THE DEPARTMENT OF VETERANS AFFAIRS' BUDGET REQUEST FOR FY 2007 FOR THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

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THE DEPARTMENT OF VETERANS AFFAIRS' BUDGET REQUEST FOR FY 2007 FOR THE VETERANS HEALTH ADMINISTRATION

TUESDAY, FEBRUARY 14, 2006

U.S. House of Representatives,
Subcommittee on Health,
Committee on Veterans' Affairs,
Washington, D.C.

The Subcommittee met, pursuant to call, at 2:03 p.m., in Room 334, Cannon House Office Building, Hon. Henry Brown [Chairman of the Subcommittee] Presiding.

Present: Representatives Brown of South Carolina, Miller of Florida, Michaud, and Snyder.

Mr. Brown of South Carolina. The Subcommittee will now come to order. I would like to take a moment to welcome everyone to the first Subcommittee hearing of the second session of the 109th Congress. I look very forward to again working with my good friend, Mr. Michaud, the Ranking Member of this Subcommittee from the beautiful State of Maine. I am assuming it must be all white today. It is all white down here. I had the good fortune to visit Maine last year.

I would also like to welcome my Subcommittee colleagues back and provide you fair warning that we have considerable amounts of work ahead of us this year, and it effectively starts with our hearing today focused on assessing, with the help of both the VA and the veterans' service organizations assembled here today, the President's budget request for fiscal year 2007.

Dr. Perlin, it seems we have come a long way since last year. I want to publicly applaud you, Secretary Nicholson, and the President for assembling a budget request that I feel speaks loudly to the needs of our Nation's veterans, and attempts to keep pace with the emerging health care requirements of those who have faithfully served this country.

I think your 12.2% increase in a time of budgetary belt tightening is impressive and characteristic of an Administration that is continu-

ing to defending the Nation. Having said that, I share the concerns of a number of my colleagues, Republicans and Democrats alike, about the Administration's continued reliance on legislative proposals requiring veterans to pay more out of their pockets for health care.

I am afraid the political will of the Congress will simply not support such a proposal and I am equally concerned about the signal it sends to the country. I am also a bit concerned about a reduction in appropriated dollars for medical and prosthetic research. While I understand the research budget predicts an overall increase in research funding, the reliance on other Federal grants and private partners gives me pause.

In my mind there are few greater pursuits aside from the provisions of direct medical care that can have a greater impact on meeting veterans' health care needs in the future than good old-fashioned clinical research. I am sure you would agree.

Even with those few concerns in mind, I am encouraged by the proposed increase of funding levels put forward in fiscal year 2007 that would address important ongoing issues like long term care, mental health, and major and minor construction projects.

I look forward to discussion here today on all these issues. I also look forward to hearing from the veterans service organizations assembled here today, those who represent the Independent Budget, and those who have alternative ideas on what VA's budget should look like. Over the course of the next few weeks I want to work with all of you on issues where common ground can be found and to forge a solid budget of which all of us can be proud.

Mr. Under Secretary, I would again like to thank you for your continued service to the Department and this Nation. I would also like to remind you of a statement made by the Chairman of the Full Committee during last year's budget hearings. Chairman Buyer acknowledged that Secretary Nicholson had inherited the budget that you and he were forced to defend but he also warned that the Secretary would own it from now on. Today you own it and I look forward to your assessment of that proposal weighed against the Department's current requirements for health care.

[The statement of Mr. Brown appears on p. 40]

Mr. Brown of South Carolina. At this time, I now yield to our Ranking Member, Mr. Michaud, for an opening statement.

Mr. Michaud. Thank you very much, Mr. Chairman. I would like to welcome both panels and also wish everyone a happy Valentine's Day.

I want to thank you, Mr. Chairman, for holding this hearing to examine in more depth the fiscal year 2007 budget for veterans' medical care proposed by the President. I look forward to working with you to make sure that the budget reflects our Nation's full debt of grati-

tude to our veterans, the men and women who answered the call to service, whether it was combat or whether they wore a uniform as a career.

I am pleased that the VA's proposed budget for fiscal year 2007 includes increases in an attempt to meet the needs of our veterans. However, in the brief time that I had a chance to look at the proposed budget, it is clear that the impact of this budget proposal does not meet the much needed efforts of our veterans.

Several proposals are nonstarters, as the Chairman had mentioned. I will oppose any proposed enrollment fees, increased copayments and other efforts to place the burden of payment on the backs of our veterans who are seeking treatment from VA. These proposals finance VA's health care out of the pockets of our veterans.

The Administration calculates that its proposals will also discourage some 200,000 patients from continuing their treatment at the VA. Some suggest that fees and increased copayments are reasonable policies given the President's proposal for military retirees.

The systems are very different in key respects. The VA proposed fees and increased copayments greatly affects priority 7's and priority 8's veterans, most of whom are over age 65. TRICARE for Life beneficiaries, who are over 65, do not have to pay any enrollment fees and TRICARE for Life pays their Medicare deductible and copayments. Most importantly, TRICARE for Life beneficiaries can count on mandatory funding to pay for their health care.

If we are to import anything from the TRICARE system into the VA health care system, it should be the mandatory funding of TRICARE for Life.

I am troubled by the Administration's claim that the budget has a $3.5 billion increase when its budget request claims $1 billion in fiscal year 2007 in savings from efficiencies. The recently published GAO report, requested by Ranking Member Evans, found that the VA was unable to provide any support for the estimates of savings through efficiencies in the President's past budget request. Given the GAO found that the VA lacks a methodology for even making the savings assumptions about efficiencies, you can understand my concerns when you look at these efficiencies. Veterans health care needs real dollars, not smoke and mirrors on accounting methods. It needs the actual dollars.

VA also was proposing to continue the temporary ban on allowing new priority 8 veterans into the VA system. This policy has shut out over a number of years more than 2,403 Maine veterans, who have turned to the VA asking for their earned benefits, and they continue to do so. Rather than seek needed funding for these veterans, the Administration is seeking to keep the door closed to these veterans.

I disagree with this approach. In fact, Maine has a program and hopefully other States will adopt this program called Project I Served.

It encourages all veterans regardless of category to attempt to enroll in the VA system so that we can understand what the real need is out there. I think that it is an important program and hopefully other states will adopt it as well.

Finally, at the last week's full committee hearing on the budget, the Administration acknowledged that it was violating the law by proposing to reduce the VA's own capacity to provide nursing home care. The law requires the VA to have a capacity of 13,391 veterans, the same as it had in 1998. The VA wants to cut this capacity by 17 percent. It is wrong for the VA to ignore the law, especially at a time when more veterans are aging and the need for this type of care is growing.

I am also concerned with a report of VA facilities experiencing budget short falls. We heard that from Congressman Miller and others last week.

We all want to do right by our veterans. Dr. Perlin, I want to applaud you and the VA employees for the high quality care that the VA does provide to millions of veterans and I also want to commend the workers of VA for the courage and dedication during the Hurricane Katrina and Rita, and I look forward to working with you.

Our returning veterans and veterans from previous wars count on us to get this budget right, and I look forward to this Subcommittee doing its work and look forward to working with you, Dr. Perlin, and to make sure that we get the adequate resources that we need to do right by our veterans. It is the right thing to do, and I look forward to working with you to make sure that we do the right thing.

Thank you very much, Mr. Chairman.

[The statement of Mr. Michaud appears on p. 45]

MR. BROWN OF SOUTH CAROLINA. Thank you. I note we are joined by Dr. Snyder. Dr. Snyder, do you have any opening statements?

MR. SNYDER. No.

MR. BROWN OF SOUTH CAROLINA. Thanks for joining us.

Before we introduce the panel, I would like to enter into the record a letter from the Friends of VA Medical Care and Health Research proposing objection to the research budget cut. Without objection, I would like to enter this into the record.

[The letter appears on p. 105]

MR. BROWN OF SOUTH CAROLINA. Our first panel is Dr. Perlin. Would you please take a moment to introduce the members of your group with you.

STATEMENT OF HON. JONATHAN B. PERLIN, M.D., PH.D., MSHA, FACP, UNDER SECRETARY FOR HEALTH DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY BRIGADIER GENERAL MICHAEL J. KUSSMAN, M.D., M.S., MACP (U.S. ARMY RETIRED), PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH FOR VETERANS HEALTH ADMINISTRATION, RITA A REED, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS, JAMES F. BURRIS, M.D., CHIEF CONSULTANT FOR GERIATRICS AND EXTENDED CARE, DEPARTMENT OF VETERANS AFFAIRS, AND MARK SHELHORSE, M.D., DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Dr. Perlin. Thank you and good afternoon, Mr. Chairman, Ranking Member Michaud and Dr. Snyder. I am pleased to be here today to discuss the Veterans Health Administration Budget, and I know this is something this committee not only takes seriously, but makes sure to get a close view of how VA operates. I want to thank both the Chairman and the Ranking Member for coming to the Gulf Coast this summer and seeing the heroism of the work, but also the extent of the challenge that our employees faced.

I am pleased to be joined today, going from my right to left, by Dr. Jim Burris, who is the Chief Consultant for Geriatrics and Extended Care; by Ms. Rita Reed, Principal Deputy Assistant Secretary for Finance and Budget; Mr. Jimmy Norris, who is our Veterans Health Administration Chief Financial Officer; Dr. Michael Kussman, Under Secretary for Health, Dr. Mike Shelhorse, who is our Acting Deputy Chief of Patient Care Services for Mental Health Care. I would like to request your permission to enter the full statement into the record.

Mr. Brown of South Carolina. Without objection.

Dr. Perlin. Thank you, sir. Mr. Chairman, the VA's fiscal 2007 year budget totals $34.3 billion, an increase of $3.5 billion over fiscal year 2006 request. This represents an 11.3 percent increase, including $2.8 billion we estimate we will collect through the medical care collections fund. It is the largest dollar increase for VA medical care ever requested by a President. The proposed increase will allow VHA to continue to provide the highest quality care of any provider of health care in the Nation and in the world.

I am proud to note that our ability to provide the best care anywhere has been extensively documented in the media, in articles in *Washington Monthly, The Journal of American Medical Association, U.S. News and World Report, New York Times, The Washington Post,* most recently, *The National Journal,* among others.

For the 6th consecutive year, VA has also set the benchmark for health care satisfaction in both public and private sectors. These ex-

ternal acknowledgements of the superior quality of VA's health care reinforce our Department's own findings. VA not only leads the Nation in quality care but we are showing the health care professions an indeed the world how quality can be measured and improved.

Fiscal year 2007 we expect to treat nearly 5.3 million patients, including more than 100,000 combat veterans in Operations Enduring Freedom and Iraqi Freedom. To date, over 433,000 veterans of the two operations have separated from service and approximately 119,200 have come to VHA to meet some or all of their health care needs. More than 36,700 hundred of these individuals visited vet centers at least once. Last year, VA began hiring an additional 50 Operation Iraqi freedom and Enduring Freedom veterans to enhance our ability to reach out to their comrades through our readjustment counseling or vet center program, joining the 50 original OIF/OEF veterans who were previously hired into those roles.

We continue to take steps to insure that our health care forecasting model projects the needs of OIF and OEF veterans and based on these actuarial adjustments we have made additional investments in key services such as mental health care, prosthetics and dental care to insure that we will be able to continue to successfully meet the health care needs of those returning veterans and the needs of veterans from other eras.

Three key factors drive our additional funding requirement for fiscal year 2007. These are inflation; the aging of our VA veteran population; and, third, the greater intensity, complexity of the services provided when veterans seek care. We anticipate a significant increase in the use of our health care services in 2007 for several reasons. These include the utilization trends for health care in the United States, which are continuing as they have for several years to increase, as well as general medical practice patterns throughout the Nation that have resulted in an increase in the intensity of health care services provided per patient due to the growing use of complex diagnostic tests, advanced pharmaceuticals and biologicals and other sophisticated medical services.

This rising intensity of care can be seen in the VA's health care system as well. It has contributed to the higher quality of care and improved patient outcomes but requires additional resources to continue to provide the kind of care America's veterans have earned.

In long term care VA's 2007 request includes over $4.3 billion for long term care, $229 million dollars more than the 2006 level. We plan to expand our extended care services. Percentage increase in funding for non-institutional care grows about twice that for institutional care.

VA works to deliver care in the least restrictive environment for veterans. Our emphasis is on community-based an in-home care to provide extended care services to veterans in a more clinically appro-

priate setting and closer to where they live and in the comfort of their family and familiar settings.

In mental health, the Department's 2007 request includes nearly $3.2 billion. This is $339 million over the 2006 level and the provides comprehensive mental health services to veterans. These additional funds help insure the VA continues to realize the aspirations of the President's New Freedom Commission Report as embodied in VA's mental health strategic plan and will continue working toward restoration of function for mental health patients throughout our system.

VA will continue to place particular emphasis on providing care to those suffering from a spectrum of combat stress reactions ranging from normal and expected readjustment issues to post-traumatic stress disorder, all of which may occur as a result of service in combat in Operations Enduring Freedom and Iraqi Freedom. This includes the December, 2005 designation of three new centers of excellence in Waco, Texas, San Diego, California, and Canandaguia, New York, devoted to advancing the understanding and care of mental illness.

In research, the President's 2007 budget also includes $399 million to support advances in medical and prosthetic research. Last year VA's partnering with a major pharmaceutical company produced a vaccine that decreases the incidence and severity of shingles and will become a world wide practice standard for preventive care.

This investigational study was one of the largest adult vaccines studies ever conducted. Through recognized studies such as these, VA continues to able to attract, what I believe, is the best team of investigational researchers in the world; scientists who are also physicians and nurses and psychologists and pharmacists and other health professionals who also bring state of the art knowledge and skills to the care of America's veterans.

The 2007 budget also includes $832 million for IT services for our medical care program. The most critical IT project or our medical care program is the continued operation of our Department's electronic health record, one of the crown jewels in VA health care. Our electronic health care system has been recognize worldwide for its ability to increase productivity, safety, quality and to increase efficiency.

The President has made the implementation of the electronic health record throughout all of health care in the United States one of his highest priorities and VHA is proud to support the President in this vital effort.

In summary, Mr. Chairman, the $34.3 billion that the President is requesting for 2007 will provide the resources necessary for VHA to provide timely, high quality care to nearly 5.3 million veterans, especially those with service connected disabilities, lower incomes or special health care needs.

I look forward to working with the members of this Subcommittee

to continue our Department's tradition of providing timely, high quality services to those who help defend and preserve freedom around the world.

So I thank you, Mr. Chairman, for the opportunity to be here today and for your continued support of VA and the veterans. At this time my colleagues and I would be pleased to answer any questions that you or other members of the Subcommittee may have. Thank you.

[The statement of Dr. Perlin appears on p. 48]

MR. BROWN OF SOUTH CAROLINA. I thank you, Dr. Perlin, and we do have some questions we would like to ask if you would bear with us just for a moment.

DR. PERLIN. Mr. Chairman, one question. We had heard there may be some interest in going through a review of the budget. That is the reason the projector is here. If you would like to go through with that, we would be happy to do that. Alternatively, our chief financial officer would be delighted to go through it with staff at another time.

MR. BROWN OF SOUTH CAROLINA. How long would it take, do you think?

DR. PERLIN. Probably not more than 10 minutes.

MR. BROWN OF SOUTH CAROLINA. Dr. Snyder, do you have a position on that?

MR. SNYDER. I will defer to your good judgment, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Dr. Perlin, the staff says they have the copies and already have been briefed. So if you would go with us on the question period, and maybe that would help us get through. I appreciate the thoroughness of your presentation, and I think you covered a lot of points. This would give us a chance to utilize your time more valuably just by responding to these questions.

DR. PERLIN. Thank you, sir.

MR. BROWN OF SOUTH CAROLINA. If I may, according to the budget submission, the VA anticipates a $13 million reduction in the appropriation request for VA research programs. I know you went through a lot of programs where additional money was being spent. While research funding overall is expected to increase due to other Federal grants and resources, why is veterans research taking a back seat in the budget proposal?

DR. PERLIN. Thank you, Mr. Chairman. I appreciate the concern of this Committee. I have a bias; I am trained as a researcher and this is an area that is particularly important to us. It is correct that there is a $13 million decrease in the 2007 appropriation request over the 2006 enacted. I would note that there is an increase of the same amount in the medical services budget, and it is anticipated that this direct appropriation and additional support can be leveraged to obtain additional Federal resources and nonfederal resources in the amount of $17 million, for a net increase in the size of the research

program of $17 million.

MR. BROWN OF SOUTH CAROLINA. Further, I am hoping that you can comment on the process we started down in my district between the VA and the Medical University of South Carolina. As we consider major and minor construction projects on an ongoing basis, can you provide me with some type of assurance that the VA and University model and their synergy can be seriously considered when new construction projects are put on the table? Also, can you provide information on any other VA facilities where this type of model may have clinical and financial utilities in the near future?

DR. PERLIN. Thank you, Mr. Chairman, for the opportunity to comment on that. I want to thank you and Chairman Buyer and the entire team because looking at the opportunities for potential collaboration at Charleston allowed us essentially not only to look to what we might be able to do to improve veteran care in the Charleston, South Carolina area and create synergies with the community, but how that might apply more broadly.

One immediate outcome of that collaborative effort with Medical University of South Carolina was the ability to determine that it would be useful to share some high tech equipment for very advanced radiation therapy and angiography in a process in which VA would provide the equipment and that the services would be provided at free or reduced cost to veterans. So this would advance care not only for veterans, but citizens in the State of South Carolina. So we think we have a template.

You asked how this might be applied, and in the spirit of that being a template, it is really a tool that we hope to look at other collaborations when we have potential for developments at new sites. Of course, as we contemplate how to recover in New Orleans, and you saw the extent of the damage yourself, and Congressman Michaud as well. We have academic affiliations there. And I think it appropriate that we use that sort of analysis to determine what the most efficient, most effective, highest quality approach to health care is, and we will be using that as a lens to look at that sort of relationship.

MR. BROWN OF SOUTH CAROLINA. How is New Orleans coming? Have you been able to make any kind of determinations whether you are going to be able to have some joint collaboration with any of those hospitals there? Are any of them back in operation yet?

DR. PERLIN. Sir, the city hospitals are not up to full level as they were before the storm. In terms of the academic affiliates, I understand that parts of Tulane University have resumed activity in town. The hospitals of Louisiana State University which operate the Charity System as well as University Hospital have a little bit deeper damage.

We affiliate and partner with both, and in fact, in terms of answering your question, we formally owe you a report of our plan on the

28th of this month. We will be actually continuing negotiations, which are really very promising in terms of looking at ways that we might be most effective and efficient in the delivery of services.

I am proud to say that we are not only coming back in terms of inpatient care but we are back in terms of outpatient care. The week before Christmas, I was really privileged to go down and open up an outpatient clinic right adjacent to the hospital site, in the building that has eight floors of parking deck and then a nursing home above it; that nursing home is now offering primary care, and within a couple of weeks specialty care services as well.

As well, I commend the staff of VISN 16 under the leadership of Dr. Lynch for really expediting three clinics from a very temporary status into a much more robust form to really serve those veterans who were forced to leave the downtown city proper.

MR. BROWN OF SOUTH CAROLINA. Do you get a feel for whether many of them are coming back or how the patient load compares to, say, the same time last year?

DR. PERLIN. That is such an important question because it, of course, is key to how we consider getting back in town. It is pretty clear that while the city population may not reach the prestorm levels, a lot of those veterans only went a short distance to a ring around the city. And even with very conservative estimates about the repopulation of New Orleans, it is clear over the 20-year period there will still be growth in the utilization of services in the metropolitan area and part of Louisiana, and even Mississippi.

MR. BROWN OF SOUTH CAROLINA. The 2007 budget before us calls for an increase of $339 million above last year's level for mental health services. In the absence of a concrete strategic plan is this adequate to address the new realities, especially in areas like PTSD?

DR. PERLIN. The increase of $339 million actually brings the mental health, in a very restricted statutorily defined definition, to $3.2 billion. It absolutely increases the capacity in our specific areas such as PTSD care. In fact, there will be PTSD care teams at every hospital, and in fact, PTSD specialists available throughout all of the of medical centers and system.

MR. BROWN OF SOUTH CAROLINA. One last question. I am interested in the Department's opinion on Senate bill 716, the Vet Center Enhancement Act of 2005. You know, it calls for 50 additional FTEE's to be used for outreach and counseling at the now 207 Vet Centers around the country, while expanding bereavement eligibility to the parents of those who are killed in service to this country.

I know that we have hired roughly 200 new FTEE's for this role over the past few years. Can you tell me whether or not those FTEE's are meeting the current requirements at the Vet Centers?

DR. PERLIN. Thank you for that question. Yes, the FTEE who are these global war on terror outreach counselors are themselves veter-

ans, and they are, in fact, going out to demobilizing units and meeting with separating service members. Sometimes when the unit comes back to drill, they meet again with them, and they really are an excellent group of individuals.

Our Department, and I honestly cannot remember the formal opinion of this prepared legislation, but this would formalize what, in fact, we are doing, which is to provide that outreach.

As to the bereavement counseling aspect, regrettably, there are times when it is necessary to provide counseling because there has been a loss of a service member, and our vet centers and the counselors do step forward, are ready to provide grief counseling to families and all survivors of a deceased service member.

MR. BROWN OF SOUTH CAROLINA. Do you think the 50 FTEE's are adequate? Is there enough demand to utilize 50 additional FTEE's?

DR. PERLIN. As I understand this bill, and I may need to check, is that this would formalize not the first 50 FTE's, but the second FTE's who are already on board. It would change their appointment category from a term limited to a permanent, which is something that I would have no objection to, particularly as some of the older members of the counselor cohort from the Vietnam era retire.

MR. BROWN OF SOUTH CAROLINA. Thank you. Thank you very much.

Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Perlin, you had talked about the increase in budget for VA. Having been Chair of the Appropriation Committee for many years in the Maine legislature, I look at when we give increases as far as the outcomes. And when you look at the need out there, particularly with the World War II veterans, as they get up in age, they require more services, plus the war in Iraq and Afghanistan, where having men and women come back and also the increase in need. Even though there has been an increase, my concern is the fact that we are not meeting that need because of these components. Although I do agree with you as far as the quality of care for those veterans who receive care from the VA. I have heard nothing but high remarks for them, so I commend you for that.

On fiscal year 2005 and 2006 budget projections and assumptions were off the mark. Fortunately, through a bipartisan effort Congress, corrected this shortfall and I am very concerned when I am hearing from facilities who are struggling to make ends meet and are facing shortfalls, and as the Chairman mentioned, this is your budget, you own it, you can't blame it on the previous administration for that of the VA.

Some of the shortfalls that we are hearing and as brought up last week as well with the Secretary is that the VA Medical Center at West Palm Beach is facing an $18 million shortfall, San Diego facil-

ity, an $8 million shortfall, the facility in Seattle, a $4 million shortfall. Iowa City is projecting it will need to convert nearly $2 million in equipment dollars. Clarksburg, West Virginia will have a $4.5 million shortfall. There are many more.

When the shortfalls were brought up last week, you said you would look into it. How many VISN's out there will be facing a shortfall?

DR. PERLIN. First, I want to thank you for your support of budget amendments in 2005 and 2006 in response to the President's request. The 2007 budget is indeed Secretary Nicholson's and my budget. We are able to understand and describe that this is a very robust increase relative to growth.

To your question of the current status of facilities, networks in terms of making sure they have the resources to provide care to veterans this year, I have queried each of the networks and they have the resources to provide care throughout the system to veterans.

Are there facilities that, at any point, which in a very early point in the year may project that things will be tighter than they would want? I think it is fair to say there are facilities that individually may believe that they face a challenge.

Our network directors, however, have the responsibility of making the allocations within the networks and moving dollars around. We feel pretty good about the VERA, Veterans Equitable Resource Allocation, model which distributes dollars to the network on the basis of a formula based on the complexity of patients and the historic workload.

On the other hand, within the network there are a lot of judgments that are made facility to facility and we will be working with network directors to make the adjustments in terms of the micro allocations to individual facilities to make sure that they have the resources necessary.

I think Florida is a very interesting area. If I remember off the top of my head, for this year the budget is $2.674 billion. This is over a of 9 percent increase in the face of a 3.6 percent increase in workload.

So there is also a question I have to ask which is how do we improve efficiency in the use of those dollars, and I think that is a fair question as well and will be working to do that and working with the networks to move resources if there are particular issues.

MR. MICHAUD. I can appreciate that and I think you ought to do everything that you can to be efficient, but an $18 million shortfall is a significant shortfall, and there are shortfalls out there. I have got, which I will not share with you, internal memos from the VA from different VISN's telling about their shortfall. And if I have those memos, I am sure that central office should be aware of, the shortfalls.

Will you be requesting a supplemental budget to help address this issue, because it is an issue that when the Secretary first came on board I had talked about shortfalls and later in the year proved out

that they were borrowing money from other VISN's just to meet the dramatic shortfall, and ultimately you came in and asked for this.

What are you doing to monitor this, the shortfall in the VISN's to make sure that they are meeting needs. I just visited Togus before I flew down here yesterday. There are about 40 vacancies at Togus. They delayed hiring. I am sure that is occurring throughout the Nation as far as hiring delays, as far as purchasing equipment.

DR. PERLIN. You have very important questions. Let me be clear, we have the resources to provide high quality care to veterans this year. I think it is important in terms of the use of the term shortfall to be clear in terms of the way funds may be reprogrammed and that is a technical and formal aspect and I would ask our chief financial officer Jimmy Norris, Mr. Norris to comment on that.

MR. NORRIS. Yes, sir. We do monitor the VISN execution on a monthly basis in looking at that, and no one, no network director or VISN CFO has told me they are having a global problem or problem with their total amount of funding. What we do know they are having a problem with is some out of balance in the accounts. We have three appropriations, and we are probably a little short in medical administration. We know there are some shortages out there in that account. We are analyzing that. We will probably be coming forth with a request to reprogram some money and move money around among accounts.

But when we add it up at the bottom line we don't see any indication at this point, and it is early in the year, but we don't see any indication at this point that overall there is a shortfall.

DR. PERLIN. I would just add if I might that Secretary Nicholson made a commitment as well to meet with our oversight committees, appropriations committees quarterly and provide that information so that you have the information as we do to see if anything is getting out of kilter.

I think it is well known that 2005 was a very tough year. In retrospect, no one has any desire to recapitulate that. This is something I can assure you we will monitor closely and look at those micro allocation aspects on the budget line appropriation transfers that Mr. Norris discussed as well.

I should note that we also have a parallel set of briefings with the Office of Management and Budget so that they are apprised and know exactly how we are executing relative to budget.

MR. MICHAUD. The VA National Leadership Board has a finance committee that I believe is meeting shortly. Will you, Dr. Perlin, direct your staff to ask about these shortfalls at the facilities and report to the Subcommittee the information that you receive. Because my concern is that VISN folks are told not to ask for any additional money and to try to keep the issue about the shortfall quiet. And I hate to read about it in the paper first before we hear from you.

My second question is I have heard that facilities must pay back the amount that they received to cover the last year's shortfall. What process do you deal with VISN's that had to borrow money, as far as paying it back?

DR. PERLIN. If I might answer your first question, which is I believe the finance committee is actually meeting yesterday and today in conjunction with the national leadership board. In fact, this is something that is discussed there but it is something that I, because of my interest, asked our office to query each of the network directors, and do this periodically.

As to the second part, I don't know whether we have determined exactly what the manner of repayment will be, and I might ask Mr. Norris to comment on that and whether we are maybe granting any leniency.

MR. NORRIS. Sir, I am not sure I am familiar with that. We did not provide any money to any VISN's or facilities that I am aware of that we have asked for them to return in a subsequent year. I do think there was some trading among themselves out there and perhaps they made deals that they would trade and pay back. I would be happy to follow up an check that out; I am just not aware of it myself at this point.

MR. MICHAUD. So you think it is within VISN's if they borrowed money from another VISN.

MR. NORRIS. Yes, sir.

MR. MICHAUD. I appreciate you checking on that.

MR. NORRIS. I think the reason is some of them were better off in their capital areas than others were and they were able to forego some of those things and so they could delay some things to a subsequent year and help their counterparts out. I will be happy to check that.

MR. MICHAUD. Thank you.

Last week, the Secretary testified that in the budget they plan on opening, I believe it is 43 new CBOC's. The CARES process identified the need for CBOC's in VISN 1 and we, Mr. Brown and I had a hearing actually in Maine and that was one of the issues that came up, Maine being a rural state and actually 16 percent of our population veterans, one of the highest percentage in the country.

Presuming that you receive the budget request for fiscal year 2007, or hopefully an improved budget for fiscal year 2007, would you envision that one of the 43 CBOC's actually as predicted under the CARES process be in Maine?

DR. PERLIN. I note that there are a number of CBOC's that have been identified in the CARES process for Maine specifically. I would prefer to look into the details and discuss with the network. As you know, the CBOC's process is a consideration where a plan is put together that especially with those that have been approved or identi-

fied in the CARES process meet certain criteria in terms of need, access, in terms of capacity.

But subsequently there is a process where an operational plan is put together, the network comes forward having to demonstrate that they have the resources, and ultimately Secretarial approval is required. And so it is something that has helped us improve health care, it is helped us move to a model that helps to promote health and prevent disease, so it is something that we very much endorse.

As I think you know, since 1996 we have increased the number of outpatient clinics by over 350 percent. So we obviously believe in this model and will open clinics as we can.

MR. MICHAUD. Thank you. My last question, Mr. Chairman. I don't know off the top of your head, but if you can provide later on, it is either to Mr. Norris or Dr. Burris. The VA is budgeting to maintain an average daily census of 11,100 in VA-operated nursing home units. The law requires the VA to maintain a level of 13,391. How does the VA project the cost to maintain the 11,100 ADC in fiscal year 2007, and how much would it cost to maintain the statutory minimum of 13,391. If you don't have those numbers with you, if you can provide it in writing to the Committee.

DR. PERLIN. I think we probably should calculate those and then provide those back to the Committee. [This information was not provided to the Committee.]

MR. MICHAUD. Thank you. Thank you very much, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Michaud.

I will take this opportunity to enter Ms. Corrine Brown's statement in the record, without objection.

[The statement of Ms. Brown appears on p. 47]

MR. BROWN OF SOUTH CAROLINA. Dr. Snyder.

MR. SNYDER. Thank you, Mr. Chairman. Dr. Perlin, I would like to continue this discussion about the research numbers that I had asked about the other day when you were here with the Secretary. In Little Rock, we get very good feedback about the patient care there and in your written statement you talk about the high quality of care. In your section on intensity of care, because of the increase of sophistication, for want of better word, of the care, but a lot of it comes from research, and a lot comes from research at the VA, so I am having trouble reaching a conclusion about why this number is not more robust in this budget at this time in our history.

My math may not be right, but I think your research number is 399 million, which you say is an increase of 17 million from 2006, is that correct?

DR. PERLIN. The 399 million; the direct appropriation is $13 million less than the direct appropriation in the 2006 budget request. $13 million is added to medical services and 17 million is what is antici-

pated to accrue from other research.

MR. SNYDER. So you are saying that is a net increase in the research budget of 4 million?

DR. PERLIN. No, sir. The 13 million that is being requested for the direct research appropriation -- the direct research appropriation is $13 million less. Medical services support component is $13 million more, offsetting any decrement in the direct medical research appropriation. So that is a sort of net of zero.

Then it is estimated that $13 million can be accrued from Federal grants and $4 million from private foundation grants, for a net increase of 17 million.

MR. SNYDER. A net increase of 17 million.

DR. PERLIN. Yes.

MR. SNYDER. Over the budget. I will begin with what I said, your number 399 million. So for the last year it must have been we are saying 282. I am sorry; 382. 382 plus 17 gets me to 399.

DR. PERLIN. No. I need to sum up the different components of the research budget. I will just take a moment.

MR. SNYDER. I know this is important but we have limited time. I am going by your number and says it is $339 million to support VA medical and prosthetic program. You stated that that is a $17 million increase, because the 13 is a wash, so why am I going wrong by saying last year's must have been 382?

DR. PERLIN. I am sorry if I made it confusing in terms of the terms. The overall research resources are $1.649 billion, $17 million more than the $1.632 last year, but you are absolutely correct that the direct research support component of that actually is $13 million less than the 412 in last year's budget appropriation.

MR. SNYDER. I want you to help me then. So we are saying the total research budget is 1.65 billion, an increase of 17 million. I don't have a calculator here with me, but that must be a .01 increase or somewhere less than -- just a very minimal increase over 1.65 million.

What do you consider is the medical inflation rate amongst VA research. How much increase do you need from year to year to hold your own?

DR. PERLIN. I would have to get back on a specific number. I know that overall inflation will certainly be higher than the number you have suggested.

MR. SNYDER. I know that but it is substantially higher than the normal inflation rate on groceries and everything else, is it not?

DR. PERLIN. That would be correct.

MR. SNYDER. I am trying to get a feeling for how you all arrived at a number when, you know, you are bragging on the research your doing at the VA and the kind of research you have ongoing, bragging on the results, and then -- I don't know if this is right or not, the FOVA letter today, they say it is going to result in cutting 286 VA direct research

employees. Because of the inflation, they don't discuss that in detail, if you have a number that is essentially a hold your own number in nominal terms, it real terms it doesn't, and you end up in cuts in the VA budget. This is a budget that cuts VA research and you can't say that it is not. It is a substantial cut in VA research because of the medical research inflation rate, which is high. Why would we end up -- is this an OMB thing? Did you all ask for a higher number and OMB said no, we can't do that?

DR. PERLIN. I am not sure on that specific aspect.

MR. SNYDER. Is the number that is in this budget that you are testifying here today, is this adequate to do the job for maintaining the level of research that is going on now at the VA?

DR. PERLIN. The proposed appropriation for direct research support of $399 million will not maintain to the level of activity of direct VA employees. It does, however, allow for leveraging for additional activity, other Federal grants, but the direct answer to your question is no.

MR. SNYDER. Even if you achieve the level of research grants from outside entities, it won't do it with the numbers you are giving me.

DR. PERLIN. In terms of the FTEE, the full-time employee equivalence, you are correct.

MR. SNYDER. So why are we doing that, Dr. Perlin. Are you satisfied with this?

DR. PERLIN. I am a researcher by background so I have to identify that I am very biased in that area. I do know that the research that is being conducted is increasingly focused on veterans issues, but I also know research is one of the most important ways of attracting topnotch physicians and scientists and, as I mentioned, nurses, psychologists and other health care professionals to both advance the science in the interests of the health and well being of veterans and serve veterans with patient care.

MR. SNYDER. My time is up, Dr. Perlin. I have great respect for you and the work you are doing. I am glad you there. Everything I have heard you say in your opening statement and written statement in response to questions from the Chairman and Mr. Michaud argue for a robust budget for research. The only thing that is inconsistent with that is the budget for research.

I don't know where the problem is. Somebody is trying to find dollars to save in an area we ought to not find dollars to save in. We ought to be doing it by increasing efficiencies and then plussing up the numbers so more good things can be done.

All your arguments point, we ought to be going in a different direction because this budget is a cut in medical research in real terms, and there is no way, I mean, as you acknowledge, there is no way to get around it.

I assume maybe we will have another round of questions, Mr.

Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Dr. Snyder. I would like to ask, on that same line of questioning, Dr. Perlin, is VA partnered with any other medical groups in research like we have been asking you to do, to partner up with the health care delivery system?

DR. PERLIN. Are there partnerships going on in research; that answer is yes, there are absolutely partnerships going on in research. Part of the capacity of the VA to really provide cutting edge research are partnerships that exist not only with 107 of the Nation's medical schools, but 1,500 programs in health profession educations, partners as well with other Federal agencies, including obviously, Department of Health and Human Services and all branches of the National Institutes of Health, but also with State agencies and of course the Department of Defense. So the answer to your question is partnership is absolutely critical.

Partnership also occurs in the private sector. I mentioned in my opening statement a vaccine that will fundamentally change preventive health care practice in adults, that was a partnership with private sector bringing this vaccine to the market, probably twice as fast as had it been done anywhere else other than in VA.

MR. BROWN OF SOUTH CAROLINA. I know we are reducing, the funding just we put in the record earlier, but are we getting the same bang for the buck by coordinating VA's research activities with other partners? I guess my concluding question would be, are we effectively cutting down research or trying to do it in a different way?

DR. PERLIN. Thank you. I will answer your question now. Yes, we are amplifying the investment that the American taxpayer through Congress at the request of the administration makes in direct VA research. $399 million in this year's budget is a direct investment that we would ask for you to make and to that budget additional funds are added for the conduct of research in VA and those come from the National Institutes of Health and from private sector, including pharmaceutical companies and other entities. In fact, the Federal grants on the back of the $399 million in the direct research appropriation, and $366 million in the support for that, that are part of medical services budget, provides leverage to bring in an additional $376 million in Federal grants and $208 million in private sector grants.

MR. BROWN OF SOUTH CAROLINA. Okay. Thank you. Thank you very much. We have been joined by Mr. Miller from Florida. Do you have any questions?

MR. MILLER. Thank you, Mr. Chairman. I also have a statement I would like to enter into the record.

[Mr. Miller's statement was unavailable at press time.]

MR. BROWN OF SOUTH CAROLINA. Without objection.

MR. MILLER. I apologize for being late. We are on the floor doing a

resolution for the 65th anniversary of the USO. You probably already have covered this but, Dr. Perlin, I would like to hear an answer and if you have already done it, you can encapsulate what you said prior to my arrival. Given the resistance of any enrollment fees in the past and increased copays, why is VA doing that again? In fact, it is the exact same policy. Can you shed some light on it?

DR. PERLIN. This budget contains a request that we understand emphatically has been rejected by Congress previously, and in the earlier comments today we heard emphatic concerns about the request for policies that would require priority 7 and priority 8 veterans to pay an enrollment fee of $250, sharing the cost of pharmaceuticals at a rate of $15.

DR. PERLIN. And sharing the cost of pharmaceuticals at the rate of $15. And I would note that the value of those policy proposals is $795 million including an offset to the first-party collections. And so I think, it is fair to say, as was indicated also earlier, that there is a belief that it is fair and equitable to ask some veterans to share modestly in the cost of their health care. We, nevertheless, hear your voice and concerns about this.

MR. MILLER. Another question, if you would, in your testimony, you said that all of the resources for capital construction are going to be devoted toward achieving the goals of achieving delivering greater access for high quality health care for more veterans as was the goal of the CARES report, and I think this has been addressed, too. And I don't think the information that I got was correct. So I am hoping that maybe I misinterpreted what was sent to me. But given the unmistakable shifts in population along the gulf coast after the hurricanes last year, do you feel the current and projected population numbers should be revisited and the 5-year capital plan adjusted accordingly?

What I heard, somebody said was reported to this committee, was that VA doesn't feel that the veterans moved away geographically from the New Orleans area but further than nonveterans. And how do you know that? And then answer that first question.

DR. PERLIN. Right. Well, thank you. This is an appropriate question in looking at how we best serve veterans in the areas devastated by Hurricane Katrina. I appreciate your support for helping us to provide that care back to those veterans.

MR. MILLER. Let me make sure you understand. I want veterans' health care for my veterans in northwest Florida, as well. So while I am concerned about making sure that those in New Orleans were taken care of, there was a declining veteran population prior to Hurricane Katrina in New Orleans, a growing population in northwest Florida, and I don't know if we need to go back as the old CARES report was established or if we need to open it up again and say, things have changed.

DR. PERLIN. That is absolutely a fair question. And I appreciate that. I have done some research. It is obviously a question that is weighing heavily on my mind.

What I understand both from the demographics in the area and from the actuaries, even with the most conservative projections, that there will be more veterans seeking care between now and 2023 in the New Orleans Metropolitan area. It is also true -- I have the data as well -- that in your area of the country, there is also growth in veterans care. But it does, even with an actuarial estimate that provides for minimal change, extreme change and a moderate change in terms of resettling New Orleans proper, it is absolutely clear, unequivocal, that there is growth in the use of VA health care services in that region, sir.

MR. MILLER. Can you define for me the difference? You say the use of the facility, but is the use of the facility including veterans who don't live in metropolitan New Orleans? It is people who travel from out of the area to go to that facility; correct?

DR. PERLIN. I want to be careful how I define this. I am going to use the CARES data and define the central southern market, which is how it is defined as the cachement of the hospitals they listed previously to include 27 Louisiana parishes. And we know that there are a band of people who emigrated slightly to a perimeter around New Orleans are now using Hammonds, Slidell and La Place for a new CBOCs as well as Baton Rouge. We know that Lake Pontchartrain area to the west of Homa, straight west as opposed to the northwest and over to the east, Slidell, and in the northeast area, that there is growth in those markets. And there was already a population shift from one part of town to the suburban surrounding areas. But it is not people from a different part of the State or region.

MR. MILLER. Do you anticipate spending $800 million in the New Orleans area for a new hospital?

DR. PERLIN. I believe that the numbers will come in well below that. But we are looking at any number --

MR. MILLER. That was what was asked for in the supplemental before we adjourned last year, and $753 million was stripped from that supplemental. So my question is, do you anticipate using those dollars for that?

DR. PERLIN. We -- I think the Secretary last week was clear--that we plan to be back in New Orleans and that we will be as efficient as possible in our operation and have a final budget estimate in the report due to you, sir, in Congress on the 28th of this month.

MR. MILLER. Thank you, Dr. Perlin.

DR. PERLIN. Thank you.

MR. BROWN OF SOUTH CAROLINA. Dr. Perlin, if you would bear with us, we would like Counsel to ask a question, particularly about the inflation rate on health care delivery.

MR. WEEKLY. Dr. Perlin, from your testimony here today and from the Secretary's testimony last week, the funding drivers associated with this year's budget request are fairly clear and I think fairly well articulated in the testimony. One is inflation. Two is the aging of VA's patient population, and the third is the greater intensity of the services provided. While we, I think, can wrestle with the latter two, that is aging and the greater intensity of services, I think there are still some outstanding questions as it relates to inflation in particular.

Your testimony, the President's budget proposal in particular, suggests that a majority of medical services, not the least of which is the procurement of medical supplies and/or pharmaceuticals, is tagged to medical CPI.

We have heard on a number of occasions that VA, both in medical services as well as procurement, does things far more efficiently than the private sector. So the question then becomes, and I think -- I hope -- a logical one, is there not or would there not logically be a delta between the inflation rate that you would normally witness at VA having statutory protection as it relates to the procurement of pharmaceuticals and medical devices et cetera and the medical procurement in the private sector?

And why then is the President's budget and VA budgeting always tagged to a higher medical inflation rate? And this may be a more appropriate question for Mr. Norris or Ms. Reed, but if you can address it, I would appreciate that.

DR. PERLIN. Let me start and I may turn to Mr. Norris to amplify. But first let me acknowledge and agree with the economy of scale that exists in VA's national health system. Our leverage, more efficient purchasing power, is clear cut. As well, you have identified some statutory opportunities to procure materiel, such as pharmaceuticals, at essentially "best price," combined with efficient formulary management. That does lead to certain efficiencies.

Our budget, and the model portion of that, in terms of projecting what the demand for resources will be to care for the population includes the factors that you have mentioned. There is an inflation factor, and that is in part given to us. And that is, in this model, at about 4 percent.

Now, I need to mention that the -- intensity of services, and that approaches 1 percent, and just to be clear in what the intensity is; it is the amount of care that is given within a particular type of service.

And with advancing technologies, new biological products, et cetera, that drives the cost up. It also improves the outcome. The utilization goes up by almost 1.2 percent. And utilization is the number of the same services provided. So in addition to getting more care per unit intensity, there are also more units of service utilization, not unexpected given that the population is one that tends to be older and

typically sicker; with three additional physical and one additional mental health diagnosis as compared to age-matched Americans and oftentimes poorer, less resources.

The aging and gender change also contributes to the cost of the care. And that approaches one and three quarters percent and then, with that, there are oftentimes shifts in income within the population of veterans that use VA. And that is another three quarters of a percent right there.

On top of that, we add certain things that we are intentionally doing to change how we deliver care. In this model, there is nearly half a percent of increase in resources based on a very clear intent to improve and enhance the mental health services delivery in areas such as those we have discussed before.

So, this model and our approach actually does exactly what you have suggested. It demonstrates that we approach with a lower rate of inflation than others might experience. It also, I think, takes into account that we have a very complex and aging veteran population by and large. And on top of that, there are some areas where we are making some very goal-directed enhancements to service.

MR. WEEKLY. So if I understand you correctly, while it may be true that the annual inflation rate, as it relates to medical services and procurement, may be dramatically lower, the other factors that you just articulated make up for that and, in fact, overcompensate for a lower inflation rate leading to one that is consistent with the rest of the nation across the whole panoply of medical services?

DR. PERLIN. I think in short that is a reasonable characterization. The inflation rate for the same services for unchanging population would be lower when you take into account the demographics of this population and the needs. It is a higher number as you see before you in this very robust budget.

MR. BROWN OF SOUTH CAROLINA. Thank you, Dr. Perlin. I have one further question. Can you tell me what, if any, progress has been made on the electronic exchange of medical information between DOD the VA at the polytrauma centers?

DR. PERLIN. Thank you, Mr. Chairman, for that question. This is an area that we think about daily. In fact -- Dr. Kussman and I were discussing that on the way over here today. Where electronic data exists within the Department of Defense, they are transmitted to VA. Not all data exists electronically. But we are pleased to report that there are advances that allow us to take better care of veterans. For example at our polytrauma units specifically, as you have identified, they now have access to tap into the health records that exist at Walter Reed. So in the large picture, we are working toward interoperability, the Joint Electronic Health Records Interoperability Program, and that is moving forward, where there are electronic data in DOD -- those data are being mapped to the electronic health record in VA,

and where this data doesn't exist electronically or where it only exists some places electronically in some places like Walter Reed, we have increased access to that. This is an area that the Secretary and deputy and I personally take an interest in and desire with you to push forward.

MR. BROWN OF SOUTH CAROLINA. Do you have target when you think the exchange will be transparent between DOD and VA, or is there anything we can do legislatively to help accelerate that process?

DR. PERLIN. Well, first, thank you for your offer of support. And let us consider if there is anything that might accelerate it. But I believe there is a good bit of progress in the first stage; the Federal Health Information Exchange (FHIE) created a repository of, predominantly laboratory and pharmacy data, but electronic data that VA can now reach into essentially as its repository and pick out that information. I personally have used that information to look up bits of patients' records for a veteran who has some electronic data. And that is available nationally. This year, we are completing the piloting of BHIE, the Bidirectional Health Information Exchange. And this will allow realtime transfer of pharmacy and lab services. The end goal is the full joint electronic health record interoperability and the time course for that is completion of our Health Data Repository, HDR, and completion of DOD's Clinical Data Repository, CDR, and only the way we in government can do, putting CDR and HDR together is the acronym for CHDR, and the goal for CHDR is, I hope, within the next couple to 3 years. And then we should have seamless interoperability of our health records.

MR. BROWN OF SOUTH CAROLINA. Is there a system in place to be absolutely sure that we aren't leaving any third party payee on the table?

DR. PERLIN. This is a great question. And I think it is an opportunity to really identify that there has been just incredible progress in the third-party collections. Even absent any of the policy proposals that were discussed earlier today, I think you see on this curve over the last 6 years that in 2000, the collections were $573 million, and even absent any additional policy proposals, in 2007, we would anticipate 2.288, really, $2.3 billion of collection, pretty significant growth.

We use the same sort of actuarial models to estimate who has insurance, and indeed, we try to determine this. I can't tell you that we would never leave money on the table. What I can tell you is that we are ambitious and assertive in terms of trying to collect that and appreciate the support of this committee in terms of improving the efficiency and timeliness of collections.

MR. BROWN OF SOUTH CAROLINA. Thank you, Dr. Perlin, and we certainly would like to do what we can to enhance that. And, remove? I know it is probably difficult to estimate, but we move from half a billion to almost $2.6 million did you say?

DR. PERLIN. 2.3, sir.

MR. BROWN OF SOUTH CAROLINA. $2.3 million, in what, 5 years?

DR. PERLIN. In the 2007 budget, without any change in policy, it will be $2.054 billion we estimate at the end of this year.

MR. BROWN OF SOUTH CAROLINA. So based on that scenario, you think you maximized it, or do you think we are 50 percent there, 35 percent there, or 90 percent there?

DR. PERLIN. I think we are getting -- I think it is substantial progress. And I can't give you a specific percentage. I think it is probably very, very high, and I would be pleased to provide better quantitative estimate for the record.

MR. BROWN OF SOUTH CAROLINA. Thank you very much. Mr. Michaud?

MR. MICHAUD. Thank you, Mr. Chairman.

Mr. Norris, did you or do you plain to make a presentation to the national leadership board on the VA's fiscal year 2006 budget? Have you already done so, or do you plan on doing it?

MR. NORRIS. Yes, sir, I plan to update that body every month with the status of where we think we are financially.

MR. MICHAUD. Would you please provide the committee with a copy of the January and February report?

MR. NORRIS. Yes, sir.

MR. MICHAUD. Thank you. My next question is about prescription drugs. What has as the CBO given the VA as estimates when you negotiate for prescription drugs? Have they put a number with that as far as the savings, and is that calculated? What is the methodology that they use, and is that calculated when you put your budget together?

DR. PERLIN. I think that is a great question. We estimate roughly that the savings approach, a billion dollars a year in terms of the pharmaceutical savings due to a variety of factors.

MR. MICHAUD. What method, does OMB, use to do that? Or do they pretty much take whatever number you give them?

DR. PERLIN. OMB has recognized that we are extremely efficient in this. You mentioned CBO, and in point of fact, there have been estimates of VA's efficiency, and I believe that has been one of the sources, sir.

MR. MICHAUD. The VA did a mental health model to project demand on returning soldiers. Returning soldiers account for roughly 2 percent of the VA's overall patient workload but nearly 6 percent of the PTSD patient workload.

Has VA revised its mental health demand model to reflect this disproportionate increase in workload, and was that budget based on that revised model?

DR. PERLIN. I would ask Dr. Mark Shelhorse to talk about what some of the percentages have been. I would be happy to follow that

with some comment on the budget estimates.

DR. SHELHORSE. Yes, sir. We are very sensitive to the issue of Post-Traumatic Stress Disorder population In the OIF/OEF returnees, last year, the figures were indeed 5 percent of the total. And it is modifying a little bit as the overall number of PTSD numbers of cases goes up and fluctuate between 3 to 5 percent right now. We are very acutely aware that we need to maintain those programs. And in 2005, we put $20 million toward additional programs for PTSD and OIF programs. That accounted for 44 new programs that focus purely on the Operation Enduring Freedom and Iraqi Freedom veterans that are returning. And we called those Veterans Outreach and Enhancement Centers. They go out, identify those veterans, try to educate them as to what services are available, what kind of symptoms they might expect, et cetera. We also put out 43 new programs for Post-Traumatic Stress Disorder.

In 2006, we will invest another $29 million in PTSD and OIF programs. And that money is yet to be distributed in the field. We are in the process of choosing those programs right now.

The model itself was a model that was generated slightly before the conflict, before we knew how many returnees we would get. It predicts PTSD population based on residential treatment beds, which are the comparable beds that would be used in the community for the types of programs that we have.

It is not sensitive enough to extract OIF/OEF veterans out of the current model. But we are using the model in terms of projection of PTSD need for the future. We have asked divisions to look at their gaps and address where the programs need to be and, in fact, have used that for the 2006 distribution, with the idea of plugging in any gaps that might be in place and making sure those veterans have access to care when they need it and where they need it.

MR. MICHAUD. If I may ask a follow-up question, Mr. Chairman. The Department of Defense has a new program, The Post-Deployment Health Reassessment. And this pilot, nearly 48 percent of the service members are referred to the VA. How does the VA support that program, number one? But how do you keep track of what they are doing?

DR. PERLIN. Thank you for that question. The PDHRA, Post-Deployment Health Reassessment, is really a very noble effort to follow up between 90 and 180 days after deactivation. And this program is being conducted in many small groups, 60 service members at a time.

In point of fact, to date, we have actually had both VHA and VBA personnel there, and so the cognizance of what is going on is really very immediate.

I think you have hit a very salient feature, and one that we were also quite attuned to is that the survey is extremely sensitive, and as

a result, a number of, a large proportion of the individuals seek care or seek to establish a relationship with VA.

We are actually currently seeking to better understand the implications from DOD and are having ongoing meetings both with the Department of Defense at regional levels where this work in the field is actually occurring nationally and hope to have continuing information on the effect of the program in terms of VA utilization.

MR. MICHAUD. Thank you.

Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Mr. Snyder, did you have any further questions?

MR. SNYDER. Yes, Mr. Chairman, thank you.

Dr. Perlin, just one quick note on this research and then I have two other questions I want to ask. If I start with $1.65 billion, and I assume a medical inflation rate of about 5 percent for medical research, which is different than research or than medical care -- it is higher, I think it is because everything has to be new; you are trying to do cutting-edge stuff, not stuff with old equipment.

So if I assume a 5 percent increase, inflationary increase, of my 1.6, I am going to say $1.633 billion, that gives me like over $80 million.

And so you all are saying, well, we have increased it by $17 million.

But in order to just to maintain a 5 percent inflation rate, it has got to be a little over $80 million which means actually in real terms a cut of over $60 million.

Now, I don't know what the medical inflation rate is but my guess is the VA is not that much different from other institutions because most medical research is done by institutions, and you have a lot of jointness with medical schools but that is a -- if you came in here today and stated -- if your written statement said, well, bad news in the research front. In real terms, we are going to cut the research number by over $60 million, that is a totally different picture than the way it is presented. But I think that is in reality what is going on. It is probably worse than that.

My two questions for the record -- would you respond for the record, please, to this letter that was sent to the committee from FOVA? And they have specific items in there about things they think are going to be cut in research. And second, for the record, would you tell us please what you think the medical research inflation rate is nationally and then also for the VA, and what distinguishes the difference between them if there are any differences? And the two questions I want to ask are on page four. You are talking about the initiatives, increased copays, you say both of these provisions would apply only to priority 7 and 8 veterans who have no compensable service connected disabilities who typically have other alternatives for addressing their medical care costs, including third-party health insurance and Medi-

care. Typically. What is your definition of typically? Do you have that number available in terms of --

DR. PERLIN. 95 percent. The Chairman hit the nail on the head because many of those veterans are older and Medicare eligible.

MR. SNYDER. So, of that number, 5 percent don't have any insurance?

DR. PERLIN. That is correct.

MR. SNYDER. And then my second question on page five is the provision in which you talked about a provision to eliminate the practice of offsetting or reducing VA first-party copayment debts with collection recoveries from third-party health plans.

This provision applies to all categories of veterans; is that correct?

DR. PERLIN. It applies to nonservice connected medical activities but across all categories, exempting the highest priorities by definition.

MR. SNYDER. My question is, have you all evaluated this from the perspective of the potential unintended consequences? I was trying to put myself in the place of veterans who may be at work, or I may have a working wife who is a bit younger than me, since I have a working wife who is younger than me, and who is paying into this insurance. I have some kind of private insurance. I am not Medicare age eligible. And then this comes down that I can't use that insurance any more, so it is costing money to have it. And I like to have my care at the VA.

Do you think there will be some potential impact, people will say let's just not carry the insurance since they are not going to use it any way and we get our care at the VA? Is that scenario a possibility?

DR. PERLIN. I think that would have to be within the realm of possibility. It is likely individuals who have insurance or have alternative coverage do so because of other factors, such as being over age 65. But in a pure sense, yes, that could, potentially do that. I would note that this is a very challenging area, the first-party offset -- it is one of the complexities in the billing process for VA. There is no other entity that offsets a copayment with a bill to an insurance company. And that almost singularly is one of the things that makes it impossible for VA to buy an off-the-shelf billing program that would be used in any other medical enterprise.

MR. SNYDER. Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Snyder. Dr. Perlin, I thank you and your team for coming here today. We certainly didn't mean to drill you so heavily, but thank you. And if there are other questions, we can certainly submit them to you for response.

While the first panel is vacating and the second panel comes forward, we are going to take about a 5-minute recess.

[Recess.]

MR. BROWN OF SOUTH CAROLINA. Meeting will now come back to order, and let's welcome our second panel.

STATEMENT OF CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, REPRESENTATIVE OF THE INDEPENDENT BUDGET; AND CATHY WIBLEMO, DEPUTY DIRECTOR FOR HEALTH CARE, THE AMERICAN LEGION.

MR. BROWN OF SOUTH CAROLINA. Mr. Carl Blake, Associate Legislative Director of Paralyzed Veterans of America, representing the Independent Budget, and Ms. Cathy Wiblemo -- is that pronunciation close?

MS. WIBLEMO. Sir, thank you. Very close. Yes.

MR. BROWN OF SOUTH CAROLINA. Thank you very much. Deputy director for health care, representing the American Legion, and we will begin with Mr. Blake.

Welcome both of you.

STATEMENT OF CARL BLAKE

MR. BLAKE. Thank you, Mr. Chairman. I would like to ask that my full written statement be submitted for the record.

MR. BROWN OF SOUTH CAROLINA. Without objection.

MR. BLAKE. Chairman Brown, Ranking Member Michaud, PVA would like to thank you for the opportunity to testify today on behalf of the IB regarding the fiscal year 2007 VA health care budget. We are proud that this will mark the 20th year that PVA along with AMVETS and Disabled American Veterans and the Veterans of Foreign Wars have presented the Independent Budget, which is a comprehensive budget and policy document.

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 60 veteran service organizations and medical and health care advocacy groups. For the first time, a reasonable starting point was offered by the President to fund the VA health care system. For fiscal year 2007, the administration has requested $31.5 billion for total veterans' health care, a $2.8 billion increase over the fiscal year 2006 appropriation. Although this is a significant step forward, we still have some concerns about proposals contained within its request.

The Independent Budget for fiscal year 2007 recommends approximately $32.4 billion for total veterans' health care, an increase of $3.7 billion over the fiscal year 2006 appropriation and about $900 million over the administration's request. We believe that the recommenda-

tions of the Independent Budget have been validated once again this year, as the administration indicated, that it will actually take $25.5 billion to fund the medical services account, an amount very close to what we recommend.

However, they only requested $24.7 billion in appropriated dollars. The administration hopes to raise an additional $800 million by instituting a new enrollment fee and an increase in prescription drug copayments to achieve the necessary funding level. We are deeply concerned that, once again, the President's recommendation proposes the $250 enrollment fee for priority 7 and 8 veterans and an increase in the prescription drug copayment from $8 to $15.

These proposals will put a serious financial strain on many veterans, including certain catastrophically disabled veterans with non service-connected injuries. These veterans, because of their catastrophic disabilities, are enrolled in VA health care as priority 4 veterans. However, due to a glitch in drafting of eligibility reform legislation in 1996, because of their income, they are still required to pay all copayments and fees as though they are priority 7 and 8 veterans. We urge the committee to correct this unfair situation immediately.

The VA estimates that these proposals will force nearly 200,000 veterans to leave the system and approximately 1,000,000 veterans to choose not to enroll. Congress has soundly rejected these proposals for the past 3 years, and we urge you to do so once again.

Our health care recommendation does not include additional money to provide for the health care needs of category 8 veterans being denied enrollment into the system. However, it is included in our bottom line for total discretionary dollars needed by the VA to provide health care to all eligible veterans.

Despite our clear desire to have the VA health care system open to these veterans, Congress and the administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1 million category 8 veterans will have been denied enrollment into the VA health care system by the fiscal year 2007.

We believe it would take approximately $684 million to meet the health care needs of these veterans if the system were reopened.

For medical and prosthetic research, the administration has requested $399 million, a cut of approximately $13 million below the fiscal year 2006 appropriation. The Independent Budget recommends $460 million. Research is a vital part of veterans' health care and an essential mission for our national health care system. It has been responsible for such advancements as the cardiac pacemaker, the CT scan, and world-class prosthetics.

Despite a reasonable request this year, the budget and appropriations process over the last number of years demonstrates conclusively how the VA labors under the uncertainty of how much money it is going to get and when it is going to get that money.

In order to address this problem, the Independent Budget has proposed that funding for veterans' health care be removed from the discretionary budget process and be made mandatory.

Mr. Chairman, I would like to thank you again for the opportunity to testify today, and I would be happy to answer any questions you might have.

[The statement of Carl Blake appears on p. 56]

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Blake.

Ms. Wiblemo.

STATEMENT OF CATHY WIBLEMO

MS. WIBLEMO. Thank you, Mr. Chairman, and members of the Subcommittee for inviting the American Legion to offer its views on the President's budget request for the Veterans' Health Administration for fiscal year 2007. It is a pleasure to be here today, and I would request that my entire testimony be submitted, entered into the record.

MR. BROWN OF SOUTH CAROLINA. Without objection.

MS. WIBLEMO. The American Legion is a member of the Partnership for Veterans' Health Care Budget Reform, and we strongly encourage the Subcommittee to hold a hearing to discuss the annual funding process for veteran's health care before the end of this session. Just recently the Veterans' Health Administration was recognized as scoring higher than the private sector industry and other Federal programs in patient satisfaction for the sixth year running, a true testament to the superb job they continue to do for the Nation's veterans.

We are all very proud of the Veterans' Health Administration. Indeed, they have received many such recognitions over the past few years, and deservedly so. Yet this fiscal year 2007 budget proposal aims to drive away over a million veterans from using the high quality health care system. In January 2003, category 8 veterans were suspended from enrolling. We would like to see that suspension lifted to allow those veterans to enroll in the health care system that was established for them.

Once again, the American Legion raises objection to the proposal that would charge an annual enrollment fee of $250 for priority group 7 and 8 veterans and the proposal that would raise the prescription copayment amount from $8 to $15.

We also question the validity of the management efficiencies in light of the recent GAO report that found VA lacked both the methodology for making health care management efficiency savings assumptions and adequate documentation for calculating and reporting management efficiency savings.

Undocumented management efficiencies result in real budgetary shortfalls of finite resources. The American Legion is also concerned with the apparent stall on the capital asset realignment for enhanced services process. With just half of the local advisory panel meetings being accomplished, we are wondering if and when the others are going to be held. CARES is an extremely important and needed initiative.

Mr. Chairman, the American Legion appreciates the administration's continued focus and increased funding for the implementation of the mental health strategic plan that will facilitate equitable access and delivery of mental health and substance abuse care across the nation to veterans in need. We would ask that the same intensity and energy poured into the strategic mental health plan be the same for the formulation of the long overdue long-term care strategic plan.

I would also like to add that Dr. Shelhorse and the mental health strategic committee did a wonderful job with the mental health strategic plan. The American Legion is working hard to ensure a true and accurate picture is portrayed of the funding and services needed to allow VHA to continue to provide high quality health care to the Nation's veterans.

In August 2005, we published the third annual system saving report, completing site visits to every VA medical center over the course of nearly 3 years. The third report revealed a critical shortage in the funding of VA health care with the biggest budgetary challenges being increased patient workload demand, upkeep of equipment and maintenance, pharmacy costs and staffing levels.

In January 2006, the American Legion's system savings task force began another round of visiting the VA medical centers. We thank Dr. Perlin for that. By the end of this week, we will have visited 12 facilities.

Preliminary reports suggest staff cuts and facilities struggling to meet patient workload increases. We plan to visit at least 45 facilities to include the polytrauma centers. Through these site visits, we learn what is going on in the trenches, where the rubber meets the road.

Indeed, we are in the gulf coast area this week with plans to publish an interim report on just those specific areas.

Mr. Chairman, veterans' health care is the price tag of freedom. The American Legion stands ready to assist you in ensuring that VA health care is adequately funded to meet the needs of all veterans. Thank you.

[The statement of Cathy Wiblemo appears on p. 65]

Mr. Brown of South Carolina. Thank you very much, and we will entertain some questions at this time.

Mr. Blake, I am going to ask you the question first, and either one of you can join in with a rebuttal or your feelings on that same question.

Mr. Blake, what is your assessment of VA's progress to date in getting veterans appointments within 30 days of request?

MR. BLAKE. Mr. Chairman, I have to say, from my professional opinion, I couldn't give an accurate answer to that. I would be happy to refer that question to our veterans benefits staff at PVA who have service officers in the field and see this happen every day and get back to you with a more accurate answer on behalf of PVA.

MS. WIBLEMO. Could you repeat that question, sir?

MR. BROWN OF SOUTH CAROLINA. What is your assessment of VA's progress to date in getting veterans appointments within 30 days of request?

MS. WIBLEMO. We, our experience has been that the priority veterans, OIF/OEF, are getting within the 30 days. We do not see, and it has not been reported to us, that they are not.

We do, though, have some documentation on the electronic waiting list, and that it is getting longer, that veterans with non service-connected conditions are waiting -- are being put on this waiting list and are waiting a significant amount of time and/or referred to the community.

MR. BROWN OF SOUTH CAROLINA. What would you recommend as the solution?

Is it because VA is understaffed or the facilities are too small or the commute is too long, or not enough nurses, etc.?

MS. WIBLEMO. Well, definitely staffing levels are a problem, but that is all a funding issue. So, you know, adequate funding of course, you hate to keep throwing money at something, but adequate funding is definitely an issue when it comes to staffing levels. Anesthesiologists are just one example of where veterans are having to wait to get surgery because they don't have enough anesthesiologists, which is a funding issue because VA can't pay.

MR. BLAKE. Mr. Chairman, I would like to concur with Ms. Wiblemo, too. Particularly in the areas of specialized care, we have seen some difficulty in hiring nurses. We all know that there is a recognized nurse shortage across the country in all fields. This is particularly true in specialized areas, and that problem is amplified by VA's inability to hire, in some cases, physicians as well.

It is one thing when you don't have the direct bedside care from nurses. It is another one when you don't have the physicians that oversee a lot of this care as well.

MR. BROWN OF SOUTH CAROLINA. That leads me to my second question. In Charleston and around some other parts of the country, we are trying to do some consolidation or at least cooperating sharing in some of the services. And so my question would be, do you agree in

concept with VA working with their medical affiliations to enter into sharing agreements that maximize the ability of the VA to provide veteran patients with the most advanced technology and treatments? How would you respond? I am sure you are involved somewhat with the idea of trying to combine some resources.

MR. BLAKE. Absolutely, Mr. Chairman. I think coordination is the key. Our position has always been, however, in any coordinated setting, veterans should still get the priority for care. If you are bringing in outside patients who are nonveterans into whatever coordinated system you may have, ultimately we believe that the veterans should still get the priority for care.

MS. WIBLEMO. I would just like to echo some of that, absolutely, coordination, you know, sharing, and all of that, to get the best care.

Our position has always been to keep the VA a separate system, because they are unique and different. And the face of the VA needs to be out there for the veterans to see.

MR. BROWN OF SOUTH CAROLINA. I think that has been a major concern, too, that the veterans would feel like they might lose their identity, and I don't think there is any effort at all to lessen that point. I think the number one point, exactly what the shortcomings you all expressed in the first question is that we want to enhance health care for veterans. It is becoming more complicated. Some of the veterans coming home today didn't come home in prior wars, but are now because of the new technology. And this is something that we mentioned with Dr. Perlin earlier about research dollars, combining some of those research resources with other like interests to try to stretch those dollars. And so this is what we are trying to look forward to in the 21st century.

MR. BLAKE. Mr. Chairman, I would like to make one other point also. We certainly support the idea of coordinated care when it comes to basic care. But one thing we have to make sure we understand is that when it comes to specialty care, we don't believe that there is another type of health care system or anybody else that the VA can coordinate with that could provide better services than the VA itself. So in this effort to require the VA work together with another system, we have to make sure that veterans with the most important needs and the specialized services, particularly, get their care directly through the VA.

MR. BROWN OF SOUTH CAROLINA. I think that is a good point, and it is certainly well taken. This is something that we certainly are trying to build on, too, because I don't know of any process where 2 units come together to try to offer some kind of a shared responsibility where you don't gain something from both.

I don't think either one comes to the table with all the technology. Something we are trying to look at as we look at new construction projects around the country, is to try to pull the best from both

worlds and try to coordinate it so that veterans themselves can get a higher level of treatment because we know the technology is going to be switching and changing as we move forward. And we have to be sure we are on the cutting edge, particularly to address the health care needs of our veterans.

Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. Before I ask my question, I think it is worth noting, Mr. Chairman, that I am very pleased to see Dr. Perlin and his staff decided to stay to hear the panel as well, and actually, I noticed last week also, Dr. Perlin, that you were here to hear the second panel. I appreciate your taking an interest in this. And I do want to thank you both for testifying and for your advocacy on behalf of our Nation's veterans. I also want to thank you both for your service in the Army. I appreciate your service to the country.

My first question, ma'am, is the American Legion produces an excellent report each year called, A System Worth Saving. This report outlines how the budget works from the ground up, from a provider, in a veteran's perspective. Previous reports have documented frustration of and harm to veterans from waiting lists, appointments and what have you. Your site visits have been an early warning sign to Congress that the system, that there are flaws in the system, particularly with inadequate budget.

Do you have an initial impression on your visits, so far, from the sites you have visited, that the new shortfalls are rearing their ugly head once again?

MS. WIBLEMO. We have, like I said, at the end of this week, we will have been to 12 facilities. I am going to Albuquerque, as a matter of fact, tomorrow.

Preliminary reports from just -- we have like 6 reports that we have in. The budgetary challenge for all of them has been the increased patient workload.

And the other we have had some reports of running in the red, facilities. These are not pictures; these are facilities' specific information that we are getting.

MR. MICHAUD. Thank you.

This one is to both of you. Could you elaborate on your concerns with the VA proposed budget for meeting the long-term care needs of our aging veterans?

MR. BLAKE. Well, Mr. Michaud, this is something we felt was really starting to rear its ugly head last year when there were some recommendations to significantly cut long-term care programs. We have always pushed for the VA to continue to maintain the capacity requirements as laid out in the mil bill. And clearly, the evidence doesn't bear out that the VA has been able to do so. We could debate the reasons for why they haven't. We firmly believe that, obviously,

not receiving the funding necessary is a large part of that.

I don't think it is appropiate for the VA, to move down the road of curbing its long-term care abilities, given that the veterans' population is certainly not getting any younger. Though I might fall into a younger veteran status, there are a whole lot more veterans that are significantly older than I am. And even a recent GAO report bore out the fact that with the aging veterans population, the VA has to do much more to be able to meet that demand as that population grows.

MS. WIBLEMO. The long-term care issue is huge, much like the mental health issue. During CARES, of course, they tabled all of that. And they have struggled to come up with a strategic plan, which I think is very, very important, so they know where they are going to go and what they need to do and where they need to put those beds.

We have always advocated for maintaining the 1998 law. And we are not quite sure where those veterans are going, you know. The VA is pushing -- as is the rest of the Nation, in long-term care, which is also struggling by the way, meaning the demand -- but the VA is pushing them to go out, you know, home, in the home, closer to home, which is fine, but that is not always relevant for some veterans, those with mental health problems. And the VA, of course, is leading the industry in that type of treatment. So, we are very concerned, but I think really it is an issue of getting that long-term care strategic plan out, published and starting to be implemented so the dollars are going where they need to go.

MR. BLAKE. I would like to make a couple other points. One, I would like to point out that one of the recommendations in the Independent Budget is that the VA immediately develop a long-term care strategic plan. The issue of long-term care and how to best provide it is something that PVA grapples with particularly because of the nature of our membership with catastrophic disabilities. On the one hand, we recognize the importance of institutional long-term care, like nursing home care, because of the ability to provide advanced services in that setting. At the same time, one of the biggest things we are advocates for is the ability of catastrophically disabled veterans to be out in society and to function and be independent.

So, while we believe that the capacity requirements for institutional long-term care are necessary, we also support additional long-term care through things like the Assisted-Living Pilot Program, which the VA conducted in a few VISNs, and we believe that the successes from that pilot program bear out that maybe this is something that should be implemented across the entire country.

MR. MICHAUD. Thank you. In my last question, and you both sat through the first panel, and I appreciate that as well, and you heard that the response and the opening statements of Dr. Perlin and the team. Is there anything that you heard from the first panel in either

any of the testimonies you would like to comment on or add or dispute?

MR. BLAKE. I don't know about dispute, Mr. Michaud. I would just like to say, I would like to reiterate our concern as was done so by the panel about medical and prosthetic research. Research is something that is very, very close to PVA's heart as well as the Independent Budget. Not only do we get support from the four organizations of the Independent Budget, but we also work hand-in-hand with friends of VA research as we develop our medical and prosthetic research recommendations.

So any time we see a cut, we are certainly concerned about the long-term effects that this may have on veterans now and in the future.

Just as I laid out in my statement, there are so many advancements that the VA has been responsible for in the medical field through this research. I think we do veterans and even all citizens an injustice by reducing the ability of the VA to conduct this much needed research.

MS. WIBLEMO. I would just like to comment on the continual comparing of DOD and VA.

They are completely different systems. They serve different populations. And so I don't think it is really a fair comparison. So we certainly don't support VA going the way of DOD. While we support the sharing agreements and the joint ventures, as long as VA has a handle on that, that is all well and good. But, you know, the copays, and DOD treats, you know, dependents, family members. Children. So, it is a little bit different.

MR. BLAKE. Ms. Wiblemo triggered something in my head. I wanted to comment on the same topic. I think it is important that we understand the difference between the TRICARE system and VA health care system. TRICARE is an entitlement for its enrollees. And VA obviously is veterans who are eligible, and it is subject to the discretionary nature of its funding. Because TRICARE is an entitlement, retirees who are enrolled in TRICARE cannot be denied access to that. Furthermore, it is really just an insurance program. VA is a provider of health care. However because it is discretionary, at any time, due to the discretionary nature of its funding process, those veterans could be cut out of the system. That is not true of TRICARE enrollees.

MR. MICHAUD. I see the VA officials shaking -- nodding their heads, yes, so I assume that they agree.

No further questions. Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Michaud.

The Independent Budget recommended $38 million in minor construction projects for the Veterans' Benefit Administration and $24 million more than the President's request. What areas does the Independent Budget recommend funding for on par with what the President requested?

MR. BLAKE. Mr. Chairman, my area of expertise is not in construction at all. However, I would be happy to take that question into writing and submit it to our people who work on the construction portion of the IB and get back to you.

MR. BROWN OF SOUTH CAROLINA. Let me ask you one further question then, and either one of you can answer this. The independent Budget expressed concern about a VA nursing shortage. Do you support specific funding to establish magnet status at VA medical centers to recruit and retain nursing personnel and improve the level of quality care?

MS. WIBLEMO. Well, I can't answer for the Independent Budget. However, the American Legion is a big supporter of the nurses -- the nurses of VA foundation and also maintaining -- and the nursing education and the furthering of that education. And since the VA is older, we would support the magnet, you know, getting the magnet certification, or whatever it is. We would support that.

MR. BLAKE. Mr. Chairman, I would say, on behalf of the IB, we would certainly support any additional resources poured into the system to support hiring more nurses. Clearly, it is a major problem as I already addressed. And I think in previous hearings before this committee and the full committee, it has been shown that magnet status for a medical center serves as a recruiting tool in bringing nurses into the system. So that being the case, we would certainly support any efforts to get VA in line with that to -- if we believe that it will, or we believe that it will allow the VA to recruit more and better nurses, and ultimately that would be a positive for the VA health care system.

MR. BROWN OF SOUTH CAROLINA. Let me just say thank you to both of you for coming, and as a member of the American Legion, I appreciate you being part of this. One minute, we are not going to conclude right yet. Mr. Michaud wants to ask one more question.

MR. MICHAUD. Thank you, Mr. Chairman. Actually, their comments triggered another question. Just a brief one, if you might. You had talked about DOD and the VA, and clearly I am not sure whether it is mandatory or not, but as far as medical records, be it shared, with DOD and the VA, my first question, is that mandatory? My second question is, seems to me if it is mandatory, that once a system is implemented that there should be some management efficiencies there. And I was wondering if you had done an analysis about those management efficiencies and whether those can be booked and if they are real, if the management efficiencies aren't there once its implemented, if we reduce the DOD's budget by that amount, if they can't meet those management efficiencies.

And it is more a question for the VA, but if you can answer that.

MS. WIBLEMO. I am probably not qualified to answer that question, other than to say that the sharing of the records, it would make sense

that there would be management efficiencies there and the savings of money. But past that, I don't know if it is mandatory or not that they share records. I don't know.

MR. BLAKE. I would say, too, I don't know if it is mandatory. It seems like to me it would only make sense. Having gone through medical boarding process when I was retired from the service due to a service-connected disability, I know that all of my medical records personally were shared with the VA facility as part of the process of filing a claim for disability. They had to request my medical records for part of that process.

So I would just assume maybe it already is mandatory, and if it is not, it would only make sense that it would be.

MR. MICHAUD. Well, thank you very much, and I also want to thank you, Mr. Chairman, for your patience this afternoon. I know the first panel went longer than you probably expected, but I really appreciate your willingness to allow members the opportunity to ask questions because as you well know this is a very important issue and really appreciate your patience, thank you.

MR. BROWN OF SOUTH CAROLINA. Well, thank you, Mr. Michaud. I appreciate, working with you in a nonpartisan spirit to support health care for veterans, as it is a top priority for both of us and its certainly meaningful for us to listen as long as we may.

I would just like to further ask you, Mr. Blake, were those records transferred electronically or did you have to manually take them with you?

MR. BLAKE. I didn't manually take them. I think they were probably transferred manually, or faxed maybe. They were faxed. I know that, in the process, there were time frames built in for requests and follow-ups and all that sort of thing, but the VA, as I understood it, requested a full copy of my medical records, and they were forwarded along to the necessary physician as I went through that process.

MR. BROWN OF SOUTH CAROLINA. That is the link we are trying to overcome -- to have that transparency between DOD and VA.

MR. BLAKE. Not on behalf of the Independent Budget or anybody else but just from a personal perspective, it seemed to me that one of the biggest challenges in going through the claim for disabilities process was time limits that were built in by nature for 30 days, from the time they file a request to receive some kind of a notification and a follow-up with an additional 30 days from that time of contact. And a lot of those time frames, it seems to me, could be shortened or done away with through electronic transfer of any kind of that information. And that would, you know, not to say that there is an example of how you can shorten the disability claims process, but it just seems like to me that could be a possibility.

MR. BROWN OF SOUTH CAROLINA. Looks to me it would be a no-brainer. Somebody said, if Walmart could tell you when they sold a box of

Tide anywhere in the world, we ought to be able to track our veterans and our DOD personnel. Looks like to me the format ought to be somewhat compatible so you can do that in an outreach effort.

Today, we are building a combination clinic on the weapon station in Charleston which is going to be a DOD and a VA outpatient clinic, and so we are trying to make sure we consolidate as many of our resources as possible.

MR. BLAKE. So what we are trying to do is consolidate as many of our resources as possible. We feel like that is going to be a good thing. But you don't think so, Cathy.

MS. WIBLEMO. Oh, no. Again, the other thing I would say about that is that the stakeholders, the veterans need to be at the table from the beginning. I know, down in Charleston, because I went down there, that that wasn't the case. So I would say that the veterans need to be at the table in any of those -- like we were with CARES, like former Secretary Principi. I think that is important.

MR. BROWN OF SOUTH CAROLINA. Thank you very much for your patience and for the knowledge that you bring to the table, and thank you for your service to the veterans' population.

Dr. Perlin, thank you so very much for staying. We all want to work together that is our goal. Thank you so very much.

[The statement of the Vietnam Veterans of America, submitted by Rick Weidman appears on p. 78]

[The statement of the American Psychiatric Association appears on p. 90]

[The statement of the American Federation of Government Employees, AFL-CIO appears on p. 95]

[Whereupon, at 4:08 p.m., the Subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT
HONORABLE HENRY E. BROWN, JR.
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
BUDGET REQUEST FOR THE VETERANS HEALTH
ADMINISTRATION FOR FISCAL YEAR 2007

February 14, 2006

The Subcommittee will come to order.

I would like to take a moment and welcome everyone to first subcommittee hearing of the second session of the 109th Congress. I look very forward to again working with my good friend Mr. Michaud, the Ranking Member of this Subcommittee from the beautiful state of Maine, which I had the good fortune to visit last year.

I would also like to welcome my Subcommittee colleagues back and provide you fair warning that we have a considerable amount of work ahead of us this year and it effectively starts with our hearing today focused on assessing-- with the help of both the VA and the

veterans service organizations assembled here today-- the President's budget request for fiscal year 2007.

Dr. Perlin, it seems we have come along way since last year. I want to publicly applaud you, Secretary Nicholson and the President for assembling a budget request that I feel speaks loudly to the needs of our nation's veterans and that attempts to keep pace with the emerging health care requirements of those who have faithfully served this country.

I think a 12.2 percent increase in a time of budgetary belt-tightening is impressive, and characteristic of an administration that is committed to defending the nation. Having said that, I share the concern of a number of my colleagues, Republican and Democrat, about the administration's continued reliance on legislative proposals requiring veterans to pay more out of their pockets for their health care. I am afraid the political will of the Congress simply will not support such a proposal, and I am equally concerned about the signal it sends to the country.

I am also a bit concerned about a reduction in appropriated dollars for medical and prosthetic research. While I understand the research budget predicts an overall increase in research funding, the reliance on other federal grants and private partners gives me pause. In my mind, there a few greater pursuits-- aside from the provision of direct medical care-- that can have a greater impact on meeting veterans health care needs in the future than good, old-fashioned clinical research. I'm sure you would agree.

Even with those few concerns in mind, I am encouraged by the proposed, increased funding levels put forward for fiscal year 2007 that will address important, ongoing issues like long term care, mental health and major and minor construction projects. I look very forward to the discussion here today on all these issues.

I also look forward to hearing from the veteran services organizations that are assembled here today; those who represent the Independent Budget and those who have alternative ideas on what

VA's budget should look like. Over the course of the next few weeks, I want to work with all of you on issues on which common ground can be found and to forge a solid budget of which all of us can be proud.

Mr. Under Secretary, I would again like to thank you for your continued service to the department and this nation. I would also like to remind you of a statement made by the Chairman of the full committee during last year's budget hearings. Chairman Buyer acknowledged that Secretary Nicholson had "inherited" the budget you and he were forced to defend, but he also warned that the Secretary would "own it" from now on. And today, you own it and I look forward to your assessment of that proposal weighed against the department's current requirements for health care.

At this time, I now yield to our ranking Member, Mr. Michaud for an opening statement.

Thank you, Mr. Michaud.

Let's now turn to our first panel. Dr. Perlin, would you please take a moment to introduce your distinguished colleagues and begin when you are ready.

PANEL 2

The Subcommittee now asks the second panel to come forward. Let's welcome Mr. Carl Blake, Associate Legislative Director of the Paralyzed Veterans of America who will be representing the Independent Budget and Ms. Cathy Wiblemo, Deputy Director for Health Care, representing The American Legion.

Mr. Blake, please begin when you are ready.

Thank you both and let me thank all of our witnesses, and our Subcommittee Members, for their participation and attendance today.

With nothing further, the hearing stands adjourned.

Statement of Honorable Michael Michaud
Ranking Democratic Member
Subcommittee on Health
House Committee on Veterans' Affairs
Subcommittee hearing on February 14, 2006

Chairman Brown, thank you for holding this hearing to examine, in more depth, the FY 2007 budget for veterans' medical care proposed by the President.

I look forward to working with you to make sure that the budget reflects our nation's full debt of gratitude to veterans. The men and women who answered the call to service -- whether it was for one combat tour of duty or to wear the uniform for a career -- deserve to know that their nation will not forget them in their times of need, when they are ill, disabled or frail with age.

I am pleased that the VA's proposed budget for FY 2007 includes increases in an attempt to meet the needs of our veterans. However, in the brief time I have had to review the budget, it is clear that the full impact of this budget proposal does not match the glittering rhetoric.

Several proposals are non-starters. I will oppose the proposed enrollment fees, increased copayments, and other efforts to place the burden of payment on the backs of veterans seeking treatment from the VA. These proposals finance VA health care out of the pockets of veterans. **The Administration calculates that its proposal will also discourage some 200,000 patients from continuing their treatment at the VA.**

Some suggest that fees and increased copayments are reasonable policies given the President's proposals for military retirees. The systems are very different in key respects. The VA proposed fees and increased copayments greatly affect Priority 7 and Priority 8 veterans, most of whom are over 65. **TRICARE for Life beneficiaries who are over 65 do not have to pay any enrollment fees and TRICARE for Life pays their Medicare deductibles and copayments.**

Most importantly, TRICARE for Life beneficiaries can count on mandatory funding to pay for their health care. If we are to import anything from the TRICARE system into the VA health care system, it should be the mandatory funding of TRICARE for Life.

I am troubled that the Administration is trying to claim a $3.5 billion increase when its budget request claims $1 billion in FY 2007 in savings from efficiencies. **The recently published GAO report, requested by Ranking Member Evans found, that the VA was unable to provide any support for the estimates of savings through efficiencies in the President's past budget requests.** Given that GAO found that VA lacked a methodology for even making the savings assumptions about efficiencies, you can understand my concern. Veterans' health care needs real dollars not smoke and mirrors accounting.

VA is also proposing to continue the "temporary" ban on allowing new Priority 8 veterans to enter VA. This policy has shut out 2,403 Maine veterans who have turned to the VA asking for their earned benefits and continues to do so.

Rather than seek needed funds for these veterans, the Administration is seeking to keep the doors closed to these veterans. I disagree with this. In fact, we have a program in Maine called "Project I Served" that encourages all veterans regardless of category to attempt to enroll with VA so that we can understand the real need out there. I fully support this program.

At last week's full committee hearing on the budget, the Administration acknowledged that it was violating the law by proposing to reduce the VA's own capacity to provide nursing home care. The law requires VA to have capacity for 13,391 veterans, the same as it had in 1998. VA wants to cut this capacity by 17% to 11,100 beds. It is wrong for VA to ignore the law, especially at a time when more and more veterans are aging and need this type of care. Mr. Chairman, I hope we can work together to restore VA's nursing home capacity.

I am also concerned with reports that VA facilities are experiencing budget shortfalls.

We all want to do right by our veterans. Dr. Perlin, I applaud you and VA employees for the high quality care the VA does provide to millions of veterans. I also want to commend the workers of the VA for their courage and dedication during Hurricane Katrina and Rita.

Returning veterans and veterans from previous wars count on us to get this budget right. I look forward to working with Chairman Brown and the members of this subcommittee to meet the health care needs of veterans.

Statement of Rep. Corrine Brown
House Veterans' Affairs Subcommittee on Health Affairs
Tuesday, February 14, 2006
334 Cannon HOB

Thank you, Mr. Chairman for calling this hearing for further discussion of the health budget for the Department of Veterans' Affairs.

I must reiterate my concerns for your legislative gimmicks you insist on including in your budget requests. While the chairman of the full committee has expressed his support for balancing the VA budget on the backs of the veterans, a $250 user fee and an increase in prescription co-pay is not something that I can support.

The House of Representatives has voted over and over again to not allow these provisions to become law.

Yet you insist on including it.

The president is spending $10 billion a month in Iraq, and yet must pay for the war on the backs of those same veterans who protect our freedoms.

I also have heard stories that VISN 8, which includes Florida, is short of funding, and there is an unofficial order to not ask for more.

Explain to me how, after last year's most recent budget debacle, where we has to get you $1.5 billion in emergency funding to turn the air conditioning on in the operating rooms, you still cannot ask for sufficient funding to treat our nation's veterans?

How do I know your numbers are right and that this is the money you need to treat our veterans? Your credibility is low, and this "landmark" budget, in the words of your boss, does not meet the standard for full care for the defenders of our freedom.

Statement of
Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health
Department of Veterans Affairs
Before the
House Committee on Veterans' Affairs
Subcommittee on Health

February 14, 2006

Mr. Chairman and Members of the Subcommittee, good afternoon. I am pleased to be here today to present the President's 2007 budget proposal for the Veterans Health Administration (VHA). The request for VHA totals $34.3 billion—an increase of $3.5 billion, which represents an 11.3 percent increase over the 2006 estimate including the $2.8 billion from the Medical Care Collections Fund (MCCF). This budget contains the largest dollar increase for VA medical care ever requested by a President.

With the resources requested for Department of Veterans Affairs (VA) in the 2007 budget, we will be able to even further strengthen our position as the nation's leader in delivering accessible, high-quality health care that sets the national benchmark for excellence. Whether compared to other federal health programs or private health plans, the quality of VA health care is unsurpassed.

Quality of Care

VA's standing as the nation's leader in providing safe, high-quality health care is evident and has been well documented. For example:

- in December 2004, RAND investigators found that VA outperforms all other sectors of American health care across a spectrum of 294 measures of quality in disease prevention and treatment;
- the Department's health care system was featured in the January/ February 2005 edition of Washington Monthly in an article titled "The Best Care Anywhere;"
- the May 18, 2005, edition of the prestigious Journal of the American Medical Association noted that VA's health care system has ". . . quickly emerged as a bright star in the constellation of safety practice, with system-wide implementation of safe practices, training programs and the establishment of four patient-safety research centers;"
- the July 18, 2005, edition of the U.S. News and World Report included a special report on the best hospitals in the country titled "Military Might—Today's VA Hospitals Are Models of Top-Notch Care;" and
- on August 22, 2005, The Washington Post ran a front-page article titled "Revamped Veterans' Health Care Now a Model."

It should be noted that for the sixth consecutive year, VA set the public and private sector benchmark for health care satisfaction based on the American Customer Satisfaction Index survey conducted by the National Quality Research Center at the University of Michigan. VA's inpatient index was 83 compared to 73 for the private sector, and our outpatient index was 80 compared to 75 for the private sector.

These external acknowledgments of the superior quality of VA health care when compared to other public and private health plans reinforce the Department's own findings. We use two primary measures of health care quality—Clinical Practice Guidelines Index and Prevention Index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the Clinical Practice Guidelines Index, an internal accountability measure focusing on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to reach 78 percent in 2007, or a 1 percentage point rise over the 2006 estimate. Similarly, VA's Prevention Index, a set of measures aimed at preventive health care, including immunization, health risk assessments, and cancer screenings, is projected to remain at the estimated 2006 high rate of performance of 88 percent.

Medical Care

The cornerstone of our medical care budget is providing care for veterans who need us the most—veterans with service-connected disabilities; those with lower incomes; and veterans with special health care needs. A key element of this effort is to make sure every seriously injured or ill serviceman or woman returning from combat in Operation Enduring Freedom and Operation Iraqi Freedom receives priority consideration and treatment.

Ensuring a Seamless Transition from Active Military Service to Civilian Life

The President's 2007 budget request provides the resources necessary to help ensure that service members' transition from active duty military status to civilian life is as smooth and seamless as possible. Last year through our aggressive outreach programs, VA conducted nearly 8,200 briefings attended by over 326,000 separating service members and returning Reserve and National Guard members. We will continue to stress the importance of an informed and hassle-free transition for all of our forces coming off of active duty, and their families, and especially for those who have been injured.

As an integral component of our 2007 goals, we will continue to work closely with the Department of Defense (DoD) to fulfill our priority that service members' transition from active duty to civilian life is as seamless as possible. If active duty service members, Reservists, and members of the National Guard served in a theater of combat operations, they are eligible for cost-free VA health care and nursing home care for a period of 2 years after their release from active military

service provided that the care is for an illness potentially related to their combat service. Of the over 433,300 service members who have already separated through July 2005, approximately 119,240 have presented to some aspect of VHA for health care services as well as over 18,700 who have presented to Readjustment Counseling Services (Vet Centers).

There are many other initiatives underway that are aimed at easing service members' transition from active duty military status to civilian life. Within the last year, VA hired an additional 50 veterans of Operation Enduring Freedom and Operation Iraqi Freedom to enhance outreach services to veterans returning from Afghanistan and Iraq through our Vet Centers. They joined our corps of Vet Center outreach counselors hired earlier by the Department to brief servicemen and women about VA benefits and services available to them and their family members. They also encourage new veterans to use their local Vet Center as a point of entry to VA and its services. Our outreach counselors visit military installations, coordinate with military family assistance centers, and conduct one-on-one interviews with returning veterans and their families.

Workload

During 2007, we expect to treat nearly 5.3 million patients including over 100,000 combat veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom.

With the proposed legislative initiatives, the 3.8 million veteran patients in Priorities 1-6 will comprise 79 percent of our total veteran patient population. This will be an increase of 2.1 percent in the number of patients in Priorities 1-6 and will represent the fourth consecutive year during which those veterans who count on us the most will increase as a percentage of all patients treated.

VA continues to adjust our actuarial model to ensure that it accurately projects the needs of veterans from Operation Enduring Freedom and Operation Iraqi Freedom. However, many unknowns can impact the number and type of services the Department will need to provide these veterans, including the duration of the military action, when these veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have made additional investments in key services, such as mental health, prosthetics, and dental care to ensure we will be able to continue to meet the health care needs of these returning veterans and veterans from other eras.

Funding Drivers

There are three key drivers of the additional funding required to meet the demand for VA health care services in 2007:

- inflation;
- the aging of VA's patient population; and
- greater intensity of services provided.

Inflation:
The impact of the composite rate of inflation within the actuarial model increased our resource requirements for medical care by $1.2 billion, or 3.9 percent. This includes the effect of additional funds needed to meet higher payroll costs as well as the influence of growing costs for supplies, as measured in part by the medical Consumer Price Index. This increases VA's cost of doing business regardless of any changes in enrollment, number of patients treated, or initiatives.

Utilization:
VA will experience a significant increase in the utilization of health care services in 2007. The biggest reason is the aging of VA's patient population, which is aging faster than the general population. As our patients age, they become sicker and require more health care services, particularly for chronic diseases. Overall utilization trends in the U.S. health care industry continue to increase and VA is following this trend. However, we should not overlook the fact that there are other key reasons that veterans are displaying an increasing level of reliance on VA health care as opposed to using other medical care options that they may have available. These include the positive experiences that veterans have had in our system, our reputation as a leader in healthcare, and the growing large difference in the out-of-pocket costs between what veterans pay at VA verses elsewhere.

Intensity:
Medical practice patterns throughout the nation have resulted in an increase in the intensity of health care services provided per patient. This is due to the growing use of diagnostic tests, pharmaceuticals and other medical services, particularly for chronic diseases such as diabetes, heart disease, and obesity. This rising intensity of care is evidenced in VA's health care system as well. While this has contributed to higher quality of care and improved patient outcomes, it requires additional resources to provide this greater intensity of services. In addition, VA is expanding access to mental health services that are critical to the health and well-being of our veterans.

The combined impact of [redacted], expanded utilization, and greater intensity of services increased our resource requirements for medical care by nearly $1.2 billion.

Proposed Initiatives

The 2007 budget includes two provisions that, if enacted, would help VA meet our primary goal of providing health care to those who need our medical services the most. The first provision would establish an annual enrollment fee of $250 and the second would increase the pharmacy co-payment from $8 to $15 for a 30-day supply of drugs. Both of these provisions would apply only to Priority 7 and 8 veterans who have no compensable service-connected disabilities, who typically have other alternatives for addressing their medical care costs, including

third-party health insurance coverage and Medicare. Prior to implementation of Eligibility Reform legislation in 1997, Priority 7 and 8 veterans were either restricted from VA medical care or only provided care on a case-by-case space available basis. Since that time VA has implemented its national enrollment authority allowing enrollment of veterans in any year that resource levels permitted.

The President's Budget includes similar small incremental fee increases for DoD retirees under age 65 in the TRICARE system.

The 2007 budget also includes a provision to eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of nonservice-connected disabilities would receive a bill for their entire co-payment. If enacted, this provision would yield about $30 million in additional collections that could be used to provide further recourse for the Department's health care system.

The combined effect of all three policies reduces our need for appropriated funds by $795 million in 2007.

Access to Care

With the resources requested for medical care in 2007, the Department will also be able to maintain its current high performance with regard to access to medical care—93.7 percent of appointments are scheduled within 30 days of the patient's desired date. For primary care appointments, 96 percent will be scheduled within 30 days of the patient's desired date and for specialty care, 93 percent of all appointments will be scheduled within 30 days of the patient's desired date. No veteran will have to wait for emergency care.

VA is also committed to ensuring that no veteran returning from service in Operation Enduring Freedom and Operation Iraqi Freedom has to wait more than 30 days for a primary care or specialty care appointment.

We have achieved improvements in waiting times in primary care and specialty clinics nationwide by developing a number of strategies, to include implementing state-of-the-art appointment scheduling systems, standardizing business processes associated with scheduling practices, and ensuring that clinicians focus on those tasks that only they can perform to optimize the time available for treating patients. To further improve access and timeliness of service, VA will fully implement Advanced Clinic Access, an initiative that promotes the efficient flow of patients, on a national basis. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In turn, this reduces unnecessary appointments.

Major Changes in Funding

VA's 2007 request includes over $4.3 billion for long-term care ($229 million more than the 2006 level). I can assure you that the patient and cost projections associated with long-term care have been checked to ensure that they represent our real need in this area. While we aim to expand all types of extended care services, we plan to increase the rate of growth of non-institutional care funding about twice as much as that for institutional care. With an emphasis on community-based and in-home care, the Department can provide extended care services to veterans in more clinically appropriate settings, closer to where they live, and in the comfort of their homes surrounded by their families. During 2007, we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to about 36,700. This represents a 14.4 percent increase above the level we expect to reach in 2006 and a 33.7 percent rise over 2005.

The Department's 2007 request includes nearly $3.2 billion ($339 million over the 2006 level) to provide comprehensive mental health services to veterans. This will help further our effort to improve timely access to these services across the country. These additional funds will help VA achieve the aspirations of the President's New Freedom Commission Report as embodied in VA's Mental Health Strategic Plan and to deliver exceptional, accessible mental health care.

The Department will continue to place particular emphasis on providing care to those suffering from the spectrum of combat stress reactions, ranging from readjustment issues to Post-Traumatic Stress Disorder (PTSD) as a result of their service in Operation Enduring Freedom and Operating Iraqi Freedom. We are firmly committed to providing these veterans the best treatment possible. In December 2005, the Department designated three new centers of excellence in Waco (Texas), San Diego (California), and Canandaigua (New York) devoted to advancing the understanding and care of mental health illness. In addition, we have increased outreach to all veterans of the Global War on Terror.

VA's medical care request includes $1.4 billion ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve the quality of life for veterans of all combat or peacetime eras.

Medical Collections

As a result of improvements in our medical collections processes and the legislative proposals presented in this budget request, we expect to collect over $2.8 billion in 2007. These collections will substantially supplement the resources available from appropriated sources. In 2005 we collected just under $1.9 billion. The collections estimate for 2007 is 37.9 percent ($779 million) above the 2006 estimate. About 70 percent of the projected increase in collections is due to the legislative proposals (a $250 annual enrollment fee, an increase to $15 in the pharmacy co-payment, and elimination of the practice of offsetting VA first-party co-payment debts with collection recoveries from third-

party health plans). The remaining 30 percent of the growth in collections will result from continuing improvements in billing and collections.

We have several initiatives underway to strengthen our collections processes:

- the Department is implementing a private-sector-based business model pilot, tailored to our revenue operations, to increase third-party insurance revenue and improve VA's business practices. The pilot Consolidated Patient Account Center will address all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes;
- we are working with Centers for Medicare/Medicaid Services contractors to obtain a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA health care services. This project will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication;
- our Insurance Identification and Verification project is providing VA medical centers with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange;
- we are testing the e-Pharmacy Claims software that provides real-time claims adjudication for outpatient pharmacy claims; and
- VA is implementing the Patient Financial Services System pilot that will increase the accuracy of bills and documentation, reduce operating costs, generate additional revenue, reduce outstanding receivables, and decrease billing times.

Medical Research

The President's 2007 budget includes $399 million to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs, most notably research in the areas of mental illness ($51 million), aging ($40 million), health services delivery improvement ($36 million), heart disease ($30 million), central nervous system injuries and associated disorders ($29 million), and cancer ($28 million).

In addition to VA appropriations, the Department's researchers compete and receive funds from other federal and non-federal sources. Funding from external sources is expected to continue to increase in 2007. Through a combination of VA resources and funds from outside sources, the total research budget in 2007 will be almost $1.65 billion, or about $17 million more than the 2006 estimate.

Capital Construction

The 2007 request for construction funding for our medical care program is $457 million—$307 million for major construction and $150 million for minor construction. All of these resources will be devoted to continuation of the Capital

Asset Realignment for Enhanced Services (CARES) program to renovate and modernize VA's health care infrastructure and to provide greater access to high-quality care for more veterans. When combined with the $293 million that was enacted in the Hurricane Katrina emergency funding package in late December 2005 to fund a CARES project for a new hospital in Biloxi, Mississippi, the total CARES funding since the 2006 budget totals $750 million and since the 2004 CARES report amounts to nearly $3 billion.

Information Technology Services

The 2007 request for IT services includes $832 million for our medical care program.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting $51 million for ongoing development and implementation of HealtheVet-VistA (Veterans Health Information Systems and Technology Architecture) which will incorporate new technology, new or reengineered applications, and data standardization to continue improving veterans' health care. This system will make use of standards that will enhance the sharing of data within VA as well as with other federal agencies and public and private sector organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to all those providing health care to veterans.

Until HealtheVet-VistA is operational, we need to maintain the VistA legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides $188 million in 2007 for the VistA legacy system.

Summary

In summary, Mr. Chairman, the $34.3 billion the President is requesting for VHA in 2007 will provide the resources necessary for the Veterans Health Administration to provide timely, high-quality health care to nearly 5.3 million patients with service-connected disabilities, lower incomes, or special health care needs.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

STATEMENT OF

CARL BLAKE

SENIOR ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE ON HEALTH

CONCERNING

THE INDEPENDENT BUDGET

AND THE DEPARTMENT OF VETERANS' AFFAIRS

HEALTH CARE BUDGET

FOR FISCAL YEAR 2007

FEBRUARY 14, 2006

Chairman Brown, Ranking Member Michaud, and members of the Subcommittee, 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 FY 2007.

Chartered by the Congress of the United States
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We are proud that this will mark the 20th year that PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars, have presented *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs (VA). *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 60 veterans' service organizations, and medical and health care advocacy groups.

Last year proved to be perhaps the most unique year ever in the debate over the VA budget. The VA was forced to admit that it did not have the resources necessary to meet the demands being placed on its health care system. Congress was forced to react quickly and decisively to address this situation. These events served to validate the recommendations made every year, by *The Independent Budget*.

For the first time, a reasonable starting point was offered by the President to fund the VA health care system. For FY 2007, the Administration has requested $31.5 billion for veterans' health care, a $2.8 billion increase over the FY 2006 appropriation. Although this is a significant step forward, we still have some concerns about proposals contained within the request.

The Independent Budget for FY 2007 recommends approximately $32.4 billion for veterans' health care, an increase of $3.7 billion over the FY 2006 appropriation and about $900 million over the Administration's request. The medical care recommendation is comprised of three

accounts—Medical Services, Medical Administration, and Medical Facilities—with the bulk of the funding going to Medical Services.

For FY 2007, *The Independent Budget* recommends approximately $26.0 billion for Medical Services, an increase of $3.5 billion over the FY 2006 appropriation and nearly $1.3 billion more than the request of the Administration. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate.....$23,350,760,000
Increase in Patient Workload.....$1,470,817,000
Increase in FTE.....$118,886,000
Policy Initiatives.....$1,050,000,000
Total FY 2007 Medical Services.....$25,990,463,000

In order to develop our current services estimate, we used the Obligations by Object in the President's Budget to set the framework for our recommendation. We believe this method allows us to apply more accurate inflation rates to specific accounts within the overall account. Our inflation rates are based on five-year averages of different inflation categories from the Consumer Price Index-All Urban Consumers (CPI-U) published by the Bureau of Labor Statistics every month.

Our increase in patient workload is based on a 6.3 percent increase in workload. The policy initiatives include $500 million for improvement of mental health and long term care services, $250 million for funding the fourth mission, and $300 million to support centralized prosthetics funding. In previous testimony, the VA testified that it is already spending more than $250 million per year on homeland security, emergency preparedness, and fourth mission requirements.

For Medical Administration, the *IB* recommends approximately $2.9 billion. The Administration requested approximately $3.2 billion for this account. The difference in our recommendations centers around the fact that we assumed that for FY 2006, the entire $1.2 billion for Information Technology was removed from the Medical Administration account as set for in the FY 2006 appropriations bill. However, the Administration assumed only a portion of this amount being removed from this account, thereby giving them a higher figure to start with. Finally, for Medical Facilities the *IB* recommends approximately $3.5 billion, approximately $100 million less than what the Administration recommends.

We believe that the recommendations of *The Independent Budget* have been validated once again this year as the Administration indicated that it will actually take $25.5 billion to fund Medical Services, an amount very close to what we recommend. However, they only request $24.7 billion in appropriated dollars. The Administration hopes to raise an additional $800 million by instituting a new enrollment fee and an increase in prescription drug co-payments to achieve the necessary funding level.

We are deeply concerned that once again the President's recommendation proposes the $250 enrollment fee for Priority 7 and 8 veterans and an increase in prescription drug co-payments from $8 to $15. These proposals will put a serious financial strain on many veterans, including certain PVA members with non-service connected spinal cord injuries. These veterans, because of their catastrophic disabilities, are enrolled in VA health care as Priority 4 veterans. However, due to a glitch in the drafting of eligibility reform legislation in 1996, because of their income,

they are still required to pay all co-payments and fees as though they are Priority 7 or 8 veterans. We urge the Committee to correct this unfair situation.

The VA estimates that these proposals will force nearly 200,000 veterans to leave the system and more than 1,000,000 veterans will choose not to enroll. Congress has soundly rejected these proposals for the past three years and we urge you to do so once again.

Our health care recommendation does not include additional money to provide for the health care needs of Category 8 veterans being denied enrollment into the system. However, it is included in our bottom line for total discretionary dollars needed by the VA to provide health care to all eligible veterans. Despite our clear desire to have the VA health care system open to these veterans, Congress and the Administration have shown little desire to overturn this policy decision. The VA estimates that a total of over 1,000,000 Category 8 veterans will have been denied enrollment into the VA health care system by FY 2007. Assuming a utilization rate of 20 percent, we believe that it would take approximately $684 million to meet the health care needs of these veterans, if the system were reopened. We believe that the system should be reopened to these veterans and this money appropriated on top of our medical care recommendation for this purpose.

For Medical and Prosthetic Research, the Administration has recommended $399 million, a cut of approximately $13 million below the FY 2006 appropriation. *The Independent Budget* recommends $460 million. Research is a vital part of veterans' health care, and an essential mission for our national health care system. VA research has been grossly underfunded in

comparison to the growth rate of other federal research initiatives. We call on Congress to finally correct this oversight.

In order to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' health care be removed from the discretionary budget process and made mandatory. 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.

Making veterans health care funding mandatory would not create a new entitlement, rather, it would change the manner of health care funding, removing the VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA is fully funded through the current process. We look forward to working with this Committee in order to begin the process of moving a bill through the House, and the Senate, as soon as possible.

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. It is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who

have served and sacrificed so much for this nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

This concludes my testimony. I will be happy to answer any questions you may have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2006

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $252,000 (estimated).

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $245,350.

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000.

William Carl Blake
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Carl Blake is the Senior Associate Legislative Director with Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for federal legislation and government relations, as well as budget analysis and appropriations. He represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management. In addition, he represents PVA on issues such as homeless veterans and disabled veterans' employment as well as coordinates issues with other Veterans Service Organizations.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998. He received the National Organization of the Ladies Auxiliary to the Veterans of Foreign Wars of the United States Award for Excellence in the Environmental Engineering Sequence.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the United States Army. He was assigned to the 1st Brigade of the 82nd Airborne Division at Fort Bragg, North Carolina. Carl was retired from the military in October 2000 due to a service-connected disability.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE PRESIDENT'S BUDGET REQUEST FOR
THE VETERANS HEALTH ADMINISTRATION

FEBRUARY 14 2006

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FEBRUARY 14, 2006

Mr. Chairman and Members of the Subcommittee:

On September 20, 2005, The American Legion's newly elected National Commander, Thomas L. Bock presented the views of its 2.7 million members on issues under the jurisdiction of your Subcommittee. At the conclusion of The American Legion's 87th National Convention in Honolulu, Hawaii, over 3,100 delegates adopted 42 organizational resolutions with 36 having legislative intent. These organizational mandates will add to the legislative portfolio of The American Legion for the remainder of the 109th Congress.

As Legionnaires gathered at the National Convention to once again determine the path of the nation's largest veterans' service organization, it was with respect for those who have worn the uniform before us, friendship for those with whom we served and admiration for those who currently defend the freedoms of this great nation. Each generation of America's veterans has earned the right to quality health care and transitional programs available through the Department of Veterans Affairs (VA). The American Legion will continue to work with this Subcommittee and your colleagues in the House to ensure that VA is indeed capable of providing *"...care for him who shall have borne the battle and for his widow and his orphan."*

The Administration's VA budget request for 2007 has been hailed for adding nearly $3 billion in real appropriations for veterans' health care, compared to 2006. Although there is a real increase in actual funding in some areas, it still relies on assumed collections from initiatives that seek to place the burden of payment on the veterans seeking treatment from VA. It's a budget request built on charging new annual enrollment fees for VA care, nearly doubling drug co-payments, charging veterans for uncollected reimbursement from third-party payers, and assumed efficiency savings. Even VA documents that these proposals may lead to the loss of more than a million enrolled veterans from VA.

This budget request relies on $1.1 billion in cost-saving "efficiencies" - the subject of a recent Government Accountability Office report that criticized past VA health-care projections from the president's Office of Management and Budget. The American Legion is extremely disappointed that this budget request continues to count "phantom savings" as real healthcare dollars. Real

veterans are suffering from real injuries and VA needs real dollars to treat them. Any increases in VA funding should be the result of actual funds and not assumed savings based on management efficiencies.

The Senate Military Construction and Veterans Affairs Appropriations Subcommittee, chaired by Senator Hutchison, expressed concern over VA being underfunded due to unrealized legislative proposals that seek to charge veterans co-payments and increased co-payments. The American Legion agrees fully with the recommendation of that Subcommittee last year that VA "request a funding level that adequately represents the real needs of veterans **without** devising new fees."

The American Legion is also concerned with the highly ambitious anticipated increase in third-party collections from insurance companies expected in FY 2007. VA's estimate for third-party collections in 2006 was just over $2 billion. The FY 2007 budget request is relying on collecting almost $800 million more, the majority of which are expected to come from new enrollments and increased prescription co-payments. Again, these numbers do not reflect actual funds and should not be considered a real increase to the VA budget. In early 2005, VA had $3 billion in uncollected debts. Assumed collections do not equate to real dollars and veterans health care should not be reliant on possible collections that never match the demand for dollars. Such miscalculations result in real budgetary shortfalls that lead to reduced care and treatment, hiring freezes, delays in nonrecurring maintenance and other tough spending decisions.

VA Research will also suffer from this budget request. It takes a $13 million bite out of VA research in medical care support and relies on increased dollars from Federal Resources and other Non-Federal Resources. Reliance on other Federal and Non-Federal Resources subjects VA research funding to an overall decrease in funding if those resources are forced to slash their respective budgets. Medical Care Support funding should be increased, not decreased. The medical advances resulting from VA research not only benefit the veteran patient, but also they benefit all Americans. Over the years many medical breakthrough have resulted from research initiatives within VA healthcare facilities and through partnerships with civilian medical schools. Adequate funding to continue the important research of VA must be provided. Such budgetary shortfalls make VA's recruiting and retention of medical researchers extremely challenging.

It is imperative that any budget request submitted for VA reflects a true estimate of the patient population. The under-estimated number of VA patients returning from Iraq and Afghanistan contributed to the $1.5 billion budget shortfall for VA health care in 2005. While we applaud Congress for responding with supplemental funding for VA in 2005, the estimates must accurately reflect the demand for care VA can expect.

With that in mind and on behalf of The American Legion, I reiterate the following budgetary recommendations for VA's discretionary funding in FY 2007:

BUDGET RECOMMEDATIONS FOR SELECTED DISCRETIONARY PROGRAMS

FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2007

Program	President's Budget Request	Legion's FY 2007 Request
Medical Care Including:	$32.1 billion	$33.5 billion
• *Medical Services*	*$25.5 billion*	
• *Medical Administration*	*$3.1 billion*	
• *Medical Facilities*	*$3.5 billion*	
Medical Care Collections	($2.8 billion)	$2.1 billion*
Emergency Supplemental		
Medical & Prosthetics Research	$399 million	$469 million
Construction		
• Major	$399 million	$343 million
- CARES		$1 billion
• Minor	$198 million	$274 million
State Extended Care Facilities	$85 million	$250 million
State Veterans' Cemeteries	$32 million	$44 million
NCA Operations	$161 million	$174 million
General Administration	$1.5 billion	$1.9 billion

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

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. This inadequacy has become even more apparent in light of the congressionally imposed moratorium on construction funding during the CARES process. The American Legion is both relieved and encouraged to see that the first two years worth of VA designated high-priority projects include critically needed seismic corrections to nine vulnerable structures in California and Puerto Rico. The American Legion has consistently expressed its concern about veterans being treated in unsafe 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. We believe these designated seismic projects, other seismic corrections and life safety upgrades, should be dealt with first on an emergency basis.

The American Legion opposes the use of medical care appropriations for construction and urges Congress to separately and fully fund these projects.

The American Legion recommends $343 million for Major Construction and a separate $1 billion for the implementation of the CARES recommendations in FY 2007.

Minor Construction

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 over the previous funding level is crucial. We question the transfer of prior-year minor construction funds into CARES. During our site visits to all VHA medical centers over the past three years, we noted a recurrent theme in which facilities managers are routinely forced to divert funds from other priorities to repair roofs, replace boilers and upgrade utilities and life safety and other critical systems. The American Legion believes that these funds should be used for the purposes for which they were intended and that the "transfer authority" does not include monies designated for patient care.

The American Legion recommends $274 million for Minor Construction in FY 2007.

THE AGING OF AMERICA'S VETERANS

A July 1984 study, Caring for the Older Veteran, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VETPOP2001Adjusted, show there were 25.6 million veterans in 2002 and 9.76 million, or 37 percent are aged 65 or older. According to the 2003 National Survey of Veteran Enrollees' Health and Reliance on VA enrolled in VA health care; 14 percent of the veteran population was under the age of 45, 39 percent were between the ages of 45 and 64, and 47 percent of veterans were 65 years or older. Compared to the 2001 Survey, in which age distribution was 21, 41 and

39 percent, it's clear that the "demographic imperative" predicted in 1984 is now upon us.

The study cited an "imminent need to provide a coherent and comprehensive approach to long-term care for veterans." Twenty–one years hence, the coherent and comprehensive approach called for has yet to materialize. The American Legion supports a requirement to mandate that VA publish a Long Term Care Strategic Plan.

The Veterans Millennium Health Care and Benefits Act of 1999 provided VA authority to act on these projections. Based on an "aging in place" continuum of care model, VA was mandated to begin providing a variety of non-institutional services to aging veterans, including; home–based primary care, contract home health care, adult day health care, homemaker and home health aides, respite care, telehealth and geriatric evaluation and management.

On March 29, 2002, GAO issued a report that stated that nearly two years after The Millennium Act's passage, VA had not implemented its response to the requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry, access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an Average Daily Census of 68,238) in non-institutional settings, VA only spent 8 percent of its LTC budget on these services. Additionally, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings.

By May 22, 2003, over one year later, GAO testified before this Subcommittee that things had not improved and that veterans' access to non-institutional LTC was still limited by service gaps and facility restrictions. GAO's assessment showed that for four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. GAO summed up the problem nicely when it testified that "[f]aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

In the area of nursing home care, VA is equally recalcitrant in implementing the mandates of the Millennium Act. The Act required VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001, 11,969 in 2002 and 12,339 beds in 2003. VHA estimates it had 11,000 beds in 2004 and projects only 8,500 beds for fiscal year 2005. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. Providing adequate inpatient LTC capacity is good policy and good medicine. **The American Legion opposes attempts to repeal 38 U.S.C. § 1710B(b).**

The American Legion believes that VA should take its responsibility to America's aging veterans much more seriously and provide the quality of care mandated by Congress. Congress should do its part and provide adequate funding to VA to implement its mandates.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious; for fiscal year 2004 VA paid a per diem of $59.48 for each veteran it places in SVHs, compared to the $354.00 VA said it cost in FY 2002 to maintain a veteran for one day in

its own NHCUs.

Under the provisions of title 38, U.S.C., VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. Grants for Construction of State Extended Care Facilities provide funding for 65 percent of the total cost of building new veterans homes. 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. State authorizing legislation has been enacted and state funds have been committed. The West Los Angeles State Veterans Home, alone, is a $125 million project. Delaying this and other projects will result in cost overruns from increasing building materials costs and may lead states to cancel these much–needed facilities.

The American Legion supports increasing the amount of authorized per diem payments to just 50 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 and 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 American Legion recommends $250 million for the State Extended Care Facility Construction Grants Program in FY 2007.

MEDICAL SCHOOL AFFILIATIONS

VHA and its medical school affiliates have enjoyed a long-standing and exemplary relationship for nearly 60 years that continues to thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce has university appointments. At some medical schools, 95 percent of medical staff at affiliated VAMCs has dual appointments.

VHA conducts the largest coordinated education and training program for health care professions in the nation and medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research; VHA research has made countless contributions to improve the quality of life for veterans and the general population.

The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VHA and the medical schools of this nation.

MEDICAL AND PROSTHETICS RESEARCH

VA's Medical and Prosthetic Research Service 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. Most recently, VA research has shown that an experimental vaccine against shingles prevented about 51 percent of cases of shingles, a painful nerve and skin infection, and dramatically reduced its severity and complications in vaccinated persons who got shingles. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects.

The American Legion supports adequate funding for VA research activities, including basic biomedical research as well as bench-to-bedside projects. 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 $469 million for Medical and Prosthetics Research in FY 2007.

MANDATORY FUNDING FOR VETERANS HEALTH CARE

A new generation of young Americans is once again deployed around the world, answering the nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom, liberty and security of us all. Also like those who fought before them, today's veterans deserve the due respect of a grateful nation when they return home.

Unfortunately, without urgent changes in health care funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was designed specifically for their unique needs. Just as the veterans of the 20th century did, they will be forced to fight for the care each one is eligible to receive.

The American Legion continues to believe that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA's health care budget competes with other agencies and programs for 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.

Under mandatory funding, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care benefits of enrolled veterans.

The American Legion is pleased to support legislation pending in the 109th Congress that would establish a system of capitation-based funding for VHA by combining the total enrolled veteran population with the number of non-veterans who received services from VHA, then dividing that number into 120 percent of the current VHA budget or to another amount, depending on the bill. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This new funding system would provide the bulk of VHA's Medical Services funding, except funding of the State Extended Care Facilities Construction Grant Program, which would be separately authorized, and third-party reimbursements. Annual funding would be without fiscal year limitation, meaning that any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury, providing VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

The Veterans Health Administration is now struggling to maintain its global preeminence in 21st century health care with funding methods that were developed in the 19th century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans.

Mr. Chairman, as a member of the Partnership for Veterans Health Care Budget Reform, we strongly encourage you to hold a hearing on the VA funding process to explore the best way to meet the budgetary needs of VA health care.

MEDICAL CARE COLLECTIONS FUND

The Balanced Budget Act of 1997, P.L. 105-33, established the VA Medical Care Collections Fund (MCCF), requiring that amounts collected or recovered from third party payers after June 30, 1997 be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription co-payments 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. In FY 2004, VHA collected $1.7 billion, a significant increase over the $540 million collected in FY 2001. In FY 2005 VA collected $1.9 billion and the VA FY 2006 budget estimate called for $2.1 billion to supplement appropriations, a 10.8 percent increase over FY 2005. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans.

Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections of accounts receivable.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used as operating funds. When developing the agency's budget proposal, the total appropriations request

is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect on VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector.

The American Legion opposes offsetting annual VA discretionary funding by the MCCF recovery.

MEDICARE

As do all other citizens, veterans pay into the Medicare system without choice throughout their working lives. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits to reimburse allowable treatment and services received in VA health care facilities. VA, unlike the Department of Defense or Indian Health Services, cannot bill Medicare for the treatment of allowable Medicare eligible veterans' nonservice-connected medical conditions. This prohibition constitutes a multibillion-dollar annual subsidy to the Medicare Trust Fund. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the allowable treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

Mr. Chairman, nowhere in this budget request does VA receive any credit for the real savings in mandatory appropriations through VA not billing Medicare for the care and treatment of Medicare-eligible enrolled veterans. By denying VA the opportunity to bill Medicare for the treatment of Medicare-eligible veterans, the VA is picking up the care and cost of thousands of veteran patients who would otherwise be billing Medicare for treatment from another health care provider.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES

VA's Capital Asset Realignment for Enhanced Service (CARES) has entered into the final steps of the process - implementation and integration. The CARES decision released in May 2004 directed VHA to conduct 18 feasibility studies at those health care delivery sites where final decisions could not be made due to inaccurate and incomplete information. The 18 studies fall into two broad categories: 1) studies of sites where no specific decisions have been made to date for the delivery of health care, i.e., do we decide to merge these facilities or not; and 2) studies of sites where the Secretary's decision defines the health care solution to be implemented, i.e., how to best use or re-use the campus as a capital planning decision. VHA contracted Pricewaterhouse Cooper (PwC) to identify and determine the best approach to provide veterans with health care services equal to or better than is currently provided and evaluate in terms of access, quality, and cost effectiveness, while maximizing any potential re-use of all or portions of the current real property inventory. The entire process was scheduled for 13 months with a completion date of no later than February 2006.

One of the components of the CARES Phase II process was stakeholder input. In order to ensure the concept was not lost during the ongoing studies, Local Advisory Panels (LAPs) were set up at each of the study sites. The membership of the LAPs consist of key stakeholders including community leaders, veterans groups, VA affiliated medical schools and VA representation. The LAPs are to hold four public meetings to gather and share stakeholder input during the yearlong studies. Ideally, PwC and LAPs will work together to develop options that PwC will eventually present to the Secretary. The American Legion was concerned when the first meetings had to be pushed back from March to the end of April. This could only mean that the final decision was

going to be delayed. VA was already behind their established timeline. When the meetings were finally held, The American Legion was present at every single one. We will ensure our presence at all LAPs throughout the process. The American Legion intends to hold accountable those who are entrusted to provide the best health care services to the most deserving population – the nation's veterans.

The implementation of the CARES decision promises to be long. VA has estimated that it will require $1 billion per year for the next six years, with continuing substantial infrastructure investments into the future. The American Legion is opposed to CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for services such as long-term care and Homeland Security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process. Without that oversight, plans and promised services may be overlooked.

CONCLUSION

Thank you for the opportunity for The American Legion to reiterate its budget recommendations for FY 2007.

Clearly, The American Legion remains deeply concerned with VA medical funding in recent years. Repeatedly, the President advanced seriously flawed legislative initiatives that undermined the "thanks of a grateful nation." Fortunately, Congress joined the veterans' community in rejecting them. The American Legion will continue to oppose any "enrollment fees" targeted towards a selected group of veterans with the goal of discouraging enrollment or that does not guarantee timely access to quality health care in return.

The American Legion has joined with eight other veterans' service organizations in calling for an immediate fix of the broken annual Federal appropriations process that is budget driven rather than demand driven. In recent years, the Office of Management and Budget's budgetary recommendations to Congress fell well short of the mark. Congress, not OMB, is responsible for providing adequate funding for VA medical care. We do not see lengthy discussions on the "right amount" for funding Social Security benefits, Medicare, Veterans' Compensation and Pension, TRICARE for Life or even your salaries as Members of Congress because they are scored as mandatory funding items and, therefore, an entitlement – funding that is guaranteed.

If an entitlement is a statement of national priority, where should the care and treatment of veterans rank among Federal spending programs?

The American Legion respectfully requests a future Committee hearing on evaluating the best funding methodology for VA medical care. This hearing would also address alternative revenue streams to complement annual Federal appropriations.

Mr. Chairman, that concludes my testimony.

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February 14, 2006

Honorable Henry Brown, Chairman
Subcommittee on Health
Committee on Veterans' Affairs
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Brown:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the February 14th hearing, concerning The President's Budget Request for the Veterans Health Administration.

Sincerely,

Cathleen C. Wiblemo, Deputy Director
National Veterans Affairs and
Rehabilitation Commission

BIOGRAPHY
CATHLEEN C. WIBLEMO
DEPUTY DIRECTOR, HEALTH CARE
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Ms. Wiblemo has been with The American Legion National headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of a ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. She is currently a Major in the reserves.

During her military service, Ms. Wiblemo received many awards, most notably the Meritorious Service Medal. In August 1999 she received her Masters of Health Administration from Chapman University.

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STATEMENT FOR THE RECORD

OF

Vietnam Veterans of America

Submitted By

Rick Weidman
Director of Government Relations

Before the

House Veterans Affairs Committee
Subcommittee on Health

Regarding

The Department of Veterans Affairs
Fiscal Year 07 Budget Request
For the Veterans Health Administration

February 14, 2006

Chairman Brown, Ranking Member Michaud, Members of the Subcommittee, thank you for giving Vietnam Veterans of America (VVA) the opportunity to make our views known here today about the fiscal needs of the Veterans Health Administration (VHA in fiscal year 2007).

GAO Report-06-359R on "Management Efficiencies"

On the eve of the Administration's budget submission to Congress, both the Chairman and Ranking Member sent press releases regarding the findings of important studies they had requested from the Government Accountability Office. Ranking Member Evans also joined Senator Akaka, the Ranking Member of the Senate Veterans Affairs Committee in releasing a report that indicated that VA essentially "manufactured" management efficiencies to fit into the "bottom line" of the approved funding level in fiscal year 2003 and 2004. Concerned about the events which led to the need for supplemental funding in fiscal year 2005 and a revised budget request for fiscal year 2006, Chairman Buyer has reported preliminary findings from a report he has requested about the flawed methodology VA was using to determine veterans' demand for services.

Both of these reports cast shadows on the credibility of the Administration's request for fiscal year 2007. VVA does not believe that the fault lies with the so-called "bean counters", however.

Instead, VVA believes that Vietnam Veterans of America and the other members of the Partnership for Veterans Health Care Budget Reform are correct to share the view that the current system we have for funding veterans' health care is fatally flawed. It must use residual funding after all the other political priorities are accommodated.

This faulty process currently being used has led us to a budget that is based not on veterans' demand for services or medical inflation, but on whatever funds the Office of Management & Budget (OMB), working with VA, has determined, are available to be provided. The budget methodology must somehow provide a justification for these inadequate figures; so impossible "stretch goals" for management efficiencies and impossibly conservative projections of veterans' health care utilization are imposed.

Mr. Chairman, VVA hopes we can stop this game and look at some real changes necessary to get the veterans budget funded at an adequate level. We urge you to hold hearings on alternative means to fund veterans' health care. VVA has joined with the rest of the Partnership in asking you to consider an assured funding bill which bases annual increments on growth in the veteran beneficiary of services population as well as health care inflation as one of the possible alternatives.

The Bad News Is the Good News Is Wrong

After the funding debacles in the Veterans Health Administration (VHA) in fiscal year 2005 and fiscal year 2006, the budget request for fiscal year 2007 is again being touted as something of a windfall for VA health care. It was even greeted as a great budget by the press, extolled as the third largest percentage increase this year of any Federal agency or department, only behind the Department of Defense and the Department of Homeland Security as to the requested increase.

VVA hopes, now that you have had the opportunity to more closely examine the submitted request for FY 2007, that this is not the prevailing view on this Committee. Vietnam Veterans of America believes that this budget will not even allow VA to tread water, and it will certainly not restore the base that has been so seriously eroded by medical inflation and the huge influx of veterans who choose to use their health care system. This budget does nothing to correct the now officially discredited so-called "management efficiencies" of the past few years.

This budget assumes that the $28.772 Billion in appropriated dollars for this year (FY '06) and calculations of $2.054 Billion in third party collections will be enough to maintain Veterans Health Administration (VHA) employment at 197,650 and full operations of all medical operations without again having to dip into funds for vitally needed construction or modernization, or having to ration care – yet again. In fact, VVA has reports of shortfalls at medical centers from all over the country. In some Veterans Integrated Service Networks (VISNs), it has been reported to us that allegedly the Medical Centers (VAMC) Directors have been told to reduce their staff by at least 2%.

In other VISNs, the VAMC Directors have reportedly been told to find ways to "save" money, which may include staff reductions, may include rationing of medical devices, and many other measures to keep within impossibly low allocations of money provided to the VAMC, ostensibly for the safe and effective operation of their medical facility. Frankly, OMB and VA are very much afraid of another public shortfall in funding this year, which would happen if not for these behind the scenes maneuvers. Even with the increases provided by the Congress, there simply is just not enough money in the FY 2006 budget to maintain safe and effective medical services to the current population served, much less serve as the publicly announced and presumed base on which the requested FY 2007 budget is predicated.

In any case, VVA does not believe the VHA will finish the year with anywhere near the announced 197,650 employees. VVA is particularly concerned about the effects of this cut on the specialized services, such as Visually Impaired Service and Training (VIST) centers, the services available in mental health (particularly PTSD), on Spinal Cord Injured veterans and the specialized units that must be available to treat this special category of veterans, on acute care services, and on prosthetics. It is already clear that there is in effect rationing of prosthetic devices in some areas.

The FY 2007 budget request still retains misbegotten policies such as enrollment fees and increases in co-payments, which have been considered and rejected by this Committee and others in Congress time and time again. It continues the degradation of the VA's long-term care—particularly nursing home--program for veterans. VVA hopes and trusts that this Committee and the Congress will reject the increased fees, and will not further reduce vitally needed long term care bed capacity.

It also keeps in place the suspension of enrollment of legally eligible new Priority 8 veterans. The "temporary" suspension of January 2003 has become a permanent bar to enrollment of these veterans. In effect, it is changing the law without full debate and public scrutiny, which is of course a less than open and honorable way to do business.

VVA recommends $35.7 billion (plus what the VA projects to be $2.2 billion in collections; if the otherwise eligible veterans are allowed to register, then they would obviously have co-payments that would increase the collections by a substantial amount) as an adequate funding level for the medical care business line in fiscal year 2007. This is more than $5 billion

greater than the fiscal year 2006 funding level, and more than $4 billion more than requested by the President for fiscal year 2007.

VVA's recommendation would allow the reinstatement of eligibility for enrollment of new Priority 8 veterans and does not assume the new cost sharing for veterans meant to discourage their use of the system. VA's proposal attempts to discourage 235,000 veterans from using VA services and more than a million from enrolling would be stopped, as well as allowing those currently "frozen out" to enroll and use the system. We estimate that about half a million new veterans—about 5.9 million users and 8.4 million enrollees—would enter the system as a result of maintaining co-payments at current levels and reinstating Priority 8 veterans. This would be about a 9% increase in utilization, including new use by some veterans—such as new Operations Iraqi Freedom and Enduring Freedom veterans—considered "high priority."

Accordingly, VVA's proposal would fund about 25,000 new employees—mostly clinicians such as doctors and nurses in the medical services budget. This staffing increase of about 18% more than levels estimated in fiscal year 2006 would also allow VA to eliminate current waiting times—about 50,000 veterans are waiting more than 6 months for care, to increase the service intensity to an aging veteran population, to fully implement the Secretary's laudable "Wellness Initiatives" and to restore and enhance long-term care and mental health services. It would allow some enhancement of some services in high demand from our troops from the war on terrorism, such as dental care.

Even with NOT allowing all statutorily eligible veterans to enroll and use the system, VVA believes that the system cannot maintain safe, effective, and efficient medical care services to the veterans currently in the system and those who are category 1 through 6 with the funding proposed for FY 2007. First, the $ 1.8 Billion in illusory "efficiencies" documented by the GAO must be added to the Administration's request for approximately $31.5 Billion in cash taxpayer dollars to restore that lost organizational capacity. Additionally the $135 Million in "management efficiencies" cited in this budget submittal must be accounted for. Additionally, VVA believes that an additional $2.2 to $2.4 Billion is needed to provide the safe operation of acute care units and also provide the specialized services needed by veterans of every age, but particularly veterans and service members returning from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). We

particularly need to concentrate on reaching veterans in highly rural areas, given that 60% of our OIF/OEF forces come from rural areas.

This budget must ensure that it has adequate mental health services, not only to meet its current veteran patients' needs, but also to meet the needs of troops returning from Operations Iraqi Freedom and Enduring Freedom. Estimates of the needs of these troops vary, but all are high—from 17-25% may have post-traumatic stress disorder or some other post-deployment issues who require clinical care. In addition to the full range of services for post-traumatic stress disorder treatment, a wide range of mental health services must be available to meet these new veterans' needs—from family counseling to substance use disorder treatment to homelessness interventions.

Increasing staff levels to adjust for the intensity of services is necessary and, in fact, was one of the factors cited in the Office of Management and Budget's request for emergency funds. The largest populations of current users are now Vietnam Era veterans—there are 8.1 million of us according to VA statistics. Most Vietnam era veterans are between fifty and sixty years old—an age range in which many chronic diseases—some the byproducts of our military experience—are uncovered. Such diseases as type II diabetes, Hepatitis C, hypertension, various cancers, and cardiovascular disease will be found at increasingly high rates as the Vietnam era population ages. VA's user population already includes disproportionate representation of individuals with infectious diseases such as AIDS. VA has become an industry leader in providing appropriate preventive care and disease management interventions, but such care requires staff time for patient education, consistent and appropriate use of pharmaceutical therapies, and training in the proper use of medical equipment. While such care ultimately prevents or limits the use of hospitalizations and thereby saves money, upfront diagnostic work and stabilization of chronically ill patients is costly.

More adequate staffing may also allow VA to finally ensure that it has a detailed military history for every veteran using its system that is part of the automated patient treatment record. Military histories can help VA identify exposures or experiences that might put certain veterans at risk for various diseases. This is clearly true of veterans returning from recent operations in the Gulf or Afghanistan where immediate screening for post-traumatic stress disorder and other post-deployment mental health issues could be the

difference between an episode of care and a lifetime of care. But military histories may also aid in identifying and assisting veterans who knowingly or unknowingly had unique exposures to such environmental or occupational hazards as depleted uranium, Agent Orange, ionizing radiation, pesticides, or even biochemical weapons, such as Sarin nerve gas found at Khamisiyah.

About 10 million veterans are more than 65 years old—a time when health care utilization is at its peak. VA health care users are also a group—particularly now that potentially wealthier and healthier veterans continue to be prohibited from enrolling—who are more difficult to treat than the general veteran population because of co-morbidities, poverty and social isolation.

These demographics also make the case for rebuilding the once robust long-term care system in the VA. In our view, long-term care includes a range of services from interim rehabilitative care to non-institutional long-term care (such as home and respite care and adult day care), to custodial care which, unless there is considerable improvement in a veteran's health status, should be available throughout the remainder of that veteran's life. Long-term care policy remains a difficult issue to address. VVA will stipulate that VA's oft-cited refrain, "No one wants to live in a nursing home" is true, but unfortunately for some there is no other humane option. Also, unfortunately for America's frailest veterans, VA does not value the role it has played in offering custodial care to those who need it. Every recent budget submission from the Administration has sought to curtail VA's role in providing long-term care and this continues in fiscal year 2007. VA does not appear interested in preserving its beds for this mission and sought to eliminate 3200 long-term care employees in fiscal year 2006. It is now reviewing the law that prohibits it from discharging the most highly service disabled veterans without the veterans' consent.

In FY 2006, the Administration also proposed offloading its role in paying for care for many of the veterans receiving care in state nursing homes. State nursing home directors told Congress that the proposal would cause about 80% of the state homes to close effectively putting to rest a successful partnership between the states and the federal that has existed for more than 100 years. We want to thank this Committee for its role in helping to shelve these proposals—hopefully for the indefinite future. The emergency funding in fiscal year 2006 sought from VA also requested $600 million for long-term care perhaps indicating that Congressional pushback may have led

the Administration to reconsider its proposals. We hope they do not re-emerge in fiscal year 2007 and that this Committee remains steadfast in its support of the state homes and the prohibition of eliminating nursing home capacity and treatment mandates for the highly service-connected.

VVA projects that inflation and increased utilization will cost the VA about $1.8 billion in fiscal year 2007. These costs include inflation for pharmaceutical drugs, durable medical and contracted services—the increases for these items are highly likely to exceed general inflation.

VVA commends Congressman Evans for his joint request with Senator Akaka for the Government Accountability Office's recent report entitled, "Limited Support for VA's Efficiency Savings." Looking at per capita costs for VA compared to the general population and Medicare enrollees, there can be no doubt that VA is an efficient provider. In fact, resources have become far to spare in an environment with costs that are often increasing at double the rate of non-medical items and in which users have almost doubled in the last decade. According to GAO's report, there was never a basis for the efficiencies VA was supposed to find in fiscal years 2003 and 2004—the President was simply unwilling to request the funds that were necessary to support veterans' growing demand.

Unfortunately the Administration continues to make brazen use of these sham savings—in fiscal year 2007 another $135 million savings is imposed to the $1.8 billion budget hole that has accumulated since 2002.

In the last few years, VA has spent millions of dollars on a plan to restructure the VA health care systems capital assets. After extensive study—although some of us believed it was flawed due to the absence of mental health and long-term care in its models—the report called for about $6 billion to be invested in the system. VVA believes this indicates the magnitude of the problem of a crumbling infrastructure for the most part built in the 1940s and 50s. The promises of CARES seem far from fulfillment as medical facilities coffers continue to be robbed to pay for medical services operations. It must be disheartening for the hard-working and dedicated employees of VA to compare the state of many of their facilities to those in the community. Some of VA's hospitals are barely maintaining accreditation because they cannot meet privacy and access standards due to overcrowding. VA has delayed vital capital equipment purchases and non-recurring maintenance projects in order to fund veterans'

health care. This must stop. As veterans, dilapidated and over-crowded facilities are symbolic of the lack of commitment the federal government has to those who have served or would serve their nation. We must do better. Congress should restore and enhance the medical facilities budget by at least $.5 billion for medical facilities in fiscal year 2007. It should increase VHA's portions of major and minor construction by $1 billion.

This authorizing Committee has made little use of the power of the purse to ensure that VA is responsive to the will of the Committee in the past. We urge you to work with the Appropriations Committee this year to ask for some line items and for report language that will force VA to be more accountable to the Congress, and not just do whatever it wishes at any given time on several issues of vital importance to veterans. VVA believes that at least some of those items are as follows:

- Provide an additional $18 million in "fenced" money to the Readjustment Counseling Service for an additional 250 permanent employees. This would provide for a family counselor with PTSD skills in each of the 208 Vet Centers nationwide, and another 30 staff to cut down on the "managing of vacancies" that is now going on just to keep all of the Vet Centers open.

- Provide a 10% increase in Research & Development funds, of which $25 Million would be a line item for the National Vietnam Veterans Longitudinal Study (NVVLS); further that report language provide that VA must let a contract to a viable vendor within 90 days of passage, properly manage the contract this time, and that the final report should be delivered to the Congress not later than September 30, 2008. Frankly, without the NVVLS, the VA will continue to underestimate the needs of combat veterans of all ages, but particularly the service members and veterans returning from OIF/OEF.

- Provide for additional reporting data on the Visually Impaired Service & Training Centers, the Multi-Trauma Centers, and other specialized services to ensure that these services, as well as all grants (such as the Mental Health, PTSD, and the OIF/OEF PTSD Outreach grants are being properly administered and that these funds are not ending up in the general funds of the VA Medical Centers that received these grants for specific purposes.

If Congress enacts an appropriation that provides for these basic adjustments—what we consider an adequate budget for VA in fiscal year 2007—it should then seriously consider how it intends to fund VA in the future. VVA is a member of the Partnership for Veterans' Health Care Budget Reform and believes that assured funding is the best and most straightforward response to the funding dilemma the Administration and Congress confront in each fiscal year.

In the near future, VVA plans to debut its revised position paper on the need for greater funding for veterans' health care, whether by means of assured funding or another reliable methodology. This paper will show that VA users' per capita spending—even without taking into account the effects of inflation—has been relatively constant since 1996 over the same period of time that national per capita and Medicare enrollee per capita costs have doubled. There can be no doubt that VA has become more efficient. The real question is whether or not VA is in a position of rationing care for those in the system, not as a matter of policy or intent, but just simply because there are too few people trying to properly serve the veterans they care about.

Let's give VA a fair and adequate budget that reflects a nation's gratitude for veterans' service. Let's stop playing games with defining the system's true needs and use a budget methodology that is transparent and rational.

Mr. Chairman, again, thank you for the opportunity to make our views know to this Committee for the Record. VVA looks forward to working with you and other members of this Committee to improve the funding – and the accountability - for veterans' health care.

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

VIETNAM VETERANS OF AMERICA
Funding Statement
February 14, 2006

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

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RICHARD WEIDMAN

Richard F. "Rick" Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. As such, he is the primary spokesperson for VVA in Washington. He served as a 1-A-O Army Medical Corpsman during the Vietnam War, including service with Company C, 23rd Med, AMERICAL Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo as statewide director of veterans' employment & training (State Veterans Programs Administrator) for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans (NCHV), and served at various times on the VA Readjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities - Subcommittee on Disabled Veterans, Advisory Committee on Veterans' Entrepreneurship at the Small Business Administration, and numerous other advocacy posts. He currently serves as Chairman of the Task Force for Veterans' Entrepreneurship, which has become the principal collective voice for veteran and disabled veteran small-business owners.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veterans affairs. He attended Colgate University (B.A., 1967), and did graduate study at the University of Vermont.

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Statement of the American Psychiatric Association

Presented to the

House Committee on Veterans' Affairs Subcommittee on Health

February 14, 2006

The American Psychiatric Association (APA) would like to thank the members of Subcommittee and your House colleagues for your commitment to providing the highest quality medical care for our nation's veterans and to supporting necessary research to advance the quality of their care.

The APA is the national medical specialty society representing more than 37,000 psychiatric physicians nationwide who specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders. At the federal level, the APA advocates for access to quality medical care, necessary supports to those living with mental illnesses and their families as well as investment in biomedical research.

The APA commends President Bush for adding **$339 million** to the FY07 budget for mental health inpatient, partial hospitalization and other services.[1] Even with these additional funds, however, the budget is not adequate to meet the growing needs of veterans with mental illnesses. According to a recent article published in the *New England Journal of Medicine*, 15 to 17 percent of returning combatants from Iraq met the screening criteria for major depression, generalized anxiety or PTSD using the National Center on PTSD's measurement scale. [2] In addition, the Veterans Administration's own researchers have published data in journal *Psychiatric Services* that documents the rise in mental health problems among its current patients, particularly younger veterans. [3]

MENTAL HEALTH CARE NEEDS OF VETERANS

- Over 470,000 veterans are service-connected for mental disorders.
- Over 130,000 of these veterans are service-connected for psychosis.
- In 2003 alone more than 77,800 veterans received specialized care for PTSD with tens of thousands more receiving some type of care through their primary care clinic.[4]
- More than 185,000 are service-connected for PTSD, a disorder most often directly related to combat duty.
- Veterans with mental illnesses also have significant medical comorbitities and are therefore difficult and expensive to treat.
- Over 30% of the homeless population in this country are veterans with mental disorders and substance use conditions.

MENTAL HEALTH SERVICES FOR VETERANS

While the Administration's budget does allow for increases in spending over FY06, the APA is concerned that the budget assumptions, such as the reliance of legislative proposals to collect user fees and copays from priority level 7 and 8 veterans, might be overly ambitious. The Friends of the VA advocacy group estimates that up 200,000 vets will drop out of the VA system with the proposed copays. While level 7 and 8 veterans are not service-connected for disability, we are concerned that the VA has not considered the impact on those 200,000 who rely on the VA to pay for psychiatric medications such as anti-depressants that keep them well and employable.

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[1] Pages 955 and 956 of the President's Fiscal Year 2007 Budget Proposal
[2] July 1, 2004 "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care", Hoge, Castro, et al.
[3] February 2006, Vol. 57, No. 2, "Mental Distress Among Younger Veterans Before, During and After the Invasion of Iraq", Alan West, Ph.D., William Weeks, M.D., M.B. A.
[4] Department of Veterans Affairs, Office of Public Affairs, Media Relations, PTSD Fact Sheet, December 2004.

We urge Congress to require clarification of the Administration's "medical usage" projections [5] which indicates the number of psychiatric patients drops as well as the number of vets in residential care. This projected decrease in care is troubling given that the VA's mental health data shows the number of patients seeking psychiatric care will increase. We request that Congress also require further information from the VA on the discrepancy between the budget estimate for 2006 which cites the average daily census of inpatients and outpatients as significantly higher than the FY2007 budget request currently reflects.

For too long, mental health care has *not* been a priority for VA. Virtually every entity with oversight of VA mental healthcare programs – including Congressional oversight committees, the GAO, VA's Committee on Care of Veterans with Serious Mental Illness, and other groups such as 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 accessible 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. We continue to receive troubling reports suggesting that mental health funds may be re-allocated by the VA for other purposes. The APA requests that Congress task the Government Accountability Office with tracking the FY05 and FY06 funding allocated for the diagnosis, treatment and recovery of mental illness and substance use disorders as well as monitor VA compliance with Congressional recommendations.

Veterans with substance use disorders are drastically underserved. The dramatic decline in VA substance use treatment beds has reduced physicians' ability to provide veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illnesses or co-occurring substance use problems does not now meet of the demand for care in that population. Additionally, despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

The APA is concerned that VA mental health service delivery has not kept pace with advances in the field. State-of-the-art 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. The VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available throughout the VA. However, 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.

PHARMACY AND MEDICATION RESOURCES

The issue of pharmacy resources and medication availability for mental illness is also important. There have been reports, including one by the GAO, that some networks have established either rigid limits for the use of some medications (for instance, atypical antipsychotics) or have simply insisted on the use of generics, together with other restrictions. The APA has joined with other advocacy organizations in opposing the implementation of the new treatment guidelines for atypical antipsychotic medications for veterans with schizophrenia. Of particular concern is the "fail first" policy that veterans with schizophrenia go through a minimum 6-8 week trial on specified medication, with access to any alternative medication limited to case failure after the end of the 6-8 week period. Patients respond differently to medications and physicians must be allowed to best respond to the health needs of their patients. This policy directly interferes with the clinical judgment of the treating psychiatrist and may put patients' lives at risk.

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[5] Vol 1 of 4 – p. 317.

As a practical matter the current VA computerized patient record system (which has been highly touted as a health information technology (HIT) model) – does not provide hyperlinks to the list of medications on the VA formulary. Such a link could assist with efficiency and patient care by speeding up medical necessity reviews for non-formulary drugs. This is especially important for patients who need psychiatric medications, because switching patients from medication to medication can have deleterious effects.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Patients with severe PTSD increased 42% from 1998 to 2003, while expenditures increased only 22% during that same time. Veterans who are service-connected for PTSD use VA mental health services at a rate at least 50% higher than other mental health user groups. It is essential that identified PTSD programs be maintained consistent with the provision of P.L. 104-262, so that veterans may reap the benefits of specialized treatment delivered by clinicians who are experts in addressing the unique needs of veterans with PTSD and its associated co-morbid conditions. The APA appreciates the President's special attention to the growing problem of post-traumatic stress disorder and the resulting need in a seamless continuum of care. Again, we would request that funds designated for PTSD services be tracked by the GAO to insure fidelity.

As you know, the Institute of Medicine is undertaking a review of PTSD diagnosis, treatment and disability determination within the VA and Department of Defense. We believe that care must be taken to distinguish between the underlying diagnostic criteria in DSM-IV and the way in which the DSM ma – or may not – be used appropriately. We would be pleased to brief members of the Subcommittee and staff on the DSM.

MIRECCs AND RESEARCH

The APA wishes to compliment the VA for initiating Mental Illnesses Research, Education and Clinical Centers (MIRECCs). The MIRECCs serve as infrastructure supports for psychiatric research into the most severe mental illnesses. However, less than 12% of the VA health research budget is dedicated to mental illness and substance use, even though 35-40% of VA patients need mental health care. The APA strongly encourages the establishment of additional MIRECCs.

The APA supports the VA Research Office's decision to initiate the Quality Enhancement Research Initiative (QUERI), which has funded two new field centers focused on putting into clinical application what is known about schizophrenia, depressive disorders, and substance use disorders. However, the nominal increase in the research budget is likely to limit the implementation of this farsighted plan.

In addition to funding MIRECC's the APA is recommending an overall FY07 appropriation of $460 million for medical and prosthetic research. This recommendation is consistent with a similar recommendation by the Friends of VA (FOVA).

WORKFORCE SHORTAGE

The shortage of physicians and other mental health professionals has compromised the delivery of healthcare and has endangered patient safety. Many veterans with mental illnesses are medically fragile – with diabetes, liver or kidney failure, or cardiac disease, for example. Their care requires a specially trained physician. A revision of salary schedules, recognition of the contributions of International Medical Graduates and minority American Medical Graduates, and the availability of Continuing Medical Education (CME) courses and other professional opportunities for advancement

need to be addressed. We understand there is a significant shortage of nursing staff, especially psychiatric nurses, and we request that the VA address this shortage area.

RECOMMENDATIONS

The APA is deeply concerned about veterans living with mental illnesses and their families. We believe it is important to secure: 1) additional and specifically allocated funding and ensure accountability mechanisms; 2) immediate implementation of clinical programs mandated within the system; 3) compliance with legislation aimed at maintaining capacity; and 4) enhanced recruitment and retention of personnel who will improve the care and lives of veterans with mental illnesses and substance abuse disorders.

Above all, a profound respect for the dignity of patients with mental and substance use disorders and their families must be duly reflected in serving the needs of veterans in the VA system. The American Psychiatric Association thanks the Subcommittee for the opportunity to submit a statement.

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STATEMENT BY

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH

REGARDING THE DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 2007 BUDGET REQUEST

FEBRUARY 14, 2006

The American Federation of Government Employees, AFL-CIO, which represents more than 600,000 federal employees who serve the American people across the nation and around the world, including 150,000 employees in the Department of Veterans Affairs (VA), is honored to submit a statement regarding the VA's Fiscal Year (FY) 2007 budget request for the Veterans Health Administration (VHA).

The VA's FY 2007 VHA Budget Fails to Address Chronic Shortfalls

The Administration's request for an 11.3% increase in funding for medical care looks like a step in the right direction – at first glance. However, a closer look reveals new and old budget gimmicks: higher co-pays and user fees, overly optimistic assumptions about collections and management efficiencies, and a hidden 13% cut in medical care dollars over the next five years, according to a new analysis by the Center on Budget and Policy Priorities.

This budget comes on the heels of years of shortfalls and short staffing, delayed construction and maintenance, and excessive, costly contracting out. VHA's dedicated employees and the veterans they serve are experiencing great uncertainty and hardship as the result of the current funding process. Medical facilities across the country have reported budget shortfalls for FY 2006, some as high as $30-40 million.

Widespread staffing shortages are taking their toll on VHA employees and veterans. In some facilities, official "hard hiring freezes" are in place, e.g. Puerto Rico/Virgin Islands, Togus, Maine, St. Louis, Missouri and Northern Wisconsin. Elsewhere, management is imposing "soft freezes" and "hiring lags" that significantly slow down the timeframe for bringing on new staff, e.g. facilities in New York, Florida, Idaho, Alaska, Wisconsin, North Carolina, Wyoming, Tennessee, California, South Dakota, Missouri, Minnesota, Nevada, Oregon and Texas. In either case, staffing shortages increase management's reliance on expensive contract care and temporary employees. VA staff are pressured or forced to work prolonged overtime.

Sometimes the effect of hiring freezes and lags is less obvious. For example, doctors and other direct care providers work overtime without pay because they must meet unrealistic performance goals (Portland, Oregon). Nurses who do not provide direct care get counted as if they do (Portland, Oregon.) A common VA practice is to keep inpatient units officially "open" even though beds are no longer available to patients because of staffing shortages (Pittsburgh, Minneapolis and Battle Creek, Michigan).

Understaffing has had an enormous effect on veterans' timely access to care. In fall 2005, over 12,000 veterans were on VISN 16 electronic waiting lists (EWL) for over 30 days, in VISN 23, 11,000 were on the EWL for more than 30 days. At the facility level, recent waiting lists have been as high as 3,000 facility-wide in Puget Sound, Washington, and 700 for primary care in Minneapolis. Veterans in Central Texas wait 6 to 8 months for specialty care.

Access to care is impacted by other practices as well. In Portland, Oregon, ambulances have been on "divert" status for two years. Veterans who are less than 100% service-connected disabled must go to other emergency rooms and often end up with large out-of-pocket bills. In Minneapolis, employees had to be pulled from other short-staffed units in order to open a new Polytrauma Unit.

Other FY 2007 Budget Concerns

AFGE is baffled and troubled by the proposed 34% cut in major construction funding. Many construction projects have already been held over from previous years. In addition, this proposal runs counter to the VA's priorities of ensuring access to a growing number of veterans, particularly those in rural areas.

Similarly, institutional care and state extended care facilities are neglected in this budget, even though the VA is facing a rapidly aging patient population. It is laudable to consider non-institutional alternatives where appropriate, but the VA is forced to contract out institutional care because some elderly and disabled veterans need a higher level of care but in-house beds are not available.

AFGE is concerned that the proposed $23 million cut in physicians pay is based on overly optimistic assumptions. The implementation process is far from over; personnel training is still underway and in many locations, compensation panels are still being formed. Locally, our members are being told that funding may not be available for *any* pay increases. To date, AFGE has been largely excluded from the physicians pay implementation process at the national and local levels, including the compensation panels making critical decisions about local market pay. AFGE urges the Committee to ensure that all aspects of the implementation process include AFGE representatives, consistent with the statute and the spirit of collaboration that existed during the legislative drafting process.

Veterans Deserve Assured Funding

Turning away hundreds of thousands of priority 7 and 8 veterans and increasing veterans' out of pocket medical costs through co-payments and user fees is not the answer. Soldiers returning from combat and their older counterparts cannot delay their medical needs because of erroneous projects and budget gimmicks. They should be able to count on access to VA's top-notch care in a timely manner. The past year's budget roller coaster has made a crystal clear case for

replacing the current flawed budget system with one that relies less on discretionary funding.

AFGE strongly urges Congress to pass the Assured Funding for Veterans Health Care Act of 2005 (H.R. 515), sponsored by Representative.Lane Evans (D-IL). H.R. 515 would require that annual VA health care funding be based on the number of enrollees and medical and hospital inflation.

The Vicious Cycle of Contracting Out and Underfunding

When hospitals and clinics lack funding for new hires and new imaging equipment, they are forced to contract out these services at much higher costs, resulting in further underfunding. Purchased (non-VA) care was the largest growing component (at 20% yearly) of the VHA budget from FY 2001 to FY 2004.

Contract care should be limited to short-term situations where specialty care or rural care cannot be provided in-house. Contracting out of laundries and food service is not a panacea for budget shortfalls either. VA's own reports indicate few or no savings from contracted out laundries, and in some cases, revenue losses. The inability (and in some cases unwillingness) to maintain or upgrade in-house laundry facilities creates the necessity to contract out laundry care, at the risk of lower hospital cleanliness. Contracting out of laundries, food service and other blue collar VA jobs deprives disabled veterans who fill many of these jobs with the chance for steady employment and self-sufficiency.

The VA's Business Process Reengineering (BPR) is not an outsourcing initiative, but rather aims to increase internal efficiencies through reorganizations and consolidations. Nonetheless, AFGE is concerned that budget pressures will encourage the use of BPR to move toward contracting out at a later date in order to fill service gaps resulting from consolidation. AFGE has another concern about BPR: The VA has stated that key employees should be part of the process, but to date, AFGE representatives have not been included in the process at either the national or local level. AFGE members stand ready and willing to contribute their expertise and insights on management efficiencies to the BPR process.

Collaboration and Its Cost Impact Must Be Closely Monitored

AFGE urges the Committee to carefully evaluate the costs and benefits of a joint venture between the Charleston VAMC and the Medical University of South Carolina (MUSC), and other joint ventures considered in the future. The VA is already a nationally recognized model for health care cost-effectiveness. An independent assessment by medical and economic experts is needed to determine which parts of veterans health care might best be improved through such collaboration. The VA should not look to MUSC to make that assessment.

AFGE shares the concern of veterans groups that a joint venture with a nongovernmental, non-VA organization could dilute VA's identity as the leader in providing specialized care for veterans. It is also unclear how two sets of personnel with different training and pay would work in the same facility.

AFGE appreciates the recommendation made by Congressman Michael Michaud (D-ME) at the September 2005 hearing that the VA and MUSC include veterans' service organizations and employee representatives in the exploration process. AFGE was pleased to hear at the Committee's February 8, 2006 budget hearing that key stakeholders will be included in the dialogue on the proposed joint venture. Our physician members in Charleston have valuable input to provide at the local level and our local president in Charleston has submitted a request to the Committee for participation in future meetings. AFGE also looks forward to being part of the national dialogue regarding joint ventures.

Summary

Persistent shortfalls and funding uncertainty are causing great wear and tear on the VA health care system. Needed medical services are being delayed or denied to hundreds of thousands of veterans. Dedicated employees are overworked and discouraged. AFGE urges the Committee to implement assured funding by supporting H.R. 515. In addition, AFGE should be included in national and local efforts to address VA's short and long term funding needs, and related dialogues about management efficiencies, joint ventures and physician pay.

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Subcommittee on Health. We look forward to working with Chairman Brown and Ranking Member Michaud to ensure that the VHA budget adequately meets the needs of our veterans in FY 2007 and beyond.

Questions for the Record
Ranking Democratic Member, Health Subcommittee Michael Michaud
House Committee on Veterans Affairs

Pre-hearing Questions for VA Budget for Fiscal Year 2007

Question 1a: According to VA enrollment data, 2,403 Maine veterans applied for enrollment in FY 2005 but VA determined that these veterans had incomes above the national means threshold and low-income geographic index and therefore VA denied them enrollment. Please provide the median income of these Maine veterans?

Response: It is important to note that 2,403 represents the total number of Maine veterans who have been impacted by the enrollment restriction on new Priority 8 applicants since January 17, 2003, through the end of fiscal year (FY) 2005. In FY 2005, 869 Maine veterans who applied for enrollment were determined to be Priority 8 and thereby denied enrollment. Currently, Department of Veterans Affairs (VA) is unable to produce a meaningful median income of this group since, by law, these veterans are only required to agree to make applicable copayments; they are not required to provide income information.

Question 1b: Please provide the total number of Maine veterans who applied for enrollment since January 2003 through December 2005 who VA determined to be new Priority 8 veterans, and therefore VA denied them enrollment.

Response: VA enrollment records show that from January 17, 2003 through the end of FY 2005, 2,403 Maine veterans were denied enrollment due to the restriction for new Priority 8 veterans.

Question 2a: The CARES commission decision of February 2004 recommends new Community Based Outpatient Clinics in Maine. The Secretary's CARES decision of May 2004 for VISN 1 targeted news sites for VA care in Maine.

a. What is the specific timeline for opening the CBOC in the Lewiston-Auburn area of Maine?
b. What is the specific timeline for opening the access point of care in Houlton, Maine?
c. What is the specific timeline for opening the access point of care in Dover-Foxcroft, Maine?

Response: The need for providing VA healthcare in the Cumberland County, Houlton and Dover-Foxcroft areas has been acknowledged. The opening of a community Based outpatient clinic (CBOC) in the Cumberland County area and outreach clinics in Houlton, and Dover-Foxcroft have been planned in accordance with the Secretary's 2004 Capital Asset Realignment for Enhanced Services (CARES) decision. These sites are targeted for priority implementation by FY 2012.

Question 2b: If the response is that the VA will open the clinics and access points by FY 2012, please explain in detail the specific reasons why the access points and CBOC will not be open sooner.

Response: Timelines are dependent on the availability of funding from year to year. VA remains committed to the CARES process for the coordination and prioritization of capital enhancements, including CBOCs based on system requirements and available resources.

Question 3: Does the FY 2007 budget provide additional funding for VISN 1 to open the Lewiston-Auburn CBOC by the end of FY 2007? If yes, how much and do these funds come from the Togus VA Medical Center's budget or the VISN budget? If not, please explain in detail how the VA will meet the projected needs of veterans in the Lewiston-Auburn area in FY 2007.

Response: Once the VA's FY 2007 appropriation is finalized, a specific allocation to Veterans Integrated Service Network (VISN) 1 can be developed to respond to an additional CBOC.

Question 4: What is the amount of funds the Togus Maine VAMC is budgeted to receive for FY 06 operations?

Response:

TOGUS FUNDING FOR FY 2006 AS OF 1/31/2006

GENERAL PURPOSE (INCLUDING CONSOLIDATED MAIL-OUT PHARMACY)	136,615,701
TRAVEL	125,868
INFORMATION TECHNOLOGY (PAY)	1,299,994
MEDICAL CARE COLLECTIONS FUND	14,784,435
SHARING GOAL	131,308
TENANT SUPPORT	725,895
TOTAL GENERAL PURPOSE	**153,683,201**
PROSTHETICS	7,900,000
INFORMATION TECHNOLOGY APPROPRIATION (NON-PAY)	808,458
SPECIFIC PURPOSE	12,839,359
TOTAL FUNDING	**175,231,018**

Does not include Capital resources

Question 5: What is the amount of funds the Togus Maine VAMC would need in FY 2006 to maintain the FY 2005 level of services and FTEE levels without using any reserve funds or converting any non-recurring maintenance funds into operating expense funds?

Response: The Togus Maine VA Medical Center (VAMC) will maintain existing services and assigned FY 2005 full time employee (FTE) level in FY 2006 within currently available resources.

Question 6: Given the continuing number of wounded servicemembers who have sustained traumatic injuries, which have resulted in amputations, blindness and traumatic brain injuries, please describe the increase for FY 2007 over FY 2006, if any, in funding for a) prosthetics research, b) prosthetics, c) blind rehabilitation and d) mental health programs targeted towards recently separated service personnel.

Response to 6A Prosthetics Research: The President's Budget Request for FY 2007 includes $399 million in direct appropriations to support VA's medical and prosthetic research program. This amount will fund more than 2,000 high-priority research projects to expand knowledge in areas critical to veterans' health care needs. VA projects $74.9 million will be devoted to research related to a general category of amputation and prosthetics, including research related to acute and traumatic injuries, sensory loss, central nervous system injury and associated disorders, and degenerative diseases of bones and joints that can be generally classified as amputation and prosthetics research. This is an increase over the FY 2006 projection of $68.2 million.

Response to 6B Prosthetics: VA's medical care request includes $1.4 billion for FY 2007 ($160 million over the 2006 level) to support the increasing workload associated with the purchase and repair of prosthetics and sensory aids to improve veterans' quality of life. The Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans returning from combat are provided state of the art devices that VA purchases.

VA will spend $20 million dollars each year specifically to meet the needs of the critically injured veterans returning from the Iraq war, who will require intensive medical care from VA throughout their lifetime. These patient groups include amputees, spinal cord injures, traumatic brain injures, hearing and visual impairments, and other conditions. This is an integrated effort that includes other patient care services groups such as Research and Development, Physical Medicine & Prosthetics and Sensory Aids.

Response to 6C Blind Rehabilitation: The limited number of recently separated service members who carry a diagnosis of legally blind also carry other medical diagnoses. VA has not tracked data on the specific population of recently separated service members who require blind rehabilitation service, therefore, funding information specific to this group is not available. However, for the overall Blind Rehabilitation program, the President's Budget Request for FY 2007 includes $81.6 million for FY 2007, an increase over $76 million in FY 2006.

Response to 6D Mental Health Programs: The President's Budget Request for FY 2007 includes a request for $3.2 billion for mental health programs, to cover psychiatric residential rehabilitation treatment, psychiatric inpatient and outpatient, and mental health initiatives. This is an increase of $339 million over the FY 2006 estimate and reflects increased demand for mental health services and other services for OEF/OIF veterans.

Question 7: Please describe, in detail, the FY 2007 budget request for VA programs to address the unique challenges of access to high quality care that face rural veterans. Are there any new initiatives the Secretary would recommend to assist in expanding access for rural veterans?

Response: VA has taken, and will continue to take steps to implement several new initiatives that provide for special consideration for veterans living in rural areas include but are not limited to the following:

- Community-Based Outpatient Clinics (CBOCs) – CBOC's assist in improving access to care for veterans in rural areas. VA's current policy for the planning and activation of CBOCs ensures that new CBOCs meet VA's goal to improve access by current users by placing them in those areas where users travel significant distances or experience excessive travel time to access care. VHA Networks will be encouraged to plan for the establishment of additional CBOCs or to expand services at existing CBOCs, where there is demonstrated need and within the context of available resources. An additional 43 potential CBOCs have been identified for consideration in 2007, pending operational funding, Secretarial approval, and Congressional notification.

- Care Coordination and Home Telehealth – Care coordination involves telehealth which enables the provison of services to rural and remote areas in CBOCs and Vet centers. In FY 2006, marked expansions will take place in tele-retinal screening for diabetic retinopathy and telemental health. Home telehealth enables non-institutional care to take place beyond the usual 20 to 40 mile restriction faced by homecare providers. VA plans on continuing to expand the use of care coordination and home telehealth in FY 2007 to meet the needs of veterans in rural areas.

- Veterans Rural Access Hospital Directive – This directive provides guidance to the field on the proper means of providing access to veterans in rural areas. There are environments where the demand supports small inpatient bed capacity. This is challenging especially in rural areas where professional service support may be limited. The directive specifies that:

    - These facilities must be part of a larger network of health care and clinical practice policies must ensure that identified support staff possesses the skills necessary to provide post-anesthesia/post-operative care.

- A VA facility with less than 25 medical or surgical inpatient beds is assessed annually to ensure that quality of care and availability of support services are maintained.

If care is not available at the VA and the care required is emergent, fee care is authorized. If not an emergency, then the VISN will refer the veteran to a tertiary care facility within the VISN or to a nearby VISN.

FOVA

Friends of VA Medical Care and Health Research

A coalition of national organizations committed to quality care for America's veterans

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February 14, 2006

The Honorable Henry Brown
Chairman
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

The Honorable Mike Michaud
Ranking Member
Subcommittee on Health
Committee on Veterans Affairs
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Washington, DC 20515

Dear Mr. Chairman and Ranking Member:

On behalf of the Friends of VA Medical Care and Health Research (FOVA) coalition, thank you for your ongoing support of the VA research program. FOVA is a coalition of 80 organizations committed to high quality health care for veterans. We are writing regarding the administration's budget request for VA research for fiscal year (FY) 2007 and urge your support for an appropriation of $460 million.

The administration's FY 2007 budget requests $399 million for VA research, a $13 million (approximately 3.2 percent) reduction from the final FY 2007 appropriation. These funds provide direct support for research projects as well as the salaries of non-clinician investigators. In its budget summary, (http://www.va.gov/budget/summary/index.htm) VA anticipates this $13 million reduction will result in the elimination of 82 investigator-initiated programs, 15 special research initiatives, and seven multi-site research projects. The department also anticipates a reduction in VA's direct research employees by 286. VA also anticipates increasing research funds for studies of acute and traumatic injury and central nervous system injury and related disorders. However, in order to fund these new studies with a shrinking budget, VA projects cuts to research in aging, cancer, infectious diseases, kidney diseases, diabetes, lung disorders, and heart diseases, among others.

As with prior years, the administration's budget also includes projections for VA research spending from the main VA medical care program. This "medical care support" is slated for a $13 million increase, from $353 million in FY 2006 to $366 million in FY 2007. While this increase might seem to offset the proposed cut to direct research funding, the medical care support allocation does not support research programs. As the budget submission indicates, this allocation funds "facility costs of heat, light, telephone, and other utilities associated with laboratory space; the administrative cost of human resource support, fiscal service, and supply service attributable to research; research's portion of a medical center's hazardous waste disposal and nuclear medicine licenses; and, most importantly, the time clinicians devote to their research activities."

The VA budget also includes non-VA funding sources among the lines of support for VA research. The budget rosily projects a $13.24 million increase (from $662 million in FY 2006 to $675 million in FY 2007) in other federally funded research conducted at VA, funds which have primarily come from National Institutes of Health (NIH) funded research projects. However, the administration's budget for NIH is flat for FY 2007. Finally, the budget includes a $4 million increase in private research funding (from $204 million in FY 2006 to $208 million in FY 2007), a projection much more aligned with reality than prior budgetary projections of

astronomical growth in these funds, which come from industry to support clinical trials as well as foundations and other non-profit entities to support research projects.

Programmatically, the budget includes plans for two special research projects to begin in FY 2007. The first project focuses on the special needs of service personnel returning from Operation Iraqi Freedom and Operation Enduring Freedom. The project envisions a wide ranging number of research efforts, including targets in post-traumatic stress disorder and other mental health issues; amputation and prosthetics research; and returning personnel reentry and reintegration. A second special project would focus on genomic medicine. The thrust of this project is to link veterans' genetic information with the VA electronic health record. According to the budget submission, "The goal is to develop genetic assessments that will potentially enable 'mass customization' of medical treatment."

FOVA supports a FY 2007 direct research appropriation of $460 million. The coalition wholeheartedly supports the vision to expand the VA research program to encompass the needs of service personnel returning from current conflicts, whether they include polytrauma, massive burn injury, or mental conditions. Such expansion of the program requires new resources so VA's other research areas, which are equally important to the long-term care of veterans, do not languish in the meantime. FOVA also supports a $45 million appropriation for VA research facilities to renovate aging research facilities and supply the necessary equipment to outfit new facilities.

Please feel free to contact the following members of the FOVA Executive Committee with questions about the FY 2007 VA research budget proposal or FOVA's support of a $460 million appropriation.

Sincerely,

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