director, no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be there when they need them.

The only solution we can see is for this committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate when it knows how much it is going to get and when it is going to get it.

This concludes my testimony. I will be happy to answer any questions you may have.

Chairman SPECTER. Thank you. Thank you very much, Mr. Fuller. Your full statements will all be made a part of the record and we will have a chance to review them in some detail and staff will analyze them. We appreciate this very impressive booklet. I

thought you would probably read it in 3 minutes, but you couldn't do it.

[Laughter.]

[The prepared statement of Mr. Fuller follows:]

PREPARED STATEMENT OF RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the Committee, as one of the four veterans services organizations publishing *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for fiscal year 2005.

This is the eighteenth year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented *The Independent Budget*, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by 32 veterans service organizations, and medical and health care advocacy groups.

Mr. Chairman, we are becoming increasingly troubled by the delays in enacting VA appropriations. In fiscal year 2000, VA appropriations were not enacted until October 20th, in fiscal year 2001 October 27th, in fiscal year 2002 November 26th, in fiscal year 2003 February 20th, and this year, January 23rd. For the past 2 years alone, the VA health care system has had to struggle along at previous year's inadequate funding levels for nearly one-third of each year. This is unacceptable. These delays directly affect the health care received by veterans. This deplorable State further points to the importance of a mandatory funding mechanism for VA health care. But until that happens, we ask that this Congress move expeditiously to put the necessary funding levels in place by the start of fiscal year 2005. We also are disappointed in the practice of using rescissions as a budgetary mechanism in the omnibus spending bills that have become far too common. These cuts also have real consequences for veterans and their families.

This year, as we did last year, *The Independent Budget* is presented in the traditional account format. The VA is once again presenting its budget in the format it unveiled last year, a format that did not find wide acceptance. The House Appropriations Committee has adopted its own format, a format adopted in the recently enacted Omnibus spending bill. Until this format dispute is settled, and until we have adequate data in which to analyze the VA health care system under whichever format is adopted, we will continue to utilize the traditional account structure. It can become confusing amid the din of competing dollar amounts based upon these different formats, but we ask you to compare oranges to oranges and to bear in mind that attractive numbers may not exactly match reality.

The Administration's budget request for health care is a shocking one, providing once again a woefully inadequate funding level for sick and disabled veterans. Calling for only a $310 million increase in appropriated dollars, a mere 1.2 percent increase over fiscal year 2004, this is the smallest health care appropriation request of any Administration in nearly a decade. Indeed, the VA Under Secretary for Health testified just last year that the VA requires a 13 to 14 percent increase just to keep its head above water.

In addition, we once again are faced by a request that relies far too heavily on budgetary gimmicks and accounting sleight of hand rather than on real dollars that veterans need. The Administration is again resurrecting its enrollment fee and increased co-payment schemes, proposals soundly rejected by both the Senate and the House of Representatives. And once again we see unrealistic "management efficiencies" utilized to mask how truly inadequate this budget is. The VA must be accorded real dollars in order to care for real veterans. Shifting costs onto the back of other veterans is not the way to meet this Federal responsibility. Punitive co-payments and charges are designed not so much to swell projected budget increases as they are to deter veterans from seeking their care at VA medical facilities. Imagine the effect of these additional costs on those who have no other choice but to get care at VA. We may indeed have the greatest health care system in the world, but if you cannot get in the door we might as well have the worst.

Mr. Chairman, *The Independent Budget* makes a strong statement in opposition to co-payments. The Congress gave the Secretary of Veterans Affairs the authority to set and raise fees. What was once thought of as only an administrative function has now become, in times of tight budgets, an easy way to try and find the dollars

to fund health care for veterans. When appropriations are in short supply and demand for health care is high, co-payments have become the new way to fund the VA out of the pockets of the veteran patient.

For fiscal year 2005, *The Independent Budget* recommends a Medical Care amount of $29.791 billion. This figure does not include funds attributed to MCCF, which we believe should be used to augment a sufficient appropriated level of funding. This amount represents an increase of $3.2 billion over the amount provided in fiscal year 2004.

The *Independent Budget* recommendation is a conservative one. The VA health care system, in order to fully meet all of its demands and to ameliorate the effects of chronic under-funding, could use many more dollars. The *Independent Budget* recommendation provides for the impact of inflation on the provision of health care, and mandated salary increases of health care personnel. It provides resources to begin funding the VA's critical fourth mission to back up the Department of Defense health care system. Make no mistake about it, the VA will be spending money to comply with its new responsibilities in this area, and if specific funding is not included, then these resources will have to come directly from dollars used to care for sick veterans. It provides increased prosthetics funding and long-term care funding, and provides enough resources, we believe, to enroll Priority 8 veterans. With the VA's decision to cease enrolling Priority 8 veterans, undertaken only because of the lack of resources, we are losing an entire class of veterans, veterans who are an integral part of the VA health care system.

Of course, these recommendations are only estimates, and our crystal ball is often cloudy. Health care inflation may be higher, or lower than we have estimated. Demand may increase, or decrease. The implications, as they pertain to VA health care funding estimates, of the 2-year grant of health care eligibility to recently discharged or released active duty personnel as provided in P.L. 105–363, are difficult to account for. But what we must account for, and provide for, are the necessary resources for the VA to meet its responsibilities, and this Nation's responsibilities, to sick and disabled veterans. These resources must be provided in hard dollars, and not dollars magically realized out of the thin air of "management efficiencies" and other budgetary gimmicks.

For Medical and Prosthetic research, *The Independent Budget* is recommending $460 million. This represents a $54 million increase over the fiscal year 2004 amount. Sadly, the Administration has proposed cutting research by approximately $21 million. Accepting this level of $385 million would set the research grant program back 6 years to fiscal year 1999 funding levels. This program is a vital part of veterans' health care, and an essential mission for our national health care system. We must provide additional dollars for VA research as we provide additional funding for our other national research endeavors. Over the course of 5 years, the budget for the National Institutes of Health was doubled. We should seek a similar commitment for VA research.

In closing, the VA health care system faces two chronic problems. The first is underfunding which I have already outlined. The second is a lack of consistent funding.

The budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of not only how much money it is going to get, but, equally important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they need them.

Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee and the Congress as a whole to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it.

We look forward to working with this Committee in order to begin the process of moving a bill through the Senate, and the House, as soon as possible.

This concludes my testimony. I will be happy to answer any questions you may have.

Chairman SPECTER. Our next witness is Mr. Rick Surratt, the Deputy National Legislative Director for the Disabled American

Veterans. Thank you for joining us, Mr. Surratt, and your full resume will be placed in the record.

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

Mr. SURRATT. Thank you, Mr. Chairman. On behalf of the DAV and The Independent Budget, I am pleased to present our views on the President's fiscal year 2005 budget and to highlight our recommendations for resources and program improvements.

Other than a cost-of-living adjustment for compensation and reinstatement of the 1-year period for filing death pension claims, the President's budget contains no positive recommendations for improvements to the benefit programs. It does, however, include two objectionable recommendations to eliminate entitlement to benefits.

It again requests the Congress eliminate entitlement to compensation for any portion of a service-connected disability attributable to the effects of alcohol or drug abuse. Under current law, alcohol abuse, for example, is not itself a compensable disability. However, when it is a secondary product and part and parcel of the manifestations of a service-connected psychiatric disorder, for example, its effects are properly for consideration in assessing the overall level of disability for compensation purposes.

There is a great difference between a veteran who uses alcohol for its pleasurable intoxicating effects and one who suffers from such unbearable and unremitting psychological distress or physical pain that he or she resorts to alcohol to escape the agony. Current law recognizes this distinction. Congress should again reject VA's recommendation.

The President's budget also proposes legislation to eliminate a veteran's entitlement to a home loan guarantee after its initial use, despite the benefits of the repeat use to the veteran and to the American economy and despite the apparent lack of any good reason for this adverse action against veterans. The IB urges you to reject this recommendation.

The IB recommends a number of beneficial adjustments in veterans' benefits programs. We hope you will favorably consider those recommendations this year as you have many of our recommendations in past years.

Veterans deserve good benefit programs and also have every right to expect to receive their benefits when they need them. The proper and timely delivery of benefits requires, among other things, resources that match the workload. Here again, we must disagree with the President's budget request.

The President's budget proposes to reduce staffing in the Veterans' Benefits Administration by 540 full-time employees. Because of the war and other factors, VBA's workload can only be expected to increase. VBA has been laboring for several years to improve proficiency and efficiency, but it has not historically achieved gains at a rate that would allow it to make up for such a large loss of personnel in a single year.

The improvident reductions in staffing suggested by the President's budget may very well make VA lose those gains and return to the entirely unacceptable situation that existed before. We urge you to reject the President's recommendation to reduce VBA's staff-

ing. In the IB, we recommend staffing levels more consistent with VBA's workload.

Mr. Chairman, that concludes my statement and I will be happy to answer any questions you may have.

Chairman SPECTER. Thank you very much, Mr. Surratt.

[The prepared statement of Mr. Surratt follows:]

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

Mr. Chairman and Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) and our partners in *The Independent Budget* (IB)—AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW)—to present our views on the budget for the upcoming fiscal year.

As with the President's budget submission, the IB is a broad plan for veterans' programs and includes recommendations for legislation to improve the benefits and services our Government provides to meet veterans' special needs. Consistent with DAV's primary responsibility in preparing the IB, and to avoid unnecessarily duplicating the testimony of my colleagues from the IB, my testimony will focus predominantly on the benefit programs, the administrative operations and resource requirements for delivering those benefits, and the judicial appeals process for veterans' claims.

The importance of an adequate budget for veterans' programs cannot be overstated. All else that the veterans' community seeks and this Committee undertakes during the year ahead is influenced to a large degree on available resources. Fortunately, the President's budget only provides a discussion document to begin deliberations. It does not dictate what Congress does for veterans. Likewise, support from the Budget Committee and appropriators is important but not entirely indispensable to what you, the authorizing committee, determine is appropriate for our Nation's veterans. Unfortunately, the Administration's budget request for fiscal year (FY) 2005 does fall short in many respects, and we are disappointed with its meager recommendations for benefit improvements.

The President's budget contains few recommendations for legislation to improve the benefit programs. For compensation, it includes the usual recommendation for a cost-of-living adjustment (COLA) based on the increase in the cost of living during the current year, projected to be 1.3 percent for fiscal year 2004. This increase for disability compensation would include dependency and indemnity compensation and the clothing allowance provided to veterans whose service-connected disabilities tend to increase wear and tear of their clothing.

To prevent the purchasing power of compensation from falling behind the cost of living as it increases, the IB also recommends a compensation COLA. However, to maintain the value of compensation in relation to the cost of living, the IB urges Congress to repeal provisions that require rounding down the COLA to the nearest whole dollar. Though this rounding down may erode the value of compensation very slightly for 1 year, rounding down year after year, with its compounding effect, eventually amounts to a significant degradation of the modest compensation veterans rely on to purchase the necessities of life.

The Administration's budget seeks legislation to bar compensation altogether for the effects of the added disability that results when veterans resort to alcohol to escape the extreme distress and disturbing symptoms of some service-connected mental disorders and other disabilities. This request reveals a callous disregard and insensitivity to the true nature of these secondary disabilities and how severely disabled veterans are victimized by them. It ignores the cause-and-effect relationship between the primary service-connected disability and the secondary effects. By using alcohol to ameliorate the psychological pain of these disabilities, veterans are attempting to quell their symptoms rather than choosing to be more disabled. In many of these instances, the underlying illness is so debilitating by itself that any additional disability attributable to alcohol accounts for no greater rate of compensation or is so inextricably intertwined with other psychiatric symptoms as to be essentially indistinguishable from them. Current law resolves these unfortunate circumstances equitably. Congress rejected VA's request for this legislation last year, and the IB urges Congress to respond with an emphatic "no" again this year.

Similarly, the IB is resolute in its opposition to any repeat of last year's misplaced scheme to fundamentally alter the bases for establishing service connection for service-related disabilities. Military service is not merely a job where an individual spends his or her regular working hours. Military service requires the service-

member to be at the disposal of the military authorities 24 hours a day 7 days a week and encompasses, indeed dictates, directly or indirectly all of a servicemember's life activities. Military service is inherently hazardous, and it involves physical and mental stresses beyond those experienced by civilian society. Current law therefore equitably treats disabilities that occur during service as service connected, without requiring a showing of cause and effect between particular activities or factors of service and the disability.

Because of the full-time, extraordinarily rigorous, and dangerous nature of service in the Armed Forces, and rather than becoming mired in the problematic nuances of causation in such a unique environment, causation is presumed. No other fair, foolproof, and practical method exists for determining service connection. The scheme devised last year for inclusion in the defense authorization bill would have been anything but fair, foolproof, and practical, although it would have been expedient for its self-serving purpose of permitting the Government to dishonorably disavow its obligation to care for our Nation's sons and daughters who are disabled in service to their country. By excluding from eligibility for service connection essentially all accidental injuries and diseases incurred during military service except those caused directly by work-related activities of servicemembers' military occupations, few would meet the extremely restrictive terms of service connection, and many would have insurmountable difficulties in producing evidence to isolate the cause to the direct performance of military duties.

The Department of Veterans Affairs (VA) projected that approximately two-thirds of the disabled veterans now entitled to disability compensation would not have qualified for service connection under these criteria. Obviously, the proposed scheme was calculated to achieve just that result. The action was brazen and reprehensible. Because its proponents were so shameless and unrestrained, we may very well see the same or similar action repeated. It will be no less repugnant, and no less objectionable to the veterans' community. We appreciate the decisive stand against this plan taken by the Chairman and other members of this Committee last year, and we urge you to again flatly reject any similar efforts this year.

The IB makes three additional recommendations to improve the disability compensation program. We recommend legislation:

- to exclude compensation as countable income for Federal programs;
- to repeal the prohibition of service connection for disabilities related to tobacco use; and
- to repeal delayed effective dates for payment of increased compensation based on temporary total disability.

The President's budget submission suggests legislation to make awards of death pension effective the first day of the month in which death occurred if the claim is filed within 1 year of the date of death. Prior amendments reduced this period from 1 year to 45 days. We have no recommendation for this legislation in the IB, but we note that it would be beneficial to needy widows of wartime veterans, and it would bring this effective date provision back into line with effective date provisions applicable to other disability benefit payments, simplifying the law for VA adjudicators.

Service-connected disabilities result in functional impairments that not only adversely impact upon veterans' ability to perform job functions but also adversely impact upon their ability to perform the everyday activities of living. For veterans suffering from service-connected blindness and physical disabilities that require special fixtures and modifications to allow them mobility and independence within the home, VA provides grants for the purchase or construction of specially adapted housing. For veterans with service-connected disabilities that interfere with their ability to operate motor vehicles, VA provides grants for the purchase and special modification of automobiles. Like other benefits that are subject to the effects of rising costs, the grants for specially adapted housing and automobiles must be increased regularly to match increases in costs of homes and vehicles. The value of these benefits has fallen substantially behind rising costs because there have been long periods between adjustments. Congress increased these grants last year, but the increase did not equal their cumulative loss in value and therefore did not fully restore them to the value they had when first established. To remedy this deficiency and to improve these programs, the IB recommends that Congress enact legislation:

- to increase the amount of the grants for specially adapted housing 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; and
- to increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs.

For the education programs, the President's budget includes suggestions for legislation to make three minor "technical" changes, although one of the amendments would make a substantive change to prohibit education benefits for servicemembers who are incarcerated for crimes and whose character of service upon discharge following their release from prison will be disqualifying. The IB has no position on these suggested legislative changes. However, for the education programs, we make two recommendations for legislation:

• to expand Montgomery GI Bill eligibility to persons who, but for service on or before June 30, 1985, would be eligible for education benefits under this program; and

• 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".

Although we have come to expect the Administration to propose actions to reduce or eliminate benefits and services for veterans, we were surprised by this year's suggestion in the President's budget for VA that Congress enact legislation to restrict veterans' use of home loan guaranties to one time. When they return to civilian life from military service, veterans often have very limited means to achieve the American dream of owning a home. They purchase "starter" homes. As their economic situation improves and families grow, they, like many other Americans, want to expand and improve their housing. In today's mobile society, veterans may be required to move to new locations to follow their jobs or the job market. If a veteran is in good standing with VA, his or her purchase of another home can be made easier by a VA guaranteed loan. Because of the limits on VA loans, veterans who use VA loan guaranty are those who must purchase moderately priced homes, and the repeat use of this benefit provides no unwarranted windfall for veterans. At the same time, it is no great burden on the Government. The ability of veterans to use their loan guaranty more than once can be very beneficial to them and to the American economy, without any undue cost to the Government. Therefore, this proposal to limit veterans to one loan seems to have as its object the reduction of veterans' benefits merely for the sake of reducing them, without any reciprocal benefit to the Government. In any event, this suggested legislation is unwarranted, and the IB urges you to soundly reject it.

The IB makes positive recommendations to improve the home loan guaranty program for veterans and other eligible beneficiaries. We recommend that Congress enact legislation:

• to increase the maximum VA home loan guaranty and provide for automatic annual indexing to 90 percent of the Federal Housing Administration-Federal Home Loan Mortgage Corporation loan ceiling; and

• to repeal funding fees imposed upon certain home loan guaranties.

For the insurance programs, the President's budget proposes legislation for technical amendments "to clarify certain points such as defining an insurable dependent, terms of coverage and premiums." According to the budget, these changes require no additional funds. Without more specifics, we have no position on the proposed legislation at this time.

The insurance programs for veterans are in need of added protections and revisions to replace long outdated rates and increase the maximum coverage available. Often, a veteran's life insurance policy is all that a veteran has to pay for his or her last expenses and burial. Yet, for nursing home care under Medicaid, the Government forces veterans to surrender their Government life insurance polices and apply the cash value toward nursing home care as a condition for Medicaid coverage.

Because of service-connected disabilities, disabled veterans have difficulty getting or are charged higher premiums for life insurance on the commercial market. VA therefore offers disabled veterans life insurance at standard rates under the Service Disabled Veterans' Insurance (SDVI) program. When this program began in 1951, its rates, based on mortality tables then in use, were competitive with commercial insurance. Commercial rates have since been lowered to reflect improved life expectancy shown by current mortality tables. VA continues to base its rates on mortality tables from 1941, however. Consequently, SDVI premiums are no longer competitive with commercial insurance, and SDVI therefore no longer provides the intended benefit for eligible veterans.

When life insurance for veterans had its beginnings in the War Risk Insurance program first made available to members of the Armed Forces in October 1917, coverage was limited to $10,000. A $10,000 life insurance policy provided sufficiently for the loss of income from the death of an insured in 1917. Today, some 87 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum

coverage, well over three quarters of a century later, clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

Similarly, the maximum coverage under the Veterans' Mortgage Life Insurance (VMLI) program has fallen behind current needs. The maximum VMLI coverage was last increased in 1992. Since then, housing costs have risen substantially. Because of the great geographic differentials in the costs associated with accessible housing, many veterans have mortgages that exceed the maximum face value of VMLI. Thus, the current maximum coverage amount does not cover many catastrophically disabled veterans' outstanding mortgages. Moreover, severely disabled veterans may not have the option of purchasing extra life insurance coverage from commercial insurers at affordable premiums.

These deficiencies substantially reduce the effectiveness of the insurance programs. To correct these shortcomings, the IB recommends legislation:

- 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 SDVI;
- to increase the maximum protection available under the base policy of SDVI from $10,000 to $50,000; and
- to increase the maximum coverage under VMLI from $90,000 to $150,000.

Veterans' benefits are for veterans, not others who have no right to them. Congress has been careful to ensure veterans receiving benefits are not easy prey for persons seeking to divert these benefits away from veterans and into their own pockets. Congress has placed restrictions on attorney fees, and Congress has included broad and sweeping protections in the law to prohibit the assignment of veterans' benefits and to protect them against the claims of third parties. Existing law provides:

> "Payments of benefits due or to become due under any law administered by the Secretary shall not be assignable except to the extent specifically authorized by law, and such payments made to, or on account of, a beneficiary shall be exempt from taxation, shall be exempt from the claim of creditors, and shall not be liable to attachment, levy, or seizure by or under any legal or equitable process whatever, either before or after receipt by the beneficiary."

Despite the prohibition against assignment, some commercial entities were enticing vulnerable veterans into arrangements whereby the veterans traded their future compensation payments for lump sums amounting to a fraction of the value of the compensation. Last year, Congress added language to the prohibition against assignment to leave no room for convenient interpretation of the law as permitting that practice. Despite the clear and emphatic language in the law shielding veterans' benefits from the claims of third parties, the courts have conveniently interpreted the law to permit what it unquestionably prohibits. As a result, veterans' benefits have become an easy target for former spouses seeking alimony. The courts show little reverence for the principle that veterans' benefits were created for veterans and little regard for congressional intent that a disabled veteran, and not someone else, should be compensated for the effects disability. Courts seem to have no hesitation in ordering disabled veterans to pay part of their disability compensation to able-bodied former spouses. This situation is appalling. The IB therefore recommends legislation to reinforce existing law so there can be no doubt that it means what it says.

While not under the jurisdiction of this Committee, we also call for legislation to remove, for all service-connected disabled military longevity retirees, the offset between their military retired pay and disability compensation. As you know, the legislation enacted near the end of the last session of Congress provides for removal of this inequitable offset for some disabled veterans. In so doing, it left the injustice in place for many other veterans. We also recommend legislation to extend the 3-year limitation on recovery of taxes withheld from disability severance pay and military retired pay later determined to be exempt from taxable income.

Although they need fine tuning from time to time, the benefit programs have been carefully crafted by Congress to alleviate the disadvantages veterans suffer as a result of disabilities and as a result of educational and vocational opportunities forgone by young men and women who chose to serve their country before personal advancement. These programs are effective only to the extent the benefits and services are delivered to entitled veterans when they need them. Efficiently and proficiently administering this broad range of programs for millions of veterans naturally and unquestionably presents formidable management challenges. Small mistakes can have major consequences for large numbers of veterans. Management and

process deficiencies, and insufficient resources, have consequences that are directly revealed through poor service to veterans.

Although such poor service frustrates veterans who must deal with a massive and complex bureaucracy, it causes more than mere inconveniences. Incorrect decisions deprive entitled veterans of the benefits they need, and long delays due to incorrect decisions and insufficient resources deprive entitled veterans of the benefits they need when they most need them. Of course, the correct and timely payment of disability compensation is imperative for veterans who must rely on compensation for food and shelter.

In fulfilling its mission of effective management of the benefit programs and effective delivery of benefits and services, the Veterans Benefits Administration (VBA) has a checkered history, especially in accurate and timely delivery of the core veterans' benefit, disability compensation. Some of the failures were self-inflicted and the product of a wrong-headed institutional mindset, others were due to more innocent mistakes, and many were caused or compounded by insufficient resources or other factors beyond VA's control.

With a focus and decisive action directed to real reforms and improvement, current management has made some headway in overcoming systemic deficiencies in the delivery of benefits. Congress has helped by providing the additional resources necessary to bring the workforce and technology to the capacity required. To continue on the course of restoring VBA to acceptable levels of performance and service to veterans—indeed, to avoid losing the gains made thus far—VBA must continue to devote its full energies to the process, and Congress must continue to provide the resources required to get the job done. The IB makes specific recommendations in both of these areas.

To enable it to more effectively enforce agency policy and performance standards, we have recommended that VBA make changes to remedy some weak links in its management structure. We have called for improvements in VA rulemaking to make VA's regulations more fairly serve veterans and to avoid litigation over challenged regulations. For VBA's Compensation and Pension Service (C&P), we have urged VA to devote more effort to attacking the root causes of errors in claims adjudication.

To ensure that VBA has the personnel and tools necessary to carry out its mission, we have made several recommendations regarding staffing and appropriations to support ongoing initiatives to develop and install modern information technology systems. Unfortunately, the President's budget request appears to seriously undermine VBA's systematic efforts to correct its deficiencies, employ better information technology, and improve its production and service to veterans.

The President's budget submission for VA clearly does not remain fixed on the objective of strengthening VBA to make it better able to fulfill its responsibilities to veterans. Due to the war in Iraq and the many hostilities in which our Armed Forces are engaged today, we can only expect an influx of new veterans needing VA benefits and services. Logically, more resources will be needed in some areas just to stay even with the workload. However, the President's budget proposes major reductions in resources for the delivery of benefits and services to veterans. For VBA, the President's budget requests 829 fewer full-time employees (FTE) for fiscal year 2005 than authorized at the end of the fiscal year we have just finished, fiscal year 2003. The request is 540 FTE below the fiscal year 2004 level. We note, incidentally, that the difference between the fiscal year 2003 and fiscal year 2005 FTE for VBA is apparently greater than the 829 employees indicated by the budget submission because, at the beginning of fiscal year 2004, the responsibilities and the 31 FTE of the Evidence Development Unit of the Board of Veterans' Appeals (BVA) were reassigned from BVA to VBA, without any corresponding request to increase VBA's authorized FTE by an equal amount.

Under the President's budget request, every benefit line except Insurance Service would lose employees. Even with all-out efforts, VBA's progress in reducing the backlog of work and the waiting times for benefits has been gradual and fairly slow-paced, representative of deliberate efforts within the limits of its abilities under the resource levels available in the past few years. We seriously doubt that VBA can suddenly accelerate and achieve enough productivity improvements to offset such a substantial loss of resources, especially against the weight of added work. The President's budget would also substantially scale back investments in ongoing programs to modernize VBA's essential information technology. These two proposed reductions strike the core of the veterans' benefits delivery system.

The President's budget proposes 7,270 FTE, or 487 fewer direct program FTE for C&P Service in fiscal year 2005 than in fiscal year 2003. In addition, the President's budget requests 185 fewer FTE for management direction and support and information technology in C&P Service for fiscal year 2005 than it had in fiscal year 2003. We also understand that the additional FTE for the Evidence Development Unit as-

sumed by VBA from BVA are charged to C&P Service. With those FTE absorbed by C&P and without any equal increase in the FTE requested for C&P, that number of employees must be calculated as an additional net reduction of FTE for C&P Service when comparing the fiscal year 2003 staffing with the request for fiscal year 2005.

We recommend in the IB that C&P Service be authorized 7,757 FTE for fiscal year 2005. VA had projected that its workload would allow it to draw down its FTE in fiscal year 2005 by approximately 268 below its staffing level of 7,757 FTE at the end of fiscal year 2003. However, those projections did not take into account additional work VA now expects incident to legislation that expanded eligibility for Combat Related Special Compensation and authorized concurrent receipt of military retired pay and disability compensation for certain veterans. VA projects that this legislation will generate 391,000 new claims and 52,869 appellate cases over the next 5 years. In addition, VA projects it will have to rework approximately 48,000 claims to meet the requirements of a court decision invalidating VA procedures that placed unlawful requirements upon veterans. Though most of that work should be done during fiscal year 2004, this additional volume will likely delay work on some of C&P's inventory and carry some extra caseload over into fiscal year 2005. This additional workload requires that VA, at least, have approximately the same direct program staffing levels for fiscal year 2005 that it had at the end of fiscal year 2003.

Just as VA must have sufficient staffing to match its compensation and pension claims workload, it must continue to have efficient procedures and technology for processing claims and related information. To aid in accuracy and uniformity in claims adjudication, and to achieve the greater efficiencies of modern information technology, VA began its Compensation and Pension Evaluation Redesign (CAPER) initiative during 2001. To determine and implement its optimum performance in record development, disability examinations, and claims decisions, VA is undertaking a review of its claims process with the goal of developing and deploying an integrated electronic format to aid in uniform and correct application of procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims data base. VA now hopes to have this system fully in place by September 2006. To achieve that goal, VA needs approximately $3.5 million in fiscal year 2005 to continue development of this system. The IB recommends that Congress provide this essential funding to VA. The President's budget requests only $2.7 million for this project.

Another aspect of systems modernization is the use of electronic files to replace manual paper transfer and storage of claims records. With the necessary imaging and other equipment, VA can acquire, store, and process claims data much more timely and efficiently, reducing task times and staffing needs. VA's project, known as "Virtual VA," has been deployed at VA's Pension Maintenance Centers and is undergoing evaluation and assessment based on experience at these three sites. With eventual full implementation, all VBA regional offices will have document imaging capabilities, and VA medical centers will have electronic access to veterans' claims folders for review in connection with disability examinations ordered by claims adjudicators. Accordingly, the IB recommends that Congress provide VA the $8 million it needs in fiscal year 2005 to continue document preparation and scanning at the Pension Maintenance Centers and to continue development of the system for application nationwide. The President's budget requests only $1.6 million for Virtual VA.

As with C&P Service, VBA's Vocational Rehabilitation and Employment Service (VR&E) faces major challenges in meeting its responsibilities to disabled veterans under circumstances of heavy workloads and limited resources. The impact of the worldwide war on terrorism, hazardous duty in other locations around the world, and major combat operations in Iraq and Afghanistan, will undoubtedly be felt by VR&E when these veterans begin pouring into the system with the need for rehabilitation training and employment suitable to their service-connected disabilities. To sustain current levels of performance with its projected workload, VR&E needs to retain the staffing strength it had at the end of fiscal year 2003. In addition, the VA Secretary's VR&E Task Team has made a number of recommendations to improve vocational rehabilitation and employment services for veterans. It is projected that approximately 200 additional FTE will be needed to implement these substantial reforms in the programs, organization, and work processes of the VR&E program. At the end of fiscal year 2003, VR&E direct program staffing was 931 FTE. The IB therefore recommends that Congress authorize 1,131 direct program FTE for VR&E in fiscal year 2005. The President's budget requests only 876 FTE for fiscal year 2005, and seeks 21 fewer FTE for management direction and support and information technology than VR&E had in fiscal year 2003.

Similarly, VBA's Education Service expects some increase in its workload, due to legislation last year that expanded coverage of the program to include additional

types of training. VA is striving to provide more timely and efficient service to claimants seeking education benefits. Education Service reports gains in these areas during fiscal year 2003. To continue on the course of improvement and to meet the added workload projected, Education Service must at least maintain its fiscal year 2004 staffing level. In fiscal year 2004, Education Service had 766 direct program FTE authorized, and the IB recommends that Congress authorize 766 FTE for Education Service in fiscal year 2005.

For veterans who do not receive a correct disposition of their benefit claims from VA's administrative claims adjudication processes, judicial review is available. Because the United States Court of Appeals for Veterans Claims is not a part of the VA or the executive branch, its funding is not included under the budget for veterans' benefits and services. The Court is nonetheless an integral part of the system of benefits for veterans, and this Committee does, of course, have oversight responsibilities and jurisdiction over any authorizing legislation pertaining to the Court and its functioning. Additionally, the United States Court of Appeals for the Federal Circuit has jurisdiction to hear appeals from decisions of the Court of Appeals for Veterans Claims and has jurisdiction to hear direct challenges to VA regulations. This Committee has jurisdiction over laws that govern review of these appeals and challenges to regulations in the Federal Circuit. For this area of great importance to veterans, the IB includes several recommendations.

In previous years, we have recommended in the IB that Congress amend the standard under which the Court of Appeals for Veterans Claims reviews the propriety of factual findings by VA's administrative appellate board, BVA. Under the "clearly erroneous" standard, the Court was essentially upholding any finding of fact against a VA claimant that had some "plausible basis" in the record although the law mandates that VA decide a factual question in a claimant's favor unless the evidence against the claim outweighs the evidence supporting it. This mandate in law is known as the "benefit-of-the-doubt" rule. This rule is based on the time-honored principle that we owe veterans greater considerations than ordinary citizens litigating in court or seeking government assistance from other agencies and that a veteran claiming benefits is therefore entitled to the benefit of the doubt when the evidence neither proves nor disproves his or her claim. With the Court upholding adverse factual findings for which there is merely some plausible basis, BVA was completely free to ignore the law and deny a claim for VA benefits even though the supporting evidence was much stronger than, or at least as strong as, the evidence against it. The Court was turning a blind eye to erroneous and unjust denials of meritorious claims, making the benefit-of-the-doubt rule unenforceable and meaningful only to the extent VA chose to observe it. Appeals to the Court often follow from arbitrary decisions in which VA chose to ignore the rule, but these appeals were essentially futile, with meritorious claims and justice denied. To correct this grave injustice, the IB recommended that Congress amend the law to require the Court to reverse any BVA factual finding against a claimant that was clearly inconsistent with the benefit-of-the-doubt rule. To accomplish this, we recommended that the clearly erroneous standard be replaced with an instruction that the Court must reverse any finding of fact adverse to a claimant that was not reasonably supported by a preponderance of the evidence, which is weight of the evidence required for such adverse finding under the benefit-of-the-doubt rule.

Seeking to continue its immunization from meaningful judicial review of its factual findings, VA opposed this change, and the veterans' committees compromised with less definite changes than the IB had recommended and thought necessary. As a result, the Court has construed the new legislation as making no change whatsoever. Indeed, VA itself argued to the Court that Congress made no substantive change in the law by these amendments. Deserving veterans are still left with no remedy for outright violations of the law. That is unacceptable. We therefore renewed in this year's IB our previous recommendation that Congress replace the clearly erroneous standard with the requirement that the Court reverse factual findings not reasonably supported by a preponderance of the evidence. Certainly, you should not again be persuaded to accept any compromise proposed by VA that will enable VA to once more argue to the Court that you did nothing. We want to reiterate here that this issue is one that remains very important to veterans and their rights.

When Congress ended the longstanding absence of judicial review for veterans' claims, it was very concerned that the formalities typical of judicial proceedings not change the informalities of VA's administrative claims processes. The legislative history for judicial review legislation emphasizes repeatedly congressional intent to preserve this informality and the pro-veteran procedures at the administrative level. Congress maintained in the law provisions that put the obligation on VA to develop the claims record and afford consideration to all possible theories of entitlement

under all relevant laws, regulations, and other legal authorities. The veteran is not required to know or argue the legal technicalities of benefits laws. Thus, failure of BVA to consider all points of law bearing on a claim is legal error, an error of omission. Yet, the Court has refused to consider these points in appeals on the grounds that the veteran failed to argue them before BVA. In effect, the Court is relieving VA of its obligations under the law and shifting them to veterans. The Court is imposing upon veterans the very thing Congress did not intend, the obligation to formally plead all the finer points of law that are often very complex and poorly understood by average laypersons. To prevent the Court from further imposing the formalities of adversarial judicial proceedings upon the non-adversarial veterans' claims process, the IB recommends legislation to prohibit judicial imposition of formal pleading or so-called "exhaustion" requirements upon the VA claims system.

Though veterans have deep frustration with some of the Court's actions, judicial review and many of the Court's precedents have added legitimacy to the process and forced VA to follow the law more carefully. Judicial review exposed deeply ingrained unlawful practices and deficiencies in VA's claims adjudication, and more than any other factor, forced VA to acknowledge these systemic defects and make fundamental reforms. As a result of the availability of judicial review and enforcement of the law by the Court, veterans stand a much better chance of getting a fair decision today than they did before judicial review was authorized by your landmark legislation in 1988. We still need to make adjustments to bring the process closer to that envisioned by Congress in its 1988 legislation, however.

The Chief Judge has begun exploratory steps toward securing a site and authority for construction of a courthouse and justice center. After an appropriate site is located, Congress must enact authorizing legislation and provide necessary funding if the project is to be undertaken. The IB fully supports the project to construct a courthouse for the veterans' court. We seek the support and essential assistance of the members of this Committee in securing a site, enacting the necessary legislation, and working with your colleagues in Congress to obtain the funding required to build this courthouse and justice center for veterans.

When Congress authorized judicial review of VA's claims decisions, it also authorized judicial review of VA's regulations. However, Congress exempted one area of VA's rulemaking from review by the courts. Congress expressly deprived the courts of jurisdiction to review VA's Schedule for Rating Disabilities. We agree with the reasoning that the courts should not be empowered to intervene in VA's application of its special expertise and the exercise of its discretion in formulating criteria for evaluating the effects of disabilities. However, we believe the United States Court of Appeals for the Federal Circuit should be authorized to review and invalidate rating schedule provisions that are, on their face, contrary to the laws enacted by Congress or are arbitrary and capricious. Such narrow review would not interfere with VA's lawful and legitimate exercise of its broad discretion, and would empower the Federal Circuit to intervene in only the most egregious abuses of discretion and invalidate only the unequivocally unlawful rating schedule provisions. Today, VA is totally immune to any remedy for flatly unlawful or arbitrary and capricious actions in adopting or revising its rating schedule. The IB therefore recommends expanding Federal Circuit jurisdiction to permit that court to review challenges to VA's rating schedule on these narrow grounds.

Finally, I want to join with our IB witness who is covering veterans' medical care in this hearing in stressing the importance of putting a mechanism in place to end what has unquestionably proven to be an inadequate process for funding veterans' medical care. Year after year, the President's budget request falls well below the minimum needed to maintain medical services for sick and disabled veterans seeking those services from the medical care system established to serve them. Year after year, we must fight an uphill battle to get more realistic appropriations, and that annual battle is getting ever more difficult despite the strong advocacy of the members of this Committee, who know what resources VA really needs. To get funding to continue operation of their medical programs, veterans should not have to compete with all the many other interests who seek part of the limited discretionary dollars. Veterans and VA should not have to face the yearly uncertainty of whether there will be sufficient funding provided to continue essential medical care services for disabled veterans. Veterans should not have to wait months to be treated for their illnesses. VA should not have to continue operating the largest medical care system in this country on the shoestring of annual appropriations and without any means to plan strategically for long-term efficiencies. We have thoroughly tested the discretionary appropriations process whereby political will, rather than actual resource needs, determines how much funding veterans' medical care receives each year. With consistent experience that funding veterans' medical care under that process has repeatedly failed, and will only continue to be unsatisfactory, the rem-

edy is to guarantee adequate and stable funding through a permanent authorization that uses a reliable formula to project resource needs. Among all the meritorious issues to be addressed by this Committee this year, this issue is the most urgent and therefore the most important to veterans. We need strong bipartisan support from the members of this Committee to get legislation for mandatory funding, and we renew our earnest request for your support this year.

In closing, I want to acknowledge and express the DAV's sincere appreciation for the advocacy and support veterans have received from this Committee. The Committee has acted favorably on many of the recommendations of the IB in past years, and many of the recommended changes are now in law, making the programs more effective for our veterans. Working together, the IB and this Committee have made numerous improvements in the benefits and the delivery system. We hope you will again find our recommendations meritorious and will shepherd legislation through this year to adopt more of them.

Chairman SPECTER. Our next witness is Mr. Paul Hayden, National Legislative Service, Veterans of Foreign Wars of the United States. Thank you for coming in today, Mr. Hayden, and we will put your whole resume in the record.

STATEMENT OF PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. HAYDEN. Thank you, Mr. Chairman, Ranking Member Graham. As a member of The Independent Budget for VA, the VFW is responsible for the construction portion of the VA budget, so I will limit my testimony to that area.

The President's fiscal year 2005 budget indicates that along with gross funding deficiencies in practically every VA account, VA construction is to be dramatically and most detrimentally short-changed, as well. In fact, since 1993, VA construction funding has been in steady decline. The fiscal year 1993 combined major and minor construction total was $600 million, and the fiscal year 2005 proposal is only $170 million.

VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets. It also flies in the face of statutory mandates to provide for the short- and long-term care needs of our most seriously service-connected veterans.

Once again, the administration is proposing counting State nursing home beds as part of its long-term care capacity. We view this as an attempt to circumvent both the letter and intent of the law with a number of our most deserving and vulnerable veterans suffering as a consequence.

Further, there continues to be a major resistance to fund an adequate construction budget before the CARES process has been completed. We have been supportive of the CARES process from the beginning as long as the primary emphasis is on the ES, enhanced services. However, we believe that it is poor policy to defer all VA construction needs until the CARES process is complete.

We agree with the findings of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. The VA must accomplish three key objectives. No. 1, invest adequately in the necessary infrastructure to ensure safe, functional environments for health care delivery. No. 2, right-size the respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements. And finally, cre-

ate abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

In order to accomplish these objectives, we recommend that Congress appropriate $571 million to the major construction account for fiscal year 2005, not the totally inadequate $97 million asked for by the administration. This amount is needed for seismic correction, clinical environmental improvements, National Cemetery Administration construction, and land acquisition.

We also call on Congress to appropriate $545 million to the minor construction account for fiscal year 2005 while rejecting the administration proposal of $69 million. These funds contribute to construction projects costing less than $7 million while providing for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects.

Mr. Chairman and members of this committee, this concludes my statement and I will be happy to answer any questions.

Chairman SPECTER. Thank you. Thank you very much, Mr. Hayden.

[The prepared statement of Mr. Hayden follows:]

PREPARED STATEMENT OF PAUL A. HAYDEN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee:

On behalf of the 2.7 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to take this opportunity to thank you for being included in today's important hearing regarding the Department of Veterans Affairs (VA) budget. As a member of The Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget, so I will limit my testimony to that area.

The VA construction budget includes major construction, minor construction, grants for construction of State extended care facilities, grants for State veterans' cemeteries and the parking garage revolving fund.

The President's fiscal year 2005 budget indicates that, along with gross funding deficiencies in practically every VA account, VA construction is to be dramatically and most detrimentally short-changed as well. In fact, since 1993, VA construction funding has been in steady decline. The fiscal year 1993 combined total was $600 million and the fiscal year 2005 proposal is only $200 million once the Capitol Asset Realignment for Enhanced Services (CARES) is backed out. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets. It also flies in the face of moral as well as statutory mandates to provide for the short- and long-term care needs of our most seriously service connected veterans. Once again, the administration is proposing counting State nursing home beds as part of its own long-term capacity. We view this as an attempt to circumvent both the letter and intent of the law with a number of our most deserves and vulnerable veterans suffering as a consequence.

Further, there continues to be major resistance to fund an adequate construction budget before the CARES process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the "ES"-enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of system-wide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance and renovations of VA facilities.

While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-term care and small-size facilities. These data should in-

clude such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In addition, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The VFW and other Independent Budget Veterans Service Organizations (IBVSO) are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

We recommend that Congress appropriate $571 million to the Major Construction Account for fiscal year 2005, not the totally inadequate $97 million asked for by the administration. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims. Allocated as follows: Seismic Improvements—$285,000; Clinical Improvements—25,000; Patient Environment—10,000; Research Infrastructure Upgrade and Replacement—50,000; Advance Planning Fund—60,000; Asbestos Abatement—60,000; National Cemetery Administration—81,000; IB Recommended fiscal year 2005 Appropriation—$571,000.

We also call for the Congress to appropriate *$545 million* to the Minor Construction Account for fiscal year 2005 while rejecting the administration proposal of $69 million. These funds contribute to construction projects costing less than $7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, a staff office account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects. Allocated as follows: Inpatient Care Support—$130,000; Outpatient Care and Support—100,000; Infrastructure and Physical Plant—150,000; Historic Preservation Grant Program—25,000; Other—25,000; VBA Regional Office Program—35,000; National Cemetery Program—35,000; and VA Research Facility Improvement and Renovation—45,000; IB Recommendation fiscal year 2005 Appropriation—$545,000.

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed as "significant" seismic risk and buildings that are at "exceptionally high risk" of catastrophic collapse or major damage. Currently, 890 of VA's 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

The IBVSO's believe, as we have indicated in the past, that there is ill-advised resistance to funding any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope. Also, consideration must be given to enhanced service recommendations provided for in CARES. Due to the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time.

We contend that Congress should appropriate $285 million to correct seismic deficiencies. Further, VA should schedule facility improvement projects and CARES recommendations concurrently with seismic corrections.

In *The Independent Budget* for Fiscal Year 2004, we cited the recommendations of the interim report of *The President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF)*. That report was made final in May 2003. To underscore the importance of this issue, we will cite the recommendation of the PTF again this year.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and DOD adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

It was also recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure."

The PTF also indicated that "Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program."

The PTF believes that VA must accomplish three key objectives:

(1) invest adequately in the necessary infrastructure to ensure safe, functional environments for healthcare delivery;

(2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and

(3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

Additionally, it was recommended by the PTF that "an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels."

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that the Veterans Health Administration's (VHA) investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2 percent and 4 percent of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is approximately $35 billion. The 2 percent–4 percent range would therefore equate to annual funding of $700 million to $1.4 billion.

The VFW supports the Price Waterhouse recommendation that VA spend at least 2 percent of the value of its buildings or $700 million annually on upkeep. Together with the IBVSO's, we believe that $400 million should be appropriated in fiscal year 2005 with continued increases in the following years until an appropriate level of funding, that will forestall the continued deterioration of VA properties, is achieved.

Congress should appropriate no less than $400 million for nonrecurring maintenance in fiscal year 2005 to provide for adequate building maintenance. VA should direct no less than $400 million for nonrecurring maintenance in fiscal year 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2 percent of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In addition, it has been suggested that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical re-

quirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger extensive "domino" impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics.

Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the "shell" space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a "gut" renovation to accommodate medical functions usually costs approximately 85 percent of the cost of similar new construction. If the renovation plan is less efficient, or the "domino" impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall "modern" structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary structures. Many current VA medical centers are built around prototypical "Bradley buildings." These structures were rapidly constructed in the 1940's and 1950's for returning World War II veterans.

Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The older hospital's wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital's central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics often make it unsuitable for modern medical functions.

VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate uses for its vacant properties.

Mr. Chairman and members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.

Chairman SPECTER. Our final witness in this round is Mr. Rick Jones, National Legislative Director of AMVETS. Thank you for being with us, Mr. Jones, and the floor is yours.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Thank you, Mr. Chairman, Ranking Member Graham. It is an honor to be here with you today and I would like to note appreciation for your strong leadership and continuing support.

Last year, Mr. Chairman, you played a critical role in terminating a dark-of-night proposal to make future disabled veterans pay the compensation of past veterans for their service-connected injury and we applaud you for your stand up, stand out defense of veterans. Thank you very much.

Mr. Chairman, without your strong commitment, Congress may fall short of providing the appropriations necessary to ensure that burial space for millions of veterans and their eligible dependents will be provided. The Independent Budget Veterans Service Organizations do work together and we work to ensure that the National Cemetery Administration remains a world class, quality service that honors veterans and recognizes their contribution to the security and development of our nation.

The members of The Independent Budget recommend Congress provide $175 million in fiscal year 2005 for the operational requirements of the National Cemetery Administration, the National Shrine Initiative, and the backlog of repairs. We recommend your support for a budget that would be consistent with NCA's growing demands and in concert with the respect that is due every man and woman who ever wore the uniform of the Armed Service of the United States. This is an increase of nearly $30 million over current year funding.

Funding for the State Cemetery Grants program, the members of The Independent Budget recommend $37 million in the new fiscal year. The intent of the State Cemetery Grants program is to develop a true complement to, not a replacement of, the National Cemetery System and it is a vital program. It has greatly assisted States to increase burial service to veterans, especially those living in more rural areas, less densely-populated areas that are not currently served by the National Cemetery System. For example, in the current year, the IBO's anticipate fast track opening in Idaho, Kansas, Massachusetts, and the Tidewater area of Virginia, where over 200,000 veterans reside.

The IB VSO's also recommend a series of upgrades on a number of burial benefits that have eroded over time since their initiation in 1973. The legislative proposals are part of the fiscal year 2005 Independent Budget and we ask for consideration of these proposals.

Mr. Chairman, I would just note one thing. On the cover of *The Independent Budget*, you will note that in the bottom left hand corner there is an individual in a wheelchair who has lost a leg who is sitting with his family. The picture above is also a picture of the same individual standing with his comrades prior to injury. I think this is important for us to note, that individuals who we expect to return, in full health as Priority 8 veterans may return otherwise. But in each case, it's a Priority 8 veteran who needs to step forward when a fellow soldier is injured, hurt, or, unfortunately, killed. We don't win our battles and we don't have victory without that commitment.

Thank you, sir, and God bless America.

Chairman SPECTER. Thank you. Thank you very much, Mr. Jones.

[The prepared statement of Mr. Jones follows:]

PREPARED STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. Chairman, Ranking Member Graham, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations at this hearing on the VA's budget request for fiscal year 2005. We are pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2005 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of *The Independent Budget*. This is the 18th year 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. Indeed, we are proud that over 30 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decisionmakers with a rational, rigorous, and sound review of the budget required to support authorized 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 health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a 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, the budget must recognize that VA trains most of the nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advances benefits all Americans. The Veterans Health Administration is the most cost-effective application of Federal healthcare dollars, providing benefits and services 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.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must address the continuing backlog in veterans waiting for health care and it must address, as well, VA's benefits 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 addressed and corrected.

As we look to fiscal year 2005, we watch a live lesson about the challenges inherent to inadequate funding. Due to a lack of resources, VA took action on January 17, 2003, to ban healthcare access to 164,000 veterans who could have enrolled last year. This ban remains in force, despite substantial increases in healthcare funding over the past 2 years. It is remarkable that after blocking entry to these so-called "high income" veterans, VA issued a healthcare directive (VHA Directive 2003–003, January 17, 2003) telling workers to send banned veterans to Community Social Work for assistance.

It is hoped that recently passed provisions contained in the fiscal year 2004 appropriations bill, which aim to overcome VHA Directive 2003–003, will remedy this breach of faith. When an individual commits to the defense of the rest of us, undertakes training that is inherently more dangerous than the typical civilian occupation, and stands ready to go into harm's way so that others need not, this country's gratitude should not be demonstrated with a simple referral, however courteous and sincere, to the welfare line.

Looking to the new year, *The Independent Budget* recommends Congress provide $29.8 billion to fund VA medical care for fiscal year 2005, an increase of nearly $3.1 above fiscal year 2004. We ask Congress to recognize that the VA healthcare system is an excellent investment for America. It can only bring quality health care, however, if it receives adequate funding.

We also ask Congress to understand that there are other potential challenges regarding veterans health care especially in regard to a new generation of veterans returning from Iraq, Afghanistan and the war on terrorism. By last year's count, more than 80,000 veterans who returned from the war have sought VA health care. And, it is likely the demand will remain strong for the foreseeable future. To facilitate their care, it is important that Congress work with the administration to accel-

erate the development of a seamless, transferable lifetime medical record between the DoD and VA.

It is also important to clearly State that AMVETS along with its IB partners strongly support shifting VA healthcare funding from discretionary funding to mandatory. Mandatory funding would give some certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has proven inconsistent and inadequate. Mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare funding matched the actual average cost of care for veterans enrolled in the system, the VA can fulfill its mission.

THE NATIONAL CEMETERY ADMINISTRATION

Before I address budget recommendations for the National Cemetery Administration, I would like members of the Committee to know that AMVETS fully appreciates the strong leadership and continuing support demonstrated by members of the Senate Veterans' Affairs Committee. AMVETS is truly grateful to those who serve on this important committee. Through your work, you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families.

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.

Currently, the National Cemetery Administration maintains more than 2.6 million gravesites on approximately 14,000 acres of cemetery land, while providing nearly 90,000 interments annually.

VA is scheduled to open new cemeteries in Atlanta, GA; Oklahoma City, OK; Pittsburgh, PA; Detroit, MI; Miami, FL; and Sacramento, CA. Also under legislation passed last year (P.L. 108–109), VA is directed to design and construct cemeteries at six new national locations in Philadelphia, Pennsylvania; Birmingham, Alabama; Jacksonville, Florida; Bakersfield, California; Greenville, South Carolina; and Sarasota County, Florida.

The strong effort to build new cemeteries recognizes the dramatic increases in the interment rate of veterans. NCA requires increases in funding if it is to carry out its statutory mandates. Without the firm 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 urge Congress and the administration to significantly boost NCA resources for fiscal year 2005. It should be recognized that not only is the interment rate increasing and the construction of new facilities accelerating, but also there are repair and upgrades needed. The Study on Improvements to Veterans Cemeteries, a comprehensive report submitted in 2002 by VA to Congress on conditions at each cemetery, identified nearly $300 million in over 900 projects for gravesite renovation, repair, upgrade, and maintenance.

As any public facilities manager knows, failure to correct identified deficiencies in a timely fashion results in continued, often more rapid, deterioration of facilities and increasing costs related to necessary repair. The IBVSO's agree with this assessment and believe that Congress needs to carefully consider this report to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. We recommend that Congress and VA work together to establish a timeline for funding these projects based on the severity of the problems.

Volume 3 of the Study describes veterans cemeteries as national shrines saying that one of the most important elements of veterans cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual even long after the visits of families and loved ones."

Indeed, Congress formally recognized veterans cemeteries as national shrines in 1973 stating, "All national and other veterans cemeteries" shall be considered national shrines as a tribute to our gallant dead." (P.L. 93–43) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and con-

tinues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

The members of The Independent Budget recommend that Congress provide $175 million in fiscal year 2005 for the operational requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces. This is an increase of nearly $30 million over current year funding.

Clearly, the aging veteran population has created great demands on NCA operations. Nearly 655,000 veterans deaths are estimated in 2005 with the death rate peaking at 690,000 in 2009; of these, it is expected that 109,000 will seek burial in a national cemetery. As veteran deaths accelerate, it is obvious the demand for veterans' burial benefits will increase.

THE STATE CEMETERY GRANTS PROGRAM

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $37 million for the new fiscal year. The intent of the State Cemetery Grants Program is to develop a true complement to, not a replacement for, our Federal system of national cemeteries.

With enactment of the Veterans Programs Enhancement Act of 1998, the NCA has been able to strengthen its partnership with States and increase burial service to veterans; especially those living in less densely populated areas not currently served by a national cemetery.

During fiscal year 2004, the IBVSO's anticipate fast-track openings at new cemeteries under construction—Boise, Idaho (the last State in the United States without a veterans cemetery); Wakeeny, Kansas (300 miles east of Denver and west of Kansas City, serving rural areas in western Kansas); Winchendon, Massachusetts (serving the densely populated northern part of the State); and Suffolk, Virginia (serving 200,000 veterans in the Tidewater area).

To augment support for veterans who desire burial in State facilities, members of The Independent Budget support increasing the plot allowance to $725 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to $725 would make the amount nearly proportional 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 Independent Budget veterans service organizations (IBVSO's) 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 IBVSO's recommend an increase in the service-connected benefits from $2,000 to $4,000. Prior to action in the last Congress, increasing the amount to $2,000, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSO's recommend increasing the nonservice-connected benefit from $300 to $1,225, 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 IBVSO's also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

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.

Chairman SPECTER. I would like to ask just a few questions at the moment. I would like each of you to comment on the proposals for mandatory funding. That has been a subject under discussion for a considerable period of time which would avoid the discretionary consideration each year, but the other side of it is it might not produce the kind of analysis and thoughtful examination depending upon the circumstances.

I would just like you to go down the row and tell me if you would like to see mandatory funding.

Mr. GAYTAN. Thank you for the question, first off. The American Legion fully supports mandatory funding and it is going to be key for the equation that reaches the amount needed for VA health care to be adequate. The equation that is used must ensure that the cost for each veteran is an adequate cost when determining exactly what the overall funding for VA would be under a mandatory funding mechanism.

Chairman SPECTER. Mr. Fuller, before you respond, Senator Graham would like to make a brief comment.

Senator GRAHAM. I apologize that I am going to have to leave for another 5 o'clock appointment, but I want to thank each of you for your contribution not only today, but with the excellent independent analysis that you have given to the VA's budget. That is very helpful to all the Members of the Congress and I thank you for that and appreciate your very helpful responses to the questions that I ask. Thank you very much.

Chairman SPECTER. Thank you, Senator. Thank you very much, Senator Graham.

Mr. Fuller, what do you think about mandatory funding?

Mr. FULLER. Paralyzed Veterans of America fully supports the concept of mandatory funding. We have become increasingly frustrated year after year after year when it is a constant battle, the budget fight that goes on. You hardly get one appropriation taken care of and you are already battling for the next year's budget request. We think that it is not only the question of how much you get, as I said in my statement, but when you get it. In the past 2 years alone, VA has——

Chairman SPECTER. Mr. Surratt, your view?

Mr. SURRATT. The DAV is one of the nine organizations, I believe, that is in the coalition supporting mandatory funding. We have a problem. We know what that problem is. We have a solution. There have been questions raised about whether a mandatory formula and the law would be flexible enough, but we project funding for discretionary appropriations and I believe that Congress can come up with a formula that makes necessary adjustments by making funding mandatory in law.

Chairman SPECTER. Mr. Hayden.

Mr. HAYDEN. VFW fully supports mandatory funding, sir.

Chairman SPECTER. Mr. Jones, do you dissent?

Mr. JONES. No, sir. No, sir.

Chairman SPECTER. On the issue of copays or entrance fees, is there any level that there would be any support for the VA proposals and their ways sprinkled all through the VA budget to try to raise some revenues, any means testing at all which would be acceptable to the veterans' organizations?

Mr. Jones.

Mr. JONES. We have a means test, sir. The interesting thing is that these user fees seem more intended to drive veterans away. VA projections last year on user fees suggested up to 1.2 million veterans who were currently enrolled would not re-enroll if they had to pay a user fee. The current projections with this smaller user fee is that over 300,000 veterans would not return and 200,000 would have trouble returning. That is about a half-a-million.

Chairman SPECTER. So you are opposed to all the user fees?

Mr. JONES. I think the user fees are intended to go about it in the wrong way, sir. Yes, we are opposed.

Chairman SPECTER. Mr. Hayden.

Mr. HAYDEN. The VFW is opposed to user fees, as well, sir.

Chairman SPECTER. Mr. Surratt.

Mr. SURRATT. The DAV is opposed to user fees.

Chairman SPECTER. Mr. Fuller.

Mr. FULLER. The PVA is opposed to user fees.

Mr. GAYTAN. The American Legion is, as well.

Chairman SPECTER. Mr. Gaytan, it is up to you.

Mr. GAYTAN. Yes, sir. We oppose it, as well.

Chairman SPECTER. The final question, and the hour is growing late and you have been very patient, the VA customer performance satisfaction rating remains low at 55 percent, despite stated increases in performance. First of all, do you think that there have been increases or improvement in performance? Does anybody think that is so in the VA?

Mr. GAYTAN. Sir, if you are mentioning performance as quality of care, yes, the American Legion recognizes the improvement in quality of care over the past 20 years. But as I stated earlier——

Chairman SPECTER. How would you account, Mr. Gaytan, for the fact that the customer satisfaction remains low at 55 percent?

Mr. GAYTAN. I think it would be due to wait times. Wait times for care——

Chairman SPECTER. Wait times?

Mr. GAYTAN. Yes, sir. Not only the extended wait times for months to get into the facility, but those wait times within the waiting rooms themselves. As I stated earlier, the American Legion has put together the System Worth Saving Task Force and we are out there visiting these facilities. Just this past week, we visited six different facilities in three different States and we are accruing that information. We are going to present that again to you this year, sir.

Chairman SPECTER. Does anybody else care to comment on that question?

Mr. Jones.

Mr. JONES. Well, it is an anomaly. It is hard to figure out, because what we hear is that once you are in, veterans are very pleased with the care. Fifty-five percent expression of performance and quality, that is interesting. I had not seen that. I thought that the performance and quality was way up and those who were in the system were well pleased with the care they received.

Chairman SPECTER. Mr. Fuller, what do you think?

Mr. FULLER. I think that we have a double-edged sword here. What we have always heard is that once you got into the VA, you said this was the greatest thing since sliced bread and I really love the VA. I am really surprised to see those figures. I would have assumed that they would have been higher, as well. I would be very interested in seeing a copy of that and also seeing if the committee staff could follow up on that for us in being able to find out from the VA what is going on here, because that is really rather astonishing.

Chairman SPECTER. Mr. Surratt.

Mr. SURRATT. I really don't have anything to add to that, Mr. Chairman. Our impression has been that veterans appreciate the care they get and think it is very good.

Chairman SPECTER. Mr. Hayden.

Mr. HAYDEN. I agree with my colleagues at the table.

Chairman SPECTER. The hearing ran a lot longer than we would ordinarily expect. You had eight Senators here today. That constituted a quorum. We haven't had a—I can't recall when we had a quorum with this hearing before, but I think that attests to the tremendous interest that the United States, this committee, and the whole Senate and the whole Congress have about veterans' issues.

We are looking at a very, very difficult budget. There is no doubt about the need for more homeland security and there has been a 9.7 percent increase there, more for national defense, 7 percent without even accounting for Iraq and Afghanistan, which is later, and the discretionaries are overall less than a half-a-percent. So the Veterans Administration did better than most.

But we will take a very, very close look at it, and I was pleased, as I said, to see Secretary Principi very candidly tell the House that they thought they ought to have more money, $1.2 billion, and we admire the work that your service organizations are giving. We are going to submit detailed questions and we will take into account your full statements and staff will be in touch with you further. Thank you for providing some bedtime reading.

[Laughter.]

Chairman SPECTER. One very short story. When I was one of the younger stories—and I say younger because I am still a young lawyer—for the Warren Commission staff, we had to produce 400 pages every Friday for Earl Warren because he was an insomniac and he couldn't fall asleep unless he had more to read than he could possibly read. So our assignment—this is a serious point, not the only serious point today but a serious point—we had to provide 400 pages for Warren every Friday. So thank you for providing some pages for me.

[Laughter.]

Mr. SURRATT. Mr. Chairman, we are disappointed to learn that the independent budget is a cure for insomnia.

[Laughter.]

Chairman SPECTER. Thank you all. The hearing is adjourned.

[Whereupon, at 5:08 p.m., the committee was adjourned.]

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