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THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2008

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THE U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2008

THURSDAY, FEBRUARY 8, 2007

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

The Committee met, pursuant to notice, at 9:30 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Herseth, Mitchell, Hall, Hare, Salazar, Rodriguez, Donnelly, McNerney, Space, Walz, Buyer, Stearns, Moran, Baker, Brown of South Carolina, Miller, Boozman, Brown-Waite, Turner, Lamborn, Bilirakis.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. This hearing of the House Committee on Veterans' Affairs is in order. Thank you all for being here. I thank the Members of the Committee.

We are here to welcome the Secretary of the VA and your staff, and we appreciate your spending the morning with us, maybe the afternoon, maybe all night. I do not know. But thank you for being here.

You have characterized the budget for fiscal year 2008, Mr. Secretary, as a "landmark budget," and we certainly appreciate that you are submitting a budget that calls for an increase for veterans' healthcare, unlike the budget that was submitted 2 years ago.

And I believe it does give us a basic framework from which to begin our analysis as to whether the VA's budget submission will meet the needs of veterans in the coming fiscal year.

Of course, our job as a Committee is to make sure that as we follow this "landmark budget", we do not get off course and lose our way.

You have requested an increase for VA medical care of $1.9 billion over the level provided in the Joint Funding Resolution for 2007. That is a 6 percent increase.

We did provide this fiscal year a 12 percent increase over 2006. Both the Independent Budget that we will discuss in the panel after you, and The American Legion, both recommend more than a 12 percent increase for fiscal year 2008.

The Vietnam Veterans of America recommend substantially more. So I look forward to your explanation as to why you believe the 6 percent increase will suffice for our veterans.

Your budget submission also states that $1.4 billion of your increase for medical care is attributable to inflation. Once this is factored in, the recommended increase leaves precious few dollars to meet the increasing needs of our nation's veterans.

And although the waiting list for new enrollees has indeed declined, and you are obviously to be applauded for that and we all appreciate that, I believe that no veteran should have to wait for healthcare appointments simply because the VA does not have the resources to care for that veteran. I would hope that you can assure the Committee that the budget request before us has the dollars to address this problem.

Last year, your budget request claimed $197 million in efficiencies for a total of $1.1 billion. This year's budget submission also claims "clinical and pharmacy cost avoidance," in your words.

Our Committee would like to know whether you believe you will achieve these efficiencies for 2007 and what exactly are your dollar estimates as to your efficiencies in these two areas for 2008.

I see that you are requesting an additional $56 million for a total of $360 million for your mental health initiative. Your submission also claims that the VA plans to spend $3 billion for mental health services and, yet, the GAO reported last November that you failed to fully allocate the resources you pledged in 2005 and 2006 for that mental health initiative.

In light of this report, I hope that the VA will fully allocate the $306 million for this initiative in 2007 and $360 million for 2008, and I hope you can assure us of that. And I would like to make sure you do answer the question, "Do you currently have the resources you need to address the mental healthcare needs of our veterans, especially in light of the significant mental issues that seem to plague those coming back from Iran and Afghanistan."

I have to note, and I know many on this Committee agree, if not all, that we are disappointed that you have once again brought forward legislative proposals as part of your budget submission. Instituting enrollment fees and increasing pharmacy co-payments have been rejected, as you know, year after year by this Congress.

Last year, you claimed that the enactment of these proposals would reduce your need for discretionary healthcare dollars. This year, your proposals are deemed mandatory spending and are taken out of your own mandatory spending allocation.

I hope you will explain to this Committee why you have offered these proposals again and the policy reasons for deeming the expected receipts from these proposals mandatory dollars.

We both agree, we all agree, that the VA is facing an ever greater claims processing crisis—over 600,000 backlogged as of today. In light of this, I would expect your budget submission to aggressively request additional dollars to address this growing problem.

But as I read the budget, and correct me if I am wrong when you testify, I see that your request for General Operating Expenses Account, which funds the claims processors at the heart of the process, is close to $9 million less than the amount provided for in the 2007 funding resolution.

I would like to know what steps you are taking to meet that challenge and why the VA has not requested a sizable increase in this account to address the claims backlog.

Your VA research request seeks less than you will receive under this year's Joint Funding Resolution. I think you should be requesting at least an $18 million increase just to keep up with inflation. This is especially true when, once again, you are seeking more resources from other Federal sources and the budget for NIH is going to be static.

I look for a full explanation of your information technology request, including transfers from other accounts. We have to ensure that the VA is moving in the right direction in Information Technology and that the funding level you receive in 2008 will lead to better security, more innovation, and fewer incidents like the one that occurred in Birmingham, Alabama last week.

I know that you are seeking increases in both the Major and Minor Construction accounts, and I am sure we will all be interested in learning how you selected the projects for this request.

There is much work to be done to ensure that the VA has the funding it needs in the coming fiscal year and to ensure that the VA spends the resources it receives properly and diligently.

Mr. Secretary, we look forward to hearing from you this morning, to work closely with you to make sure that the needs of our veterans, especially in the midst of war and those returning from Iraq and Afghanistan and the veterans from our previous conflicts, are met.

I would like to just add a personal note for my colleagues. As the Secretary and I have met and talked together on more than a few occasions since the change in the Congress, I appreciate that dialog. I appreciate your keeping me in touch with things that need to be touched upon. We will be traveling together to see some things in the VA that we want to do together. I think we have set up a good working relationship, Mr. Secretary, and I appreciate the response to the new situation, the new majority in this Congress.

And I want to assure our colleagues on both sides of the aisle that we have, I think, established the basis of a relationship that we will be working together and that we will seek what is best for our veterans.

I think your commitment does not need to be questioned on that, Mr. Secretary, and this Committee will work with you to ensure that every one of our veterans is cared for properly.

I will yield to the Ranking Republican, Mr. Buyer, for a statement.

[The prepared statement of Chairman Filner appears on p. 62.]

OPENING STATEMENT OF HON. STEVE BUYER
RANKING REPUBLICAN MEMBER
FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. BUYER. Thank you, Mr. Chairman, and good morning. I would like to welcome everyone to the first hearing of the 110th session of Congress.

And, wow, Mr. Chairman, you have come a long way from sitting in this chair demanding that the Secretary resign 9 months ago. So I am glad you two have been able to work this out.

For housekeeping, before we move into these questions, I have sent you a letter, Mr. Chairman, requesting next week for us to bring in the VSOs and the MSOs to go over the budget.

As you know, last year when we ended the joint hearings, we opened up the unprecedented access for the VSOs and the MSOs so we could get all of their testimonies prior to doing the budget views and estimates. And we also then did the look back, look ahead. So never before had the VSOs and the MSOs had such access to this Committee, and I am hopeful that you will give consideration to the request.

Secondly, you still have not submitted to the minority a proposed budget for the operations of this Committee, and so you and I need to start out on a bipartisan basis and you do that by talking about the budget of this Committee. So I am still utterly dumbfounded, and so I still await that draft budget so you and I can move on with business.

Mr. Secretary, I am glad you could be with us today to share with the Committee the President's proposed budget for 2008. I commend you yet again for embracing the challenge of improving the VA's budget process.

Building on last year's progress, when we had that hearing to examine the budget modeling and you disclosed the shortfall on a budget that you had inherited, you said you were going to take ownership of that budget, and you did that. And you are a man of your word, and you submitted to us a pretty big budget increase.

Obviously with the challenges last fall, the Senate not completing its work, I compliment the Democrat majority in working with the budget that we had last year and we got that CR. We are interested in your input from us.

I am sure you have had some management challenges over those last four months and what impact that is going to have upon your budget and whether or not you expect any carry-over funds into next year would be interesting to find out.

Mr. Secretary, as you observe your second anniversary as the chief steward of our nation's veterans, we can look back and note it has been a year of challenges and successes. I thank you for your willingness to squarely meet the challenges and commend you on your successes as you work with all Members of this Committee.

Based on the priorities in the last Congress, this Committee focused on the disabled veterans, those with special needs, and the indigent veterans. We passed major legislative initiatives, Public Law 109–461, the "Veterans Benefits, Health Care, and Information Technology Improvement Act." This bill was the result of a strong bipartisan effort of this Committee in concert with our colleagues in the Senate. They brought issues to the table. We brought issues to the table. And the democratic process worked.

We also listened to 20 VSOs and MSOs and incorporated many of their suggestions. We authorized 24 major construction projects in 15 States, approved continued leasing of eight medical facilities and required VA to explore options for construction of a new medical facility in San Juan, Puerto Rico.

With regard to our returning Iraq and Afghanistan veterans, we added 65 million to increase the number of clinicians treating post-traumatic stress disorder and improve their training. Public Law 109–451 further authorized spending for collaboration in PTSD diagnosis and treatment between the VA and DoD.

We authorized more funding for additional blind rehabilitation specialists and increased the number of facilities where these specialists could be located.

We expanded the eligibility for dependents' education assistance to the spouse and child of a servicemember hospitalized or receiving outpatient care before the servicemember's discharge for a total permanent service-connected disability. The intent here was to help enhance the spouse's earning power as early as possible before discharge of the servicemember. We made Chapter 35 more flexible for you, Mr. Secretary, so you can be responsive to the spouses and the dependents.

We restored entitlements for members of the National Guard and Reserves who care for the active duty during the school year. We extended work study provisions to ensure a veteran did not lose a job during the school year, and required the VA to report ways to streamline administration of the GI Bill to shorten the time to get that first check.

And I look forward to working with the Chairman on his proposed improvements to the GI Bill.

Listening to the VSOs and MSOs who expressed concerns about the veteran's ability to afford a home, we authorized VA to guarantee co-op housing units, which are often the most affordable housing in many areas. And so if you have any comments on it, Mr. Secretary, please let us know.

This Committee also focused on the disabled veteran-owned businesses, so we gave the VA the tools to increase the amount of business they do with veterans by giving service-disabled veterans-owned business preference over all other set-side groups and ensuring that the survivors of veterans business owners who acquired ownership continue their veteran-owned status with the VA.

The VSOs and MSOs also expressed the need to revitalize the veterans employment programs at the Veterans Employment and Training Service, so we made several changes to strengthen mandatory training for DVOPs and LEVRs, revise the incentive program to make it more effective, and establish a pilot licensing and credentialing program.

And the VVA especially noted that the Department of Labor needed to develop regulations to implement the "Jobs For Vets Act," so we did that too.

Since this time last year, we have seen the Department embrace the idea of centralizing its IT under the VA's CIO. I believe that this innovation has been seen as part of your legacy, Mr. Secretary, to the Department of Veterans Affairs, and I congratulate you. And I am sure Mr. Filner joins all Members of this Committee who unanimously supported and endorsed that move, and we congratulate you.

As part of our work on IT, we engaged in a bipartisan fashion to increase data security in order to protect our Nation's veterans. Recognizing that as you centralize that system, breaches are still going to occur, we set forth those mitigation efforts and gave you the tools.

And so that is why we recognize that when you had this latest breach in Alabama, you did not see the outrage of alarm from Mr. Filner and myself because we pragmatically have given you the

tools and we understand these things are going to happen, and we want to work with you when they do. And we appreciate also the notification process that you have been giving to the Committee and to the Senate and the Armed Services Committee.

We also worked through the complexities and will continue to work with the Charleston model, whether it is in Charleston, South Carolina or as we move with the facility in New Orleans. This is a new way and exciting way to build a hospital, and we want to work with you.

It is our job also to preserve those areas of excellence and to work together in a bipartisan fashion to ensure every service of the Department meets its highest standards. One of the most important services remains the determination awarding of benefits, and I think, Mr. Chairman, you said it about right. The claims backlog has reached an all-time high. It is the big elephant in the room, and we have to go after this.

To help lead the way, Mr. Chairman, I organized a Compensation of Benefits Accountability Task Force in December of 2005, and it had almost 1 year of work. They provided me a powerful work product with numerous recommendations, and I want to commend those who spent many hours working on this valuable product.

Mr. Wartman, the Associate Legislative Director of PVA; Mr. Dorn, the National Service Director of AMVETS; Rick Wiedman the National Legislative Director of Vietnam Veterans of America; John Lopez, Chairman of the Association of Service-Disabled Veterans; and Mr. Smithston, the Assistant Director of the National Veterans Affairs and Rehabilitation Commission of The American Legion.

Gentlemen, I thank you for your efforts. We will take that. We will work with the Chairman as we approach these issues along with the Secretary.

It is also worth noting again this year, the President proposed substantial increases in the budgets of agencies focused on fighting the War on Terror, the Department of Defense and the Department of Homeland Secretary.

I am pleased again this year, the Department of Veterans Affairs, an agency focused on caring for those who have borne the battle, also received a substantial increase of approximately 8 percent over the level contained in House Joint Resolution 20.

At a time when much of the rest of the government received a 2.2 percent increase, I believe this reflects a commitment of you, Mr. Secretary, and of the Administration to care for our nation's veterans during time of war.

As you know, Mr. Secretary, a budget is more than numbers and in the end, it must translate into real actions on the ground, for a positive effect on America's veterans. As I look at this budget, I view it in light of my three top priorities which I discussed, focusing on the disabled, caring for the special needs, and the indigent.

We have an obligation to those who bear those burdens of war and military service and their survivors, and our work must move toward fulfillment of that obligation. Therefore, I will judge this budget not just by the numbers, but for what it does for America's veterans given these priorities.

When you send us a budget of this magnitude, Mr. Secretary, I expect also to find those outcomes you seek successful. This Con-

gress is not a blank check. We will be looking for accountability. Generally I think this is a good budget.

As we look at desired outcomes, we will work with the VSOs and the MSOs. I am hopeful we can do those hearings. If we cannot do those hearings, I invite all the VSOs and MSOs to be in touch with me to get your input. If you choose not to be in touch with me, then I understand what your positions are.

Mr. Secretary, I applaud you for the direct and forthright budget process that you have used in developing this year's budget. It appears to be the gimmicks of years past have been removed. And so I want to applaud you for that. That is a leadership statement that I took out of this budget when I looked at it.

Mr. Secretary, last year, you brought us similar requests for the enrollment fees and co-pays. I recognize I am a minority here in Congress. I support co-pays. I support enrollment fees. When I created TRICARE for Life, I included those.

There was an error that we made. When we opened up the process here on this Committee, we did not give sufficient management tools to the Executive Branch. That is an error that we made. And there is a lack of will for people to now give you those tools. So I understand what you are doing.

At this point, I will yield back.

[The prepared statement of Congressman Buyer appears on p. 63.]

The CHAIRMAN. Thank you, Mr. Buyer.

I will entertain short opening statements from our colleagues.

Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD CHAIRMAN, SUBCOMMITTEE ON HEALTH

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

This is an extremely important first hearing for our Committee. We have a responsibility to make sure that the VA is provided with the dollars that it needs and that the VA spends those dollars in a wise manner.

Budgets do reflect our priorities and I think it is important for this Congress to make sure that veterans are high on our priority list. We have a lot of work to do in this Congress dealing with PTSD, homeless veterans, and making sure that the CBOCs under the CARES process are implemented.

So with that, Mr. Chairman, I look forward to working with you and Ranking Member Buyer and the Ranking Member of my Subcommittee, the Subcommittee on Health, Mr. Miller, as we move forward in this Congress. Thank you very much, and I am looking forward to hearing both panels today as well.

I yield back.

The CHAIRMAN. Mr. Moran?

Mr. MORAN. I have no opening statement.

The CHAIRMAN. Thank you.

Mr. Baker?

Mr. BAKER. No statement at this time.

The CHAIRMAN. Mr. Brown?

Mr. BROWN OF SOUTH CAROLINA. No statement.

[The prepared statement of Congressman Brown of South Carolina appears on p. 65.]

The CHAIRMAN. Mr. Miller?

Mr. MILLER. No statement.

[The prepared statement of Congressman Miller appears on p. 65.]

The CHAIRMAN. Mr. Boozman?

Mr. BOOZMAN. I have got a statement that I would like to submit——

The CHAIRMAN. Thank you.

Mr. BOOZMAN.—in the interest of time. Thank you.

[No statement was submitted.]

The CHAIRMAN. Mr. Mitchell, Chairman of our Oversight Investigations Committee?

Mr. MITCHELL. No.

The CHAIRMAN. Mr. Hall, Chairman of our Disability Committee?

OPENING STATEMENT OF HON. JOHN J. HALL CHAIRMAN, SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

Mr. HALL. I would just say that I am looking forward to working with you, Mr. Chairman, and Mr. Ranking Member and the Secretary and staff in providing a more seamless transition from active duty to veteran status, in retaining the facilities and not prematurely closing or discarding of Veterans Administration facilities before we know what the true demand will be in returning veterans coming back from the wars that we are currently fighting, and mainly in reducing what most people consider to be a scandalous backlog of claims and also a scandalous number of homeless veterans. So those are the priorities that would leap to the top of many for me, and look forward to working with you and thank you.

The CHAIRMAN. Thank you, Mr. Hall.

Mr. Hare?

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman. I look forward to serving with you on the Committee.

I actively sought this Committee out because after working for Congressman Evans for 23 and a half years, I saw firsthand what veterans go through in our district and whether they are homeless and having to do stand-downs or whether it is the backlog, as my colleague has mentioned on the disability claims, you know, we can do better.

And I think we have a responsibility to the veterans. I am concerned about the numbers of veterans that are coming back, whether or not we have the personnel and the facilities. And also, as you said, Mr. Secretary, in your statement, for those who have given the ultimate price to make sure that our veterans are honored with the services and the type of funeral befitting heroes.

So I look forward to serving on the Committee, and thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Hare.

Ms. Brown-Waite.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman. I have a statement that I will submit.

Once again, we are seeing the imposition of enrollment fees for category seven and eight. The Committee has rejected it soundly in the past and probably will again, and I am sorry to see that this keeps popping up.

I look forward to hearing from the Secretary, but I will submit the full statement. I think we are all here to hear the Secretary and discuss the budget.

The CHAIRMAN. Thank you.

Ms. BROWN-WAITE. But thank you for the opportunity.

[The prepared statement of Congresswoman Brown-Waite appears on p. 67.]

The CHAIRMAN. And all the opening statements will be printed as part of the record.

Mr. Rodriguez?

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman, for being here and thank you for allowing me just a few comments.

I know my concerns, I still have a district that is spread some 700 miles. We still have people that have to travel two, three hundred miles for services, and so I am going to continue to work on trying to get access to some of those individuals, as well as now the concerns that I personally have in terms of a lot of our national Guard and Reservists that are out there doing the Lord's work and representing us in Iraq.

Over 40 percent of our soldiers are out there and, yet, when they do retire will not have similar access to veteran services, and I think it is an area that we need to kind of revisit and check out.

And in addition, I am also extremely concerned in terms of the waiting list that we are seeing and also the vacancies throughout our hospital systems and those areas that have not filled those vacancies.

Thank you.

The CHAIRMAN. Thank you.

I skipped Mr. Salazar. I apologize.

OPENING STATEMENT OF HON. JOHN T. SALAZAR

Mr. SALAZAR. Thank you, Mr. Chairman. I will submit my full statement for the record.

Mr. Secretary, I have enjoyed working with you over the years, being from Colorado as well. Two things that really have concerned me.

I was out at Walter Reed Hospital on Monday and saw many of our soldiers returning from Iraq and Afghanistan. I spent time with a 25-year-old double amputee. I also met with a third soldier, a native from Colorado, out from Burlington, who was recently fitted with a prosthetic leg. And it is my understanding that this budget cuts funding for research of prosthetic limbs. I would certainly appreciate you looking into that and making sure that we can care for our returning troops.

So with that, Mr. Chairman, I yield back.

[The prepared statement of Congressman Salazar appears on p. 67.]

The CHAIRMAN. Thank you.

Mr. Lamborn?

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman. I do have a full statement that I will submit for the record.

But very briefly, I just want to say I am honored to be on this Committee and to be helping where I can with my other colleagues here for those who have served our country. And so I am just very excited and honored to be on this Committee.

[The prepared statement of Congressman Lamborn appears on p. 67.]

The CHAIRMAN. Thank you.

Mr. Donnelly?

OPENING STATEMENT OF HON. JOE DONNELLY

Mr. DONNELLY. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here.

During the time I was back home in the past few years, in our district, we had a complete meltdown in clinic service and wait times, and the pledge I gave to the folks back home was that I would come here to try and make sure that never happens again. And I actively sought out the opportunity to be on this Committee.

In addition, we have been in limbo in our State in regards to our VA Hospital in Fort Wayne for a long, long time. And my commitment is to try to make sure, Mr. Secretary, with your help, that we end that limbo and make sure Fort Wayne is buttoned down and will be in service to us for a long, long time in the VA system in the years ahead.

It is an honor to be on this Committee, and I want to make sure that those who are serving not only from my district but from all across the country that when they come back, they can get not only the physical care they need but the counseling that they may require as well.

Thank you very, very much, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Donnelly.

Mr. Bilirakis?

OPENING STATEMENT OF HON. GUS M. BILIRAKIS

Mr. BILIRAKIS. Yes. Thank you, Mr. Chairman. Thanks for scheduling this hearing.

And I want to welcome the Secretary. And it is a top priority of mine to take care of our true American heroes, and it is an honor to serve on the Committee. And I will submit my statement to the record. Thank you.

[The prepared statement of Congressman Bilirakis appears on p. 66.]

The CHAIRMAN. Thank you.

Fresh from his appearance on the "Colbert Report," Mr. Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you for reminding me, Mr. Chairman.

The CHAIRMAN. You may speak as a Republican if you want. You had to watch the show to know what it is.

Mr. SPACE. Rather than simply reiterate the remarks of my colleagues, let me state that I am just honored to be on this Committee and looking forward to the challenges that it represents.

The CHAIRMAN. Thank you.

Mr. Walz?

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Thank you, Mr. Chairman, and thank you, Mr. Secretary, and all the gentlemen joining us today.

I would like to give a special thank you to those of you who are from our VSOs who are sitting out here. For many years, I am a member of multiple organizations with you. I am a life member of some of those, and I spent a lot of years trying to make sure the people setting here heard what you had to say.

So I cannot tell you how much I appreciate you being here. The only thing better is if you were sitting right alongside me. I am not quite sitting high enough on this thing to make that decision, but we appreciate you being here.

Please know that this Committee is absolutely committed to solving these problems in a nonpartisan—it does not need to be bipartisan—these are nonpartisan issues of taking care of our veterans.

And I thank the Chairman profusely for giving me this opportunity to do exactly that.

[The prepared statement of Congressman Walz appears on p. 68.]

The CHAIRMAN. Mr. Secretary, again, welcome. We hope you will introduce your staff at the table and then the floor is yours.

STATEMENT OF HON. R. JAMES NICHOLSON, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL J. KUSSMAN, M.D., MS, MACP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION; HON. WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION; PAUL J. HUTTER, ACTING GENERAL COUNSEL; HON. ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT; AND HON. ROBERT T. HOWARD, ASSISTANT SECRETARY FOR INFORMATION TECHNOLOGY AND CHIEF INFORMATION OFFICER

Secretary NICHOLSON. Thank you, Mr. Chairman, and good morning all. I have a written statement that I would like to submit for the record of this hearing, Mr. Chairman.

The CHAIRMAN. So ordered.

Secretary NICHOLSON. And I would like to introduce my colleagues that are with me at the table. I will start at my left and your right with the Under Secretary of Veterans Affairs for the National Cemetery Administration, Mr. Bill Tuerk.

Next is the Under Secretary for Veterans Benefits Administration, Admiral Dan Cooper. You will have to grant him some indulgence. He spent most of his life below the sea in a submarine, but he is doing a great job. Next is the Acting Under Secretary for the

Health Administration, Dr. Mike Kussman. Mike has had a lot of experience including that of commanding Walter Reed Hospital. To my far right and your left is the Acting General Counsel of the VA, Mr. Paul Hutter.

Next is the Assistant Secretary of the VA for Information Technology, and he is the Chief Information Officer of the VA, Mr. Bob Howard, or I should probably say General Bob Howard.

And next to me is Assistant Secretary for Management of the VA. He is also the Chief Financial Officer of the VA, Mr. Bob Henke.

Mr. Chairman, if you would permit me to preface my remarks by saying that I look forward very much to working with you in the 110th Congress and particularly our Veterans Committee in a bipartisan, bicameral way as someone said, and I believe it strongly that taking care of veterans is not a partisan matter. It is a patriotic matter.

And I look forward very much in that vein to working together, for us benefiting from your scrutiny, your oversight, and your support.

I am here today to discuss President Bush's 2008 budget proposals for the Department of Veterans Affairs. The President is requesting, using your term and mine, Mr. Chairman, a landmark budget of nearly $87 billion to fund our nation's commitment to America's veterans.

This budget will allow us to expand the three core missions of the VA, those being to provide world-class healthcare, provide broad, fair, and timely benefits, and dignified burials in shrine-like settings for our nation's veterans.

This budget will allow us to continue our progress toward becoming a national leader in information technology and data security. I believe that with the right resources in the hands of the right people, anything and everything is possible when it comes to taking care of America's veterans.

At the VA, we have the right dedicated people. With the President's proposed budget, we have the right resources too. The $87 billion requested for the VA represents a 77 percent increase in veteran spending since this President took office on January 20th, 2001. Medical care spending is up 83 percent.

Mr. Chairman, I will outline the major portions of our proposed budget at this time. For the Veterans Health Administration, our total medical care request is $36.6 billion in budget authority for healthcare. VA healthcare is the best care anywhere. That sounds boastful. It is perhaps. Where I come from, they used to say it is not bragging if it is true.

We have asked your staff to distribute to you some materials for you to peruse about what others are saying about the VA and the quality, the supremacy of its healthcare, medical journals, national media, institutions such as the Harvard University, who twice in the last 12 months cited the VA as providing the best healthcare and leading this Nation in healthcare delivery, safety, and technology.

During 2008, we expect to treat about 5.8 million patients. This total is more than 134,000 or 2.4 percent above the 2007 estimate. Patients in priorities one to six, veterans with service-connected

conditions, lower incomes, special healthcare needs, and service in Iraq and Afghanistan will comprise 68 percent of the total patient population in 2008. They will account for 85 percent of our healthcare costs. I repeat, 68 percent of them will take 85 percent of our resources.

The number of patients in priorities one to six will grow by 3.3 percent from 2007 to 2008. In 2008, we expect to treat about 263,000 veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom. This is an increase of 54,000 or 26 percent above the number of veterans from these two campaigns that we anticipate will come to the VA for healthcare in this fiscal year. And it is 108,000 or 70 percent more than the number we treated in 2006.

Regarding access to care, with the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to healthcare. Ninety-six percent of primary care appointments and 95 percent of specialty care appointments will be scheduled within 30 days of the patient's desired time for an appointment.

We will minimize the number of new enrollees waiting for their first appointment to be scheduled. In the last 8 months, we reduced this number by 94 percent, and we will continue to place strong emphasis on this effort.

Regarding mental health services, the President's request includes nearly $3 billion to continue our effort to improve access to mental health services across the country. The VA is a respected leader in mental health and PTSD research and care. About 80 percent of the funds for mental health go to treat seriously mentally ill veterans, including those suffering from post-traumatic stress disorder.

On medical research, the 2008 budget includes $411 million to support the VA's unparalleled medical and prosthetic research program. This amount will fund nearly 2,100 different high-priority research projects to expand knowledge in areas most critical to veterans' particular healthcare needs.

Most notably, research in areas of mental illness, 49 million; aging, 42 million; health services delivery improvement, 36 million; cancer, 35 million; and heart disease, 31 million. Nearly 60 percent of our research budget is devoted to OIF–OEF healthcare issues.

Regarding polytrauma care, I have traveled to three of our four polytrauma centers, and there is no doubt that these centers of compassion are where miracles are performed every day.

In response to the need for such specialized medical services, the VA has expanded its four traumatic brain injury centers, which are in Minneapolis, Palo Alto, Richmond, and Tampa, expanded the system to have regional polytrauma centers, 17 additional of those accompanying the specialties of these traumatic brain injury centers, but in 17 more locations making them more accessible, more convenient to veterans who settle outside and around the country.

These expanded 21 polytrauma network sites and clinic support teams will provide state-of-the-art treatment and, as I said, will provide it closer to the injured veterans' homes.

On seamless transition, one of the most important features of the President's 2008 budget request is to ensure that servicemembers'

transition from active duty to veteran status or a demobilized National Guard or Reserve person to civilian life is as smooth and hassle-free, as seamless as possible.

And we will not rest until every seriously injured or ill service man or woman returning from combat in Iraq or Afghanistan receives the treatment that they need in a timely way and in a manner free of tension and hassle.

The Veterans Benefits Administration, let me focus on veterans' benefits and VA's primary focus within the administration of benefits remains unchanged. As I said, delivering timely and accurate benefits to veterans and their families and improving the delivery of compensation and pension benefits has become an increasingly challenging issue, as several of you have noted so far, during the last few years.

The volume of claims applications has grown substantially during just the last few years and is now the highest that it has been in a decade and a half. We received more than 806,000 claims in 2006. We expect this high volume of claims to continue as we are projecting to receive about 800,000 claims a year in both 2007 and 2008.

However, through a combination of management and productivity improvements and our 2008 request to add approximately 450 additional staff, we will improve our performance while maintaining the high quality that we have today.

We expect to improve the timeliness of processing claims to 145 days with this 2008 budget. We will make better use of new technologies and have more trained people to process and evaluate claims. With this budget, we project that we can reduce our claims processing time by 18 percent.

For the National Cemetery Administration, we expect to perform nearly 105,000 interments in 2008 or 8.4 percent higher than those done in 2006. This is primarily the result of the aging of the World War II and Korean War veteran population and the opening of new cemeteries. Parenthetically, especially for those of you who are new in the Committee, every day in our country now, about 1,800 veterans die. There are slightly more than 24 million veterans, and about 1,800 every day pass away. About 600,000 a year pass away. And on a net basis, the veteran population in our country decreases between 400 and 500,000 a year currently.

The President's 2008 budget request includes $167 million in operations and maintenance funding to activate six new cemeteries and to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment.

For capital programs relating to the National Cemetery Administration, this budget request includes overall 1.1 billion in new budget authority for capital programs. It includes $727 million for major construction projects, $233 million for minor, $85 million in grants for State extended-care facilities, and $32 million in grants to build State veterans' cemeteries.

The 2008 request for construction funding for healthcare programs is $750 million. These resources will be devoted to the continuation of the Capital Asset Realignment for Enhanced Services or CARES Program. Over the last 5 years, $3.7 billion in total

funding has been provided for CARES. Within our request for major construction, resources are there to continue six medical facility projects that are already underway. They are in Pittsburgh, Las Vegas, Denver, Orlando, Lee County, Florida, and Syracuse, New York.

Funds are also included for six new national cemeteries in Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; southeastern Pennsylvania; and Sarasota County, Florida.

For information technology, the VA's 2008 budget request is $1.8 billion, which includes the first phase of our reorganization of IT functions within the Department, and establishes a new IT management system in VA. This major transformation of IT will bring our program in line with the best practices in the IT industry. Greater centralization will play a significant role in ensuring that we fulfill my promise to make the VA the gold standard for data security within the Federal Government. To that end, our 2008 IT budget includes almost $70 million for enhanced cyber-security.

Mr. Chairman, I know the Committee shares with me the concern about the VA's ability to secure all our veterans' personal information. There have been security incidents that are simply unacceptable, and I have made it a priority to assure our veterans that we are addressing their concerns. It is not that these incidents will never occur. But when they do, the VA now has a process to properly respond to them.

We are encouraging all of our employees to report, including self-reporting, thefts or other losses of equipment whether in the workplace, at home, or on travel, so that we can strengthen our information security procedures through lessons learned, reviews, and personal accountability.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health records. I have made it a point for the past year to praise our electronic health records for their ability to survive hurricanes Katrina and Rita, for example, where we had over 50,000 veterans affected, and not one of them lost a health record. Compare that to the civilian record, where over a million people lost health records.

Electronic health records are a presidential priority, and VA's electronic health record system has been recognized nationally for increasing productivity, quality, and patient safety.

Within this overall initiative, we are requesting $131.9 million for ongoing development and implementation of the Healthy VetVISTA system. This is the program to modernize our existing electronic health records. It 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 organizations.

Additionally, Mr. Chairman, in closing, I want to take this opportunity to inform you and the Members of the Committee of my plan to create a new Special Advisory Committee to the Secretary. We have several of these Committees, some chartered by statute, some by regulation. This will be a very important Advisory Committee to me. It will be on the subject of OIF, OEF veterans and their families.

The panel of the Committee will include veterans, spouses, parents, combat veterans, and survivors. It will report directly to me and will focus on ensuring that all men and women with active military service in Iraq and Afghanistan are transitioned to the VA in that seamless manner that I spoke of earlier, seamless and informed. The Committee will pay particular attention to severely disabled veterans and their families.

Mr. Chairman, this concludes my remarks. I look forward to your questions. Thank you.

[The prepared statement of Secretary Nicholson appears on p. 70.]

The CHAIRMAN. Thank you, Mr. Secretary, and I think all of us have had experience with advisory committees. They can really work well, so we congratulate you on setting that up.

We will have a first round of questions, 5 minutes from each Member. That will include the Chair and the Ranking Member.

The audience cannot see it, but we have a green, yellow, and red light system in front of us. So when you see the yellow light, you have got one more minute. And we will have a first round, and if there is a need for a second, we will do that too.

Mr. Secretary, on the enrollment fees, last year you estimated that the proposal would cause almost 200,000 veterans to leave the VA. This year, you do not have an estimate as to the number of veterans who might leave the VA if the proposal is enacted and we start charging an enrollment fee in 2009.

In addition, differently than last year, you deem any revenue that would be collected from an enrollment fee to be mandatory instead of discretionary revenue and subtracted, therefore, from the VA mandatory amounts.

Do you have an estimate for how many veterans would leave the system if the enrollment fee was proposed? What is the policy that led you to change from the use of those fees from discretionary to mandatory?

And I guess the same question enters all of our minds. Every year that you have been there, you have submitted an enrollment fee proposal. Each year, we reject it. Do you think this year will be any different, and why is it still in there? Why does it keep popping up like this?

Secretary NICHOLSON. You are right, Mr. Chairman, we had had this discussion in the two previous times I have been up here on the budget. And I will tell you and the Members of the Committee that I support this system of a modest enrollment fee and co-payments.

I think there is an equity there with retired military, for example, who go on TRICARE, and pay an enrollment fee and they pay a co-pay. These are people that may have served 30 or 35 years in the active military. And to ask a person to whom the VA is providing full medical care, which are only people, by the way, who have no service-connected disabilities, and who are working and have jobs and have incomes, to pay these modest fees to participate in this great system, to me, makes sense. It makes sense because of the equity that I have described, and it allows the VA again to give better care, have a system that serves those that really need it better.

And as to your question about why we did not have it in our proposal, again, it only applies to categories seven and eight. And the thing that is different about this year—there are two, I think, substantial differences.

First, the approval of it is not assumed in this budget. So if you do not approve it, you the Congress, it will not work a deduction from this budget and the application of the funds in this budget. That is a change.

Second, we have a progressive schedule in here. There would be no enrollment fee for anyone—and, again, we are only talking about people that have no service-connected injuries—but there would be no enrollment fee for anyone making less than $50,000, and that is new. For those that are in the income of 50 to 75,000, it would be $250 a year and so forth.

Because we are not showing it as a policy initiative with efficiencies that would help fund this budget, it would take 18 months to implement and the funds would go to the Treasury in 2009 and subsequent years. And for a 10-year period, it would accrue to $1.1 billion.

The CHAIRMAN. Thank you. I agree it is better than last year's. If it does not go through the mandatory budget, somewhere in the budget it is affected. So it is not as if it is free money somewhere that the President has not counted on in his mandatory budget. But I think it is dead on arrival, and you can tell the President he is going to have to make it up somewhere else.

Mr. Buyer, you have 5 minutes.

Mr. BUYER. Mr. Secretary, that is the attitude that I said that is here in Congress. We erred, yet Congress never likes to live up to our error when it is our fault. We love to bash you. We love to bash other people, blame other people for our mistakes. But these management tools are necessary. And we did not put them in, and we should have.

And I erred when I created TRICARE for Life. I should have given some more of these cost containment management utilization tools to the Secretary of Defense and asked for these annual increases. That did not happen. Congress is unwilling to do that and especially at a time of war.

And so the political speeches that could be used against a Member are so easy. So they are frightened, Members are. And so they would rather then throw their arm around the veteran and say I am going to stand with you rather than effectively managing government programs that we created.

Now, I do compliment you because you adapted the recommendations that I did on the tiered process with regard to enrollment fees. And I agree with you, Mr. Secretary. I am the first to apologize because when I created the TRICARE for Life, I created those enrollment fees and co-pays, and now you have got that military retiree that you described, 30-year military retiree paying those things sitting next to someone who served one tour of duty who does not have to.

And then there are Members of Congress who would tell that person who had one tour of duty, oh, well, you are entitled to lifetime healthcare. And then there are veterans' groups out there that are advocating, well, that is the cost of national security. Social-

ism? I do not think so. We fight for freedom. And if these individuals can then gain access to government programs, they ought to be willing to pay for it.

I compliment you because you are having to manage a ghost population that is ebbing and flowing in and out of this system and it is very, very challenging. It is very, very difficult. Yet, we are not going to give you any management tools.

You know what I would suggest when you have got these fees? I wish Congress would adopt them. I would not do them for deficit reduction as recommended. You know what I would do with them since you have got them on the mandatory side of the House? I would apply it to DIC. I would take those dollars. I would eliminate the offset with the survivor benefit plan. I would take those and say I will stand with the widows and the orphans. I mean, there are some things that we can do with those dollars. But you had an idea. I have one. Everybody has a particular idea.

For an example of how difficult, Mr. Secretary, your challenge is, you came to us and we went into the budget modeling and we found out the errors and the stale data, and you said to this Committee I have a $975 million shortfall. Then the Senate, playing one-upmanship with the House, put in 1.5. Then a few months later, the carryover into the budget that you are to claim ownership over is $1.1 billion.

Now, nobody ever even said anything about it. They said, oh, my gosh, you said $975 million. They gave you $1.5 billion. Your carryover was $1.1 billion. It is the challenge of trying to manage that system.

And, Dr. Kussman, when you were on active duty, it was no different than managing TRICARE. When I chaired Personnel, guys would come over and you would testify on the military budgets and you would come up with shortfalls, and we would have to then come in in a military appropriations supplemental and plus it up because you are trying to manage the ghost population. And you are doing the very same thing in the ebbing and flowing of these people in and out of the systems.

And you are absolutely right, Mr. Secretary, these are not the disabled. They are individuals who by choice are gaining access to that system. And why? A lot of them wanted access to the low-cost medications.

So let me ask you this specific question. Mr. Secretary, I am sure you are aware in previous Congresses, in particular, the 102nd Congress back in the 1990, 1992 time frame, there were changes that were made to the Medicare, Medicaid programs to allow purchasing and gaining access to the Federal supply schedule. The Democratic controlled Congress immediately repealed it because it had an impact upon the price of drugs for veterans.

What would the financial impact be on the VA of House Resolution 4 that just passed this House here in January when we said, alright, we are going to let Medicare Prescription Drug Purchasing Bill? What is the impact of that bill on VA drug pricing?

Secretary NICHOLSON. Well, it is difficult for us to know that because we do not know whether we are going to be able to continue to access our pharmaceuticals in the same way and at the same

prices that we have been, which has been very efficient. And we certainly hope that we can continue to do that.

We have a very unique distribution of pharmaceuticals in the VA, and it is extremely efficient. And it is another area of innovation that the VA has created that a lot of people look at. We dispense most of our pharmaceuticals through the mail.

And I would invite any of you on the Committee, and I will say this generally, to visit any of these unique facilities we have, polytrauma centers and so forth.

But one other unique thing that we have is called CMOP, which is a consolidated mailing of pharmaceuticals. And if you want to think Home Depot for the minute and maybe a bigger version, mega store, you go in there and you see these little carts running around on ball-bearing driven things, all computer driven, we dispense in those things about 100,000 prescriptions a day. And they go out UPS, FedEx, or through the mail, including registered and controlled substances in certain instances.

So we have a very efficient system that allows us to serve so many patients. We dispensed over 200 million individual prescriptions last year. And I can only say I hope it does not affect us. I could not predict that.

Mr. BUYER. Mr. Chairman, I note that the light is on. You provided information that it would cost between six to seven hundred million would be the maximum financial impact annually to the VA. Was that accurate?

Secretary NICHOLSON. That this bill would?

Mr. BUYER. Yes.

Secretary NICHOLSON. I cannot verify that, Mr. Buyer.

Mr. BUYER. Please do that.

Secretary NICHOLSON. I will look and respond back.

[The information was provided in the response to question one from Mr. Buyer's post-hearing questions for the record, which appears on p. 133.]

Mr. BUYER. Thank you.

The CHAIRMAN. Thank you, Mr. Buyer. I see your new slogan. We can do it, you can help.

Mr. BUYER. We what?

The CHAIRMAN. We can help. You can do it, we can help. It is Home Depot's slogan.

[Laughter.]

The CHAIRMAN. Alright. Mr. Michaud, you are recognized for 5 minutes.

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

Thanks once again, Mr. Secretary. A couple of questions.

How much of the money that you are requesting in this budget dealing with minor construction will be allocated for the construction of the new CBOCs that are recommended under the CARES process, and how many of the 156 high-priority CBOCs recommended under CARES have been built and are fully operational?

Secretary NICHOLSON. At the end of fiscal 2006, we had 717 fully operational community-based outpatient clinics, CBOCs.

Mr. MICHAUD. What is the number again?

Secretary NICHOLSON. Seven hundred and seventeen.

Mr. MICHAUD. Thank you.

Secretary NICHOLSON. There was an addition of eight new CBOCs in fiscal 2006. We have approved 24 so far in fiscal year 2007. For 2008, we have not yet finalized the total.

Mr. MICHAUD. Okay. And how much of the money in the minor construction are for the—have you set a certain amount aside or is all that going for——

Secretary NICHOLSON. Congressman Michaud, the CBOCs are not in the minor construction budgets. They are in the operating budgets of the VISNs.

Mr. MICHAUD. Okay. Thank you.

My next question dealing with PTSD. We have heard statistics that over 25 percent of the men and women coming back from Iraq or Afghanistan have some form of mental health issue or PTSD. I was reading an article the other day where the Minister of Defense of England figures that only 2 percent of their folks have a lasting form of PTSD.

My question is, as it relates to PTSD, how does the VA, and how does the Department of Defense, determine or diagnose PTSD? Is there a difference in the diagnosis of PTSD?

Secretary NICHOLSON. No, there is no difference. And I would maybe ask Dr. Kussman to expand on this very important subject. Let me give you an overview.

Of those who have returned from OIF–OEF, which is over a million servicemembers, about 610,000 of them have returned to civilian life, either having been discharged or having come off active duty as a Reservist or Guardsman.

Of that number, we have seen about a third. We have seen a little over 200,000, and we have screened each of them for any mental health problems, just as we do for physical health.

And of that number, that 200,000, I think it is about 206,000 we have seen, for about 60,000 of them we have identified some mental health issue; that is because they have noted that they are having sleeplessness or some other symptom.

And of that number, about half of them we are treating for PTSD. It is actually a little over half. That is about 39,000. So, you know, each of them, individually it is an important case. But as a percentage, you can see that, of the 200,000, it is a little less than 20 percent.

I would ask, Dr. Kussman, do you have anything to add?

Dr. KUSSMAN. Thank you, sir.

The diagnosis and evaluation of PTSD is the same for DoD and the VHA. We have a joint clinical practice guideline that we do together. So I think it is pretty standard how you evaluate people.

Furthermore, besides all the outreach that we have in reference to mental health and PTSD in particular, when anybody comes to us of the 205,000 that the Secretary mentioned, there is a drop-down menu, as he said, to ask people whether you have the symptoms.

The CHAIRMAN. Dr. Kussman, is your microphone on?

Dr. KUSSMAN. I thought it was on. I was too far away.

So I think that we have a very aggressive outreach both with our own system and in partnering with DoD for the post-deployment health risk assessment programs that are aggressively done, particularly with National Guard and Reserve 90 to 180 days after

they come back, to ask them if they have any issues related to the things consistent with mental health and PTSD.

The CHAIRMAN. Thank you.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you very much.

Mr. Secretary, thank you for joining us this morning.

I recently had what I call a veterans' forum in one of my communities, and we had both the healthcare side of the VA and the benefits side of the VA. And it was evident that the healthcare side continues to receive more and more compliments all the time.

In the time that I have been in Congress, it is clear to me that the VA has improved its delivery of healthcare, and veterans are appreciative, not that it is not without challenges and problems and individual circumstances. But on the benefit side, constant criticism of the time frame, the wait, the backlog.

And I have a couple of questions, a specific question about, does this budget—how successfully will we be if we adopt the administration's budget in eliminating the backlog of cases on the benefit side?

And also a second question. I would like to see an Administration budget that tells us how we eliminate the category seven and eight discrimination. I would like to see the categories eliminated. I believe you have the authority every year to make that determination. And my assumption is that, based upon priorities and resources, you make the determination that the category seven and eight will remain in place.

What would it take for us to work with the Department of Veterans Affairs to eliminate that distinction?

And, finally, I want to tell you that I am working very closely with the VISN Director in Denver. The eastern part of your State and the western part of my State are inadequately cared for when it comes to clinics, and I am pleased to know that the VISN Director is in the process of adding a CBOC in our region.

As you know, the eastern part of Colorado, the western part of Kansas is sparsely populated and many veterans have a 4- or 5-hour drive to either Wichita or to Denver in order to access even routine care. So I am thankful for the process as I see it occurring, and I am hopeful that you will encourage that a CBOC be located in western Kansas.

And, finally, we are working on a veterans' cemetery, and this may be a question for Under Secretary Tuerk, near Fort Riley, a State veterans' cemetery. And I am interested in knowing whether the Administration's budget provides for money for construction in fiscal year 2008.

Thank you, Mr. Secretary.

Secretary NICHOLSON. Thank you, Mr. Moran. Let me address these issues in the order you did.

I appreciate the kind remark about veterans' healthcare. Veterans' benefits is a very important part of what we do. It is a very important part of the predicate for the VA in the first place, which is to make whole a person who raises their hand, takes the oath, and goes off and is in some way diminished as a result of that service, either physically or mentally.

And so while we take care of them on a contemporary basis in our healthcare, many of them need to be supported. So it is a very important activity, and we take it that way. And I wanted to compliment Chairman Filner and thank him because we are going to have a roundtable just on the subject of veterans' benefits because it is a very complicated, massive undertaking. And I think it would benefit those that could make it to really learn about the internal workings of the veterans benefits system.

I do not want to sound overly defensive in my response because I do not mean it that way. One of the reasons for the current condition is that our outreach, which has been very robust, is really working because veterans are responding, and the outreach is unprecedented.

For example, those people that are on active duty in the military today benefit from the presence of over 140 outreach VA counselors imbedded in these active military installations to get them tutored, if you will, on what they are entitled to before they come off active duty.

Well, we are doing a good job in marketing ourselves because they are coming in in very big numbers. As I said, last year, 806,000 individuals presented themselves for benefits.

But the other thing that is happening is that some of them are like me, they are getting longer in the tooth, and when you do that, you know, it is not just the arthritis in your knee, but it is the rotator in your shoulder and maybe it is something in your plumbing.

And so the average of these now is about six different issues which means that they have to go to six different clinics for evaluations. And our system under the law is that we have to make some causal connection to that malady to their service, unless they are a Vietnam veteran where there are certain presumptions now due to their service in Vietnam, things like diabetes and leukemia. They do not have to make that verification if they served in Vietnam.

And if we want to maintain the integrity of this system, you have to do it that way and you have to plumb for those records. And so that is kind of an overlay, and I hope this workshop, we can really get into it, maybe even walk you through a case and take a look at some of these files, some of which are two or three feet high for a 30-year member of the service.

In this budget, we have a plan to bring this number down by 18 percent. And I will say that when this Administration took over, the waiting time was well over 200 days. It is now at 171 days, which is too long. It is longer than I want it to be and certainly longer than the veterans want it to be.

If we get this funding, we will be able to pull it down to 145 days. We are also going to employ additional technology to perfect this VETSNET System, which is really starting to kick in and help. That is the overlay on that.

The question about category sevens and eights is an important one. Historically there was open enrollment until January of 2003 when eights were no longer enrollable. Eight is a person with no service-connection disability and have an income above a certain threshold. Priority seven veterans have lower incomes than priority eights.

It is a matter of resources. We have a war going on. We have people coming back with a very high priority. We have a record number of veterans coming to us for care. If you want to accept the proposition that there are not unlimited resources for this, then it is a matter of priority and that that priority judgment is right now that they are not enrollable. Most of them, by the way, have health insurance.

Mr. MORAN. Mr. Secretary, what amount of money would it take to eliminate the distinction on seven and eight?

Secretary NICHOLSON. My Chief Financial Officer just told me it would take $1.7 billion a year. But it is progressive and over 10 years, it would be an additional $33 billion.

Quickly on your mention of rural health, that is another legitimate challenge that we have in trying to be available to all veterans wherever they decide to live in our country. And many of them decide to live in rural areas. As we just said, we have 717 clinics now, and 39 more in the pipeline. We are trying to get ourselves out there closer to where veterans are.

We also are doing a lot more in our rural healthcare initiative for telehealth and telemedicine. At the end of the last Congress, the omnibus veterans bill mandated to us to put together an enhanced rural healthcare initiative, which we have now put a planning committee together to do that.

The CHAIRMAN. Thank you, Mr. Moran. You brought up issues that I think we are going to take up as a Committee just focusing in on both those questions.

Mr. MORAN. I thank the Secretary and I look forward to attending your forum on benefits.

The CHAIRMAN. Thank you.

Ms. Herseth.

Ms. HERSETH. Thank you, Mr. Chairman. I would defer to any Member who was here prior to me.

The CHAIRMAN. Okay. Mr. Hall, please. You have 5 minutes.

Mr. HALL. Thank you, Mr. Chairman, and thank you, Mr. Secretary.

The VA announced yesterday that it will be opening a new veterans center in Middletown, New York, right on the edge of my district, but in a location that will serve many veterans who live in my district, and I am grateful for that.

I want to thank you on their behalf and mine and thank the Department and say that I look forward to working with you to make sure that it is fully staffed. I cannot say enough good things about these regional vet centers.

And the first question for you is, is the VA allocating enough resources to ensure that these vet centers are fully staffed and functioning?

Secretary NICHOLSON. I suppose, sir, that would be a value judgment that someone could decide. We think we are, and they are growing. Currently there are 207 Vet Centers and through this budget, there would be 232 of them.

And additionally, in these Vet Centers, we are imbedding a mental health specialist and we are trying to staff them with Global War on Terror veterans to the extent that we can, as long as they meet the qualifications.

Mr. HALL. Thank you for that information. I guess time will tell, you know, as we see how well it is working.

My second question is that I have heard feedback from veterans in my district and also from the management and staff at the Montrose and Castle Point VA facilities that they would be interested in a paperless outreach program so that veterans who are newly returning and maybe are shying away from getting involved in the system for various reasons can be spoken to by a staffer who visits them without having to fill out paperwork and at least have an offer of, you know, or a description of the services and benefits available to entice them to take that step of signing up.

Have you considered such a thing?

Secretary NICHOLSON. A paperless enrollment?

Mr. HALL. Paperless outreach.

Secretary NICHOLSON. Paperless outreach. Well, we do some of that. I mean, some of it is using technology such as e-mails and the Internet. I would have to consider it and, I guess, fully understand what you are envisioning there.

Mr. HALL. Maybe at the round table, we can get into that. It may come up from other people, but I first heard that from vets and VA staff in my district.

And as the Chair of the Subcommittee, which I am honored to be chairing, on Disability Assistance and Memorial Affairs, I wanted to ask you about the backlog. How many of those 600,000 or whatever the actual number is, approximate number of backlog claims are due to—how much of the problem is due to a technology fix that is needed and how much of it is due to a personnel shortage to process the claims or is there a third factor that I am missing?

Secretary NICHOLSON. The question is that waiting time to adjudicate a claim, how much is personnel and how much is technology? It is probably a little bit of both of those. And, again, I do not know how much time you want to spend on this.

But this system, as soon as it is kicked off, when a veteran files a claim, then we start doing what they call developing the claim. And they have to write, call, fax the veteran for certain pieces of information to verify the incident that is the subject of the claim. They have 60 days to respond. By law, they have 60 days to respond to each request.

And the truth is that they have more than that because we are lenient on that. If they did not make the 60 days, that is not an absolute. But it can stretch the time period out.

The technology piece that we are implementing with VETSNET is going to help more on the back end after we finally get the claim developed and adjudicated, to get it processed and get the pay starting to flow because then that is not a judgmental issue anymore. We are going to pick up several days with that. That is overdue, that technology, because this is the 21st century, and it is high time we do that. But that is going to happen in this budget.

Mr. HALL. Thank you, Mr. Secretary and Mr. Chairman.

The CHAIRMAN. Thank you. We will resume with Mr. Baker after a 5-minute recess. We will return at eleven o'clock exactly.

[Recess.]

The CHAIRMAN. The Committee will resume. Thank you, Mr. Secretary, for spending this time with us. Mr. Baker from Louisiana is next for 5 minutes.

Mr. BAKER. Thank you, Mr. Chairman. I shall work very diligently to get my comments in within the 5-minute allocation.

Mr. Secretary, I need to provide a short narrative for the record and for Members of the Committee to understand the particular frustration which I share, but wish to make clear at the outset my frustration is neither with you, the Administration, nor the agency which you are charged to operate.

For the Members, I need to go through just a quick explanation of how I got to where I am so it will make sense as to the questions I finally offer.

Pre Katrina, the New Orleans veterans hospital served about 500,000 visits annually of veterans in the region. Post Katrina, we have no hospital. We have been working since that point a conclusion as to how to best address this healthcare need.

Six months after the storm's land arrival, there was an MOU signed by the VA and State officials on February 23rd to evaluate the best and most advisable method of healthcare delivery. Only 2 months later, on April 30th, there was issued a collaborative opportunity study group report which set out a way in which the LSU healthcare facility and the veterans' healthcare needs could be jointly met.

On page 30 of that report, Mr. Chairman, there was a time line established to set clear landmarks for the steps necessary. The LSU planning and programming was to have concluded by early 2007, VA planning and programming to have concluded by early 2007, with LSU land acquisition to have begun 2006, to be completed by 2007, with the ultimate completion of the facility, and opening by 2012.

This plan was ultimately delivered to the Louisiana Recovery Authority, the entity created for resolution of post Katrina recovery. I would note as just some basic observations about very simple elements of the plan as outlined at that time, there were some concerns.

First, the first 15 feet of elevation of the new structure would not be for patient occupancy. There would be a defend in place strategy adopted where people could stay within the facility for up to 8 days without external assistance. There would be consideration of an elevation of the perimeter of the site of post Katrina flood levels. I call that a levy in our terms.

So what it means is that if we had a recurrence of the same circumstance, we would have an isolated facility capable of standing for 8 days surrounded by water that you could not get through by highway access.

Whether or not an isolated island is appropriate for veterans' healthcare, I do not know. Those are certainly things that need to be considered. But when the Recovery Authority considered adoption of the plan requiring $300 million of State funding, they denied all elements of the plan save for three.

The legislature reacted to that by, since they are not in session, by consideration of an interim emergency ballot, a mail ballot to force the LRA to spend $300 million on the completion of this plan.

The trouble with that is the $300 million will actually come from the Department of HUD or CDBG money which the Secretary of HUD must approve, so we will have the State using Federal dollars to match Federal dollars.

The further difficulty with the matter is to date, I am not aware of a plan that has been publicly submitted by any of the State officials for public discussion or consideration, and I do not know if there has been a demographic survey of patient distribution and where our veterans are, why there is necessity to insist on construction of a facility in urban New Orleans given the apparent concerns for patient safety, and whether or not there is a way to calculate the overall cost of the project without an operating plan in hand.

Therefore, how could we possibly come up with a dollar cost figure for the State to match either on the Federal or State end without having such a business plan in the public domain?

At the end of the day, I am only concerned about one thing from this perspective on this Committee, and that is getting healthcare restored for veterans in Louisiana at the earliest possible date. Given the time line in the well-conceived plan that I hope would be executed as it is outlined, it will be 2012 before we would open doors on a facility.

Now, given the State's inability, and this is my conclusion, given the State's clear inability to provide the agency with a business plan outlining what it is we choose to do and how the shared responsibilities will be designated, Mr. Secretary, the MOU provides only one methodology for cancelation of the contract, and that is by either party to unilaterally withdraw by written notice to the other. There is no other term for elimination of the MOU.

Will you at some point take it as an important public policy matter to establish a clear-cut date by which the State of Louisiana must provide you with a clear operating plan that outlines financial terms, business operations, and relationships between VA and the LSU healthcare providers or, in the alternative, how long do I tell veterans in Louisiana they have got to wait for Louisiana to get its act together?

Secretary NICHOLSON. Well, thank you for that question, Congressman. It has a lot of parts to it and it is important. We have been working that really since just after Katrina. We have a collaborative work group.

And I had a meeting in my office several weeks ago and told the people that were up from Louisiana, the decisionmakers from both LSU and the Recovery Authority that we at the VA essentially are ready to start a hospital. We have even selected the architectural and engineering firm.

And we have entered into that memorandum of understanding with LSU because we think it makes great sense.

Mr. BAKER. Mr. Secretary, if I may, because my time is limited, I want to commend you for your effort. As I said at the outset, this is not about your agency's failure. This is about Louisiana's failure to meet any reasonable time line.

As I understand it, this was supposed to have been done and submitted to you and to Secretary Levitt, because this has a lot of moving parts, Mr. Chairman—this is also a general healthcare

issue that must be considered with another agency—but to have submitted to you in 2006 a plan for consideration and adoption.

I am appreciative of the fact you are ready to move forward. The trouble is I do not know what we are ready to move forward with and where the State of Louisiana is going to get its money and by what time can I say either do it or do not. We are going to provide a healthcare facility in Louisiana one way or another. If they want to get their act together and be a participant, great.

I think you are absolutely on target. This is a great plan if it can be better refined. But if they do not get to you, when? March, June, December? Is there any signal we can send back to folks in Louisiana and say let us get this thing done?

Secretary NICHOLSON. There is a signal I think you can go back with, which is that our patience is wearing a little thin in that we want to get going.

Mr. BAKER. Mine is gone.

Secretary NICHOLSON. You know, it is not so easy. The sites do not grow on trees around there. The site that we are sort of focused on with LSU, the site is five feet under sea level and it is——

Mr. BAKER. Mr. Secretary, that is why in the authorization language adopted by this Committee 6, 8 months ago, I insisted on the inclusion of in or near New Orleans. That was of some controversy. People thought I was trying to move it to my back yard in Baton Rouge. I am not. I am trying to get a facility that will not flood, that veterans can get to when they need it.

Siting is not the big issue. The State has to come up with an operational agreement on who is going to do what and who is going to pay for what. They have not done that. That is unacceptable.

Secretary NICHOLSON. Well, you are right. And as I started to say, we told them we are ready to go. You show us that you have the site confirmed and that you have the money to do your part.

Mr. BAKER. And they are going to get that from HUD.

Secretary NICHOLSON. And when you have that, we are ready to be a partner and move out——

Mr. BAKER. Mr. Secretary, I do not——

Secretary NICHOLSON. —because it makes good sense to——

Mr. BAKER. I do not want to harangue endlessly, but I will formally write to you asking for a date by which you expect the State to give you an answer. We have to have closure. And if the State cannot perform to your expectations in a reasonable time line, it is the veterans who have the expectation of being served here.

And this is not Democrat, Republican. This is not anything but people who are still dealing with the aftermath of a storm which was devastating, and this is an essential component of our recovery and it is absolutely necessary that we get this project underway.

I again state for the record I appreciate your diligence, your work, your agency's direction and motivation. This is not about you or your agency nor the Administration. This is about getting something done that is inexcusable if we do not move ahead.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Baker. And this is not just a problem for you. I think this is a national problem. And I just want to inform the Committee at Mr. Baker's request, this Committee will go to New Orleans and the surrounding area, have a tour, and

have a hearing on this within a few months. And we can let Mr. Baker——

Mr. BAKER. And let me express my appreciation to you for that, Mr. Chairman.

The CHAIRMAN. So we will be looking at this because it is part of a national necessity that we do this.

Ms. BROWN OF FLORIDA. Mr. Chairman, would you yield to me——

The CHAIRMAN. I yield to Ms. Brown.

Ms. BROWN OF FLORIDA. —on that subject because I have already gone and taken a look at the facility and was involved in the negotiations with the House and the Senate to make sure that it was authorized, and now I understand that it is funded and it is moving forward.

A lot of times, New Orleans gets bogged down in a lot of things. I do not want the veterans in that area to be like the veterans in Orlando, waiting 25 years for a facility.

So I am pleased that it is moving forward, working with the ultimate kind of campus when you have the urban campus, a college, and the community working together. So I am pleased that it is moving forward.

And I have already gone down and taken a look at it. And the people in that area, they have waited too long for assistance. And the government has reacted too slowly, and I am very pleased that you are moving forward with this facility.

The CHAIRMAN. Thank you, Ms. Brown.

Mr. Mitchell, you are recognized for 5 minutes. Mr. Mitchell.

Mr. MITCHELL. Thank you, Mr. Chairman.

Mr. Secretary, I want to thank you and your staff for appearing before this Committee. I want you to know that I look forward to working with you. I believe that the best organizations are those that monitor their own performance and solve problems before they become too large and even more difficult to solve.

I am proud to be the new Chairman of the Oversight and Investigations Subcommittee, and I look forward to working with you to find and correct small problems before they grow into large and costly catastrophic ones.

As you know, since fiscal year 1999, the VA's Inspector General's Office has delivered a return on investment of over twenty-five to one for every dollar we have invested. This is accomplished in part through fines, penalties, restitution, savings, and cost avoidance.

The Inspector General's contract reviews have returned millions of dollars to the VA, yet the VA's Inspector General's Office is the smallest relative to its parent agency from among all the statutory Inspector Generals. If the number of employees in the IG's Office were to grow to meet the ratio of the next smallest IG to parent agency ratio, the number of employees in the Office of the VA's Inspector General would double.

In fiscal year 2007, the IG had a significant budget shortfall. And in the Administration's budget, the number of IG employees is cut even more. If the VA is to find and correct internal problems, find and implement best practices, and the Inspector General has a history of providing the VA with a significant and positive return on investment, shouldn't the size, and this is the question, shouldn't

the size of the Inspector General's Office grow instead of shrink in this and future budgets? I think it should, and I am curious to find out why the Administration disagrees, and how can you explain the shortsightedness?

Secretary NICHOLSON. First, let me say that I agree with your statement of the importance and cost effectiveness of the IG. In fact, since I have been in this job in 2 years, I really have come to respect the brilliance of the people that put this IG system into place in the government.

I really welcome them and their services because this is a vast organization spread all over the world, including the Philippines and Guam, and it gives me some comfort that people are helping me watch these activities.

And my impression based on discussions with our IG, who I consider a vital part of my management team, is that he is adequately staffed. They work very hard over there. And he would probably welcome your overture to expand, but he is a pretty forthcoming guy. And my impression is that he has got what he needs to do the job.

Now, we did get an increase in this 2008 request right at the end so that he can hire some additional people.

Mr. MITCHELL. Mr. Secretary, you are saying then that the IG is satisfied with the number of people he has and he thinks he can do an adequate job with the people he has?

Secretary NICHOLSON. Yes, sir.

Mr. MITCHELL. Thank you.

The CHAIRMAN. I think you have a topic for one of your Subcommittee meetings.

Mr. MITCHELL. Yes, we do. Thank you.

The CHAIRMAN. Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you for coming today. And I have a broad question and a narrow question.

First, my narrow question is, part of the length of time, and we are all concerned about how long it is taking for claims to be processed, is a mandatory 60-day waiting period on the part of the VA while the claimant is gathering material and information to substantiate his claim. And that is for the benefit of the claimant, the veteran, but has the consequence of prolonging this what, 170-day average period right now.

So if we were as a Committee to take action to reduce that 60 days to 50 or 40 days or something like that, and I know it is only procedural, it would have the effect of speeding up the whole process, but would require the veteran making a claim to speed up his or her activity. What would you feel about a proposal like that?

Secretary NICHOLSON. It would speed it up, but it could work a hardship on some veterans because some of them use that time, either because they really need it to try to find a colleague that was in a unit to verify that they took a parachute jump that day and, you know, he did get hurt or he did land in a tree or he did serve here or there, which is the purpose of that. But if you narrowed that time period, it would speed it up. There is no question about it.

Mr. LAMBORN. Well, I know it is a waivable period right now, but maybe we should consider shortening that with extensions easily available.

And then my second broader question is for you or the Under Secretary, Admiral Cooper. What does the budget propose for new technology or personnel to process claims and is that doing enough or at least can you tell us what you are proposing in the budget?

Secretary NICHOLSON. I will comment and then ask Admiral Cooper if he would elaborate.

We really need to be making better use of technology and we are now finally getting there. And Dan will comment on the VETSNET part of that. We could really highlight this in a workshop if we can have it and demonstrate to you that every veteran comes to us from the Department of Defense with a paper file.

Now, this is parenthetical to your question, but we are now finally really starting to collaborate with DoD to get a common interconnected electronic medical record. We had a very good meeting and, in fact, announced this at a joint press conference the week before last.

I had lunch this week with Deputy Secretary England of DoD with his key staff. This is finally starting to happen. But that is very prospective, and that will really help this down the road because those new veterans will come to us with electronic files. We do not have this paper chase that goes on. But we cannot do anything about it with the millions that are currently there. We have to deal with that.

But I am going to ask Admiral Cooper if he would elaborate on the technology.

Admiral COOPER. Yes, sir. Let me mention a couple of things. One, there is an increase in our budget this year for our primary resource, which is people. And we will have an increase with this budget of about 450 people.

On top of that, the primary technology that we work with is a system called VETSNET. This system has had a rather tortuous past, but we have made a lot of progress in the last couple years.

We have three of five components and we are fully utilizing those at every regional office today. Those are the components that help us to take in the claim and adjudicate the claim.

The components we are working on now are those to help us pay the claim, pay it faster, pay it more effectively, and ensure the retroactive pay we send to a veteran is computed properly. It will also fight fraud.

So it is the VETSNET System that we are working on wholeheartedly that will help us as far as technology goes.

The CHAIRMAN. Thank you.

Ms. Herseth, you are recognized for 5 minutes.

Ms. HERSETH. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you for your testimony.

As you may know, I am the Chair of the Economic Opportunities Subcommittee, continuing to work with my friend, Mr. Boozman from Arkansas, as we focus on the myriad of issues under our jurisdiction I want to pose a question specifically with regard to the VA Education Service in a moment.

But some of the questions raised have already dealt with access to healthcare for rural veterans. And in South Dakota, we have some CBOCs and others that have been proposed, and I just need to clarify with you a couple of things.

First, you had mentioned in response to Mr. Michaud's question about the minor construction projects that the CBOCs, actually, come out of the operating budget of the VISNs, but my understanding is that the VISNs submit business proposals for these clinics to the CARES Program, that the actual construction of the clinics comes under the minor construction projects and then the operation of the clinics does come out of the operating budget.

So could you just clarify how that has worked in the past and then I do want to ask a parochial question about where you are with the fiscal year 2008 list that has yet to be finalized.

Secretary NICHOLSON. I am pondering whether there are any exceptions because I know we are building almost a 100,000 square foot clinic in Columbus, Ohio, a non-inpatient clinic. So I reserve that question.

But generally, the CBOCs do not fall into the minor construction budgets. They are funded out of the operating budgets of the VISNs and they are consequent to the CARES analysis that has gone on using a lot of demographic information. And the plans should be compliant with that master plan.

As I said, we have 717. We did eight in 2006 and for 2007, we have approved 24 so far. And in 2008, can somebody help me? I do not think we know that, what that number is going to be. We are working on those business plans.

Ms. HERSETH. I appreciate that, but as you determine that number, I assume you are analyzing what number you are going to finalize and propose for fiscal year 2008 based on the budget. And so which budget line item would you direct me to evaluate as it relates to how many new CBOCs would be approved and operational in fiscal year 2008?

Secretary NICHOLSON. Well, for you, probably the best path would be to go take a look at the VERA allocation that would be for your VISN and what the CARES study has said about the needs of that VISN.

I was just handed a note saying that our planning predicate in that number for 2008 is 29 new CBOCs.

Ms. HERSETH. Twenty-nine additional?

Secretary NICHOLSON. Yes.

Ms. HERSETH. Okay. We will follow up on others, but let me just ask a question particular to the jurisdiction of the Economic Opportunities Subcommittee.

For fiscal year 2006, as well as fiscal year 2007, the VA's Education Service was allocated $19 million from the readjustment benefits account to enter into contracts with State Approving Agencies for purposes of approving courses for education under the Montgomery GI Bill and other related activities.

Now, under Section 301 of Public Law 103–330, at the end of fiscal year 2007, the SAA funding would decrease to $13 million. Is the VA planning to, or are you requesting within what has been submitted already, resources to maintain funding levels at the 2007 level?

Secretary NICHOLSON. I am going to ask Admiral Cooper to answer that, if you would.

Admiral COOPER. No, ma'am. We have not requested that. That money, as you know, goes to the States who then hire the SAAs. It is my understanding that about 5 years ago it was increased to 19 million, and it was stated that at this time, it would be reduced to 13 million.

We are meeting next week or the following week with the SAA group as they come in to determine just what we will have to do with that.

Ms. HERSETH. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bilirakis.

Thank you, Ms. Herseth.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

I have a specific question with regard to my district. The James Hailey VA Medical Center in Tampa, Florida, is one of the busiest, if not the busiest, medical centers in the country. Parking is a critical issue at the facility. Veterans complain about having to drive for long periods of time to find a parking space.

As part of the fiscal year 2007 budget submission, the Department included a project to, "improve patient parking at the Tampa VA Center, as a potential site for future construction."

What is the status of this proposed project and—well, if you can answer that question first, please.

Secretary NICHOLSON. You are right, Congressman. We have had a real parking problem down there and we have taken steps to improve it. We have gotten and have applied about two and a half million dollars to that problem and acquired, I want to say—I remember looking at this yesterday—I think it is 2.6 acres of land that we have been able to acquire for additional parking on. And that is well underway, which will go a long way to alleviate the parking problem that does exist there.

Mr. BILIRAKIS. Okay. I appreciate it. One additional question.

An issue that I am particularly interested in is helping our servicemembers—I think John talked about this—returning from Operation Iraqi Freedom and Operation Enduring Freedom transition back into civilian life.

Your testimony highlights the VA's Coming Home to Work Initiative. How many veterans have taken advantage of this program?

Secretary NICHOLSON. I will have to see if someone can help me with that number. One hundred and eighty-eight, I'm told.

Mr. BILIRAKIS. One hundred and eighty-eight. What can we do to enhance or improve the program?

Secretary NICHOLSON. That is a good question and is one that concerns me when I first came into this job and looked at those unemployment numbers of that age cohort of 20 to 25, which was then about three times the national rate for people that age. It has gone down now. It is about one and a half times more than the national rate. So it is still too high.

I have made a lot of presentations to trade groups, National Governors Association trying to get people to reach out to hire veterans. The lead on this in the government is really at the Department of Labor, and so we are now collaborating with them.

It is a combined effort that is needed to get the employees of this country to realize what outstanding prospects for employment these veterans are, and certainly to include the injured veterans or the seriously injured veterans. We are doing that. We are trying to model that ourselves, and we have twenty-some people working in our headquarters now, some still as interns from Walter Reed and Bethesda.

We have one boy that I would like to talk about so much because he came back in a coma, was in a coma for weeks. He had a spinal cord injury. They did not think he would ever walk. The system really performed miracles on him. He now works for us full time and came into my office recently with a smile on his face telling me he was going to run a 5K race.

But his real satisfaction in the restoration—he is still handicapped some—but is the fact that he is working. He has a job. He has value. And that is the best thing we could do for these veterans.

And so we are trying to leave no stone unturned. The lead with Federal resources for that is really DoL.

Mr. BILIRAKIS. Thank you, Mr. Secretary.

The CHAIRMAN. If I had not assumed this position, I would be tempted to say something like it seems like the coma is a good background for some people.

Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you.

Mr. Secretary, first of all, I always like to start out with the words of the first President of the United States, George Washington. The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country.

And with that, I want to thank you. The veterans in central Florida have been waiting 20 years in Orlando for a hospital and it is going to be announced soon, and that thank you for the cemetery in Jacksonville. And last, I understand yesterday a new vet center will be built in Gainesville.

But coming to the overall issues that I am concerned with, every year, you all come forward and put up increasing co-payments and enrollment fees that the Congress rejects. And in your own estimate, it discourages veterans from enrolling, at least 200,000. And you still are not allowing new priority eight veterans into the system.

And I was just doing a quick analysis. To fund that entire program, how much did you say it was, sir, $1.7 billion? Is that what you said?

Secretary NICHOLSON. One point seven billion dollars for 2008 and $33 billion over the next 10 years.

Ms. BROWN OF FLORIDA. Well, you know, I was just looking at the news and most people up here cannot visualize a billion. But it's my understanding, about $12 billion in Iraq that is unaccounted for. $12 billion.

So we could entirely fund the veterans if we could just identify $1.7 billion, and that is one point—how many millions of veterans that we could fund, over a million veterans that we could fund if

we could identify those funds. So I think it is important that Members on both sides figure out where that money is.

But another area. You all issued cuts to research that will come up with innovative ways to help people who have lost limbs because of this recent war. I do not understand that. Why would we be cutting research in that area?

And lastly, we have had round-table discussions, lengthy discussions on security. And recently in Alabama, a portable computer hard drive containing personal information on veterans was reported missing from a VA facility in Birmingham, Alabama. I mean, I do not understand how that could happen after all of our discussions.

So, thank you for your investment in Florida. Please address those issues that I pointed out.

Secretary NICHOLSON. Yes, ma'am. Prosthetics, our prosthetics budget is up in this budget by 9 percent, up $1.3 billion in prosthetics.

Ms. BROWN OF FLORIDA. Yes. I was asking about research because that is coming up with the newest technology to assist them. Is there a cut in the research? I guess that is what I am asking.

Secretary NICHOLSON. The research budget, the overall VA portion of it is about level because we get grants both from Federal and non-Federal sources each year. So our overall research budget will be up in 2008 if it is approved. And the total amount would be about almost $1.4 billion, and that includes just under 2,100 different research projects which includes prosthetic research. And it is at 114 different locations around the United States.

Ms. BROWN OF FLORIDA. And the question about the computer?

Secretary NICHOLSON. I am sorry?

Ms. BROWN OF FLORIDA. The computer, the computer that is missing from Birmingham, Alabama.

Secretary NICHOLSON. Yes, ma'am. That is a data breach. It does not make you happy and it does not make me happy.

Ms. BROWN OF FLORIDA. Did we fire anybody?

Secretary NICHOLSON. Pardon?

Ms. BROWN OF FLORIDA. Did we dismiss anyone, terminate?

Secretary NICHOLSON. Well, no, we have not yet because it is still under a very active investigation by our Inspector General. And we do not have all of the facts in yet on it. We do not know yet the magnitude of it and we do not know yet what has happened in our chain of command. But those are under active investigation and, believe me, it has my attention and focus.

And I will say about that, we have made a lot of progress. We are transforming that system. We have moved thousands of people that were decentralized into this IT sector, and they now work under an identified commander, if you will, and Assistant Secretary Howard.

But I was asked this question a few weeks ago up here. At a press conference, somebody said can you guarantee me that there will be no more data breaches at the VA, and I said I cannot. And I cannot at this time.

If I thought, you know, I had such a good team that we were going to win the pennant, but I could not guarantee we would not make any errors during the season, I cannot sit here today and tell

you we are even ready to win the pennant, let alone make any errors.

But we have made tremendous progress. But we have a lot more to go because the system, this was a research—one of these 114 research sites. People need to get disciplined in the way they handle this data. In this case, this person alleges that his hard drive was lost. We do not know if it was lost. We do not know yet what was on it.

Ms. BROWN OF FLORIDA. Mr. Secretary, how can we help you? Because when this happened, it compromises the veterans, their families, the entire system. I mean, because they could take that and they could—identity theft is so rampant. What can we do?

Secretary NICHOLSON. I appreciate that question, maybe more than you realize.

Ms. BROWN OF FLORIDA. I am sincere about this question.

Secretary NICHOLSON. First and foremost, it is the violation of the privacy of the people that are involved, but it also sort of damps out all the other great work that we are doing here in this really great agency. And it gets a lot of attention and it pains me.

I think you can help, A, by understanding it and as B, we may need some help in dealing with personnel, as far as ability to discipline them, because that is what it is going to take in the end is to have some examples, to have people realize that this is serious business, that we are serious, that they need to deal with encrypted information, they need to open that password protected device every time they go back on it instead of leaving it open. They need to deal with other people's information as they would deal with their own privacy. And we are not there yet, but we have made a lot of progress.

Ms. BROWN OF FLORIDA. Thank you, Mr. Secretary.

The CHAIRMAN. Thank you.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, and thank you, Mr. Secretary for being here today and bringing your team along.

My question is centered around the Charleston model that we have been working on for a goodly number of years. We are grateful for you and Dr. Perlin and others from the VA that have been down to try to work out some kind of a solution that will be able to unite some services between the VA and the Medical University of South Carolina.

We are grateful for Mr. Michaud for coming down, who is now the Chairman of the Health Committee, and certainly the Chairman at that time, Mr. Buyer, for his interest and for all the consolidation and concerted efforts that have been put forth up to this time.

I know last year as we passed the Construction Bill through the House and then finally to the Senate, there was a lot of debate about where we would go with it and finally, at the last moment, with the help of a lot of people—I am glad Ms. Brown was in the room as we debated with the Senate—finally come up with a resolve. And I think at that time, they included some $36 million for the Charleston plan.

And I am just wondering, in this budget, with moving forward the plan that you have for construction for the VA, where does the Charleston model fit into that?

Secretary NICHOLSON. Thank you, Mr. Brown.

As you know, I think we have an agreement with the Medical University of South Carolina to create a new model, a prototype of sharing medical equipment to avoid the redundancies when we are essentially collocated. And we expect a final contract for that, for implementation to be signed by the end of this month.

Thirty-six point eight million dollars has been authorized for the continued planning and design of a collocated facility in Charleston, but it has not been appropriated. And we have not in this budget asked for an appropriation of that money. We support very much the collaboration. I think it makes a lot of sense avoiding redundancies, efficiencies and better care by having more acute care offerings in one location.

But, again, we have to take a look at the whole panoply of issues and we have a CARES process also that guides us in prioritizing where new hospitals should go. And our estimate for the cost of this project would be about $550 million and on our priority list right now it is not on there.

Mr. BROWN OF SOUTH CAROLINA. As we listened, you know, intently to Mr. Baker and his concern with New Orleans, and I did have the privilege to go there with you to look at the situation in New Orleans, Mr. Secretary, what we were hoping to do is be proactive in this location. We recognize that Charleston is in the same hurricane plain as New Orleans and we would be devastated with the current VA facilities if, in fact, we had a similar tide rise as we had in New Orleans.

What we were hoping to do, particularly with the construction process now at the Medical University, is somehow or another coordinate some of those construction savings by including the VA hospital under this same time line. It seemed like by being proactive, it would save the taxpayers money, not just from the Federal level, but also from the State level in order to be able to work in a coordinated method now rather than try to duplicate the VA hospital at some later date once the whole plan has been implemented through the Medical University.

I would hope, Mr. Secretary, that you would be more proactive in trying to implement some process now to try to get the process moving along.

Secretary NICHOLSON. Well, I think, Congressman Brown, that this opportunity steering group that we have underway would be a good first step. And if we do some shared facilities, shared acquisitions, expensive diagnostic equipment and so forth, it would help demonstrate the value of that kind of collaboration.

We also have a CMOP there in Charleston and we have that hospital which is generally in pretty good shape. Those that are new to the Committee may not know. We have 154 of these hospitals around the United States existing and the average age is 56 years old. The average age of the hospital in the civilian economy today is about 14 years. So we have some hospitals, some Members in the room know, that were built right after the Civil War. So it is a matter of prioritization. But we will continue to work it.

Mr. BROWN OF SOUTH CAROLINA. Okay. And I appreciate that. I know this hospital is probably in the high 40s itself. And I know with the planning, as it moves along, you know, will add another 10 to 12 years to that.

But I am saying there are some economics of scale that we can all benefit for the taxpayers if we can move that project forward now, and at least I would hope that we would commit some kind of design or engineering funding in this appropriation so we can at least, you know, do something besides just talk about it.

Secretary NICHOLSON. Well, if, as I said, it is authorized and if it is appropriated, we will go to work. That is our job.

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

Mr. Boozman, I appreciate you yielding your time for me to make those questions. Thank you so much.

The CHAIRMAN. Thank you, Mr. Brown.

Mr. Snyder.

Mr. SNYDER. That is "Boze" not "Booze," Mr. Brown, Boozman. If we start calling him "Boozeman" he loses like 11 percent of his vote.

[Laughter.]

Mr. BROWN OF SOUTH CAROLINA. Yeah. But this is South Carolina talk.

Mr. SNYDER. At least 11 percent.

Mr. Secretary, I appreciate the work that you do on behalf of veterans. You have been at this long enough now that when you come before us, you probably can predict what Members are going to ask certain questions. And I want to follow up on what Ms. Brown was asking about, which is the research budget. We have talked about this in past years.

The President's request is for a fiscal year 2008 level of $411 million out of the VA budget. In fiscal year 2004, that was $405 million. And so if you just look at the biomedical inflation rate alone, we are down. That means we are down by almost $60 million.

And so you can look at this two ways. One of them is that is $60 million, that is in real dollars, that is real money. And so I hope you are talking to your researchers about the level of their morale and what things, you know, could be being done and what you call the high-priority research projects if you had the real dollars.

Now, what you all will say is, well, you leverage other dollars, but there is two aspects to that. Number one is you expect help from other parts of the Federal budget. You expect help from NIH because you do not fund properly in your VA line item for research and have not for several years.

Number two is if you would fund that at a level at least commensurate with the biomedical inflation rate, you would be able to leverage more dollars. I will accept your argument that you leverage moneys.

And so I do not understand why we go through this each year, that we are not looking to at least keep up with the biomedical inflation rate.

By the way, you are not alone in this. The Defense budget came out at our hearing a couple days ago or yesterday with Secretary Gates that the President's budget and the Defense budget cuts basic research by 9 percent and applied research by 18 percent.

And Secretary Gates was very concerned when he heard that because he did not—I mean, I do not expect him to know. I do not expect you to know all these numbers. He did not know that that was what was being done. He was going to readdress that.

So, again, please address this issue. Why do you all not feel a responsibility to at least have the President's number, your number, keep pace with biomedical inflation, and it has not done that for several years now?

Secretary NICHOLSON. Congressman, we look a lot at the total number and we have been pretty adroit at getting grants and matching. And if the research budget for 2006 was $1.29 billion, this research budget is up $1.38 billion in 2 years. So the overall budget——

Mr. SNYDER. You mean your prediction of what you will be able to leverage from other parts of the Federal budget at a time when we are under great fiscal stress in this country, you are betting on the ability of pulling dollars from other parts of the budget?

Why not step forward and say you are right, fiscal year 2004, we have not kept pace with inflation, we are going to make our budget this year $469 million coming from the VA and we are going to leverage even more projects? I mean, how many more beyond the 2,100 high-priority projects could you be funding if you would do what I have suggested?

Secretary NICHOLSON. Well, I am going to point out to you, Congressman Snyder, that we also get money from the private sector. In fact, in——

Mr. SNYDER. I am aware of that.

Secretary NICHOLSON. It is over $200 million. So it will not all be dependent on other parts of the Federal——

Mr. SNYDER. I did not say it all would. But substantial portions of it, you are counting on other parts of the Federal budget.

Secretary NICHOLSON. I would also like to add that we analyzed the application of this and 60 percent of this research contemplated under this, and I think what is true of that is that what we are spending currently is applicable to OIF and OEF combatants.

Mr. SNYDER. I appreciate what you are saying and I appreciate your chasing after the dollars from both private and public funds. But it still does not make sense to me why your number for medical research and what I think is one of the great medical research institutions in the world, in the world——

Secretary NICHOLSON. Thank you.

Mr. SNYDER [continuing]. Does not even keep pace with the rate of biomedical inflation. It just does not make sense to me. On another topic, you mentioned the seamless transition with regard to medical records. Where are we at with regard to the single exit exam?

Secretary NICHOLSON. I have a good report for that. That is working extremely well and expanding and allowing us to be very timely in the decisions that are coming out of those BDD sites. We now have that enterprise going at over 140 locations; most of those being DoD sites pre-separation mode. We are very pleased with that.

Mr. SNYDER. Thank you, Mr. Secretary. Thank you for your work.

The CHAIRMAN. Thank you.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, and your staff for being here. I appreciate your hard work.

We had the opportunity to go to Iraq together and I really enjoyed that. And, you know, when you were there, you were there not as the former ambassador to the Vatican or, you know, as the Secretary of the VA, but I was really impressed that when you, you know, talked with the men and women that were over there, it was as an old Marine. So I really understand that you——

Secretary NICHOLSON. Excuse me. I am not a Marine. I am an Army Ranger.

Mr. BOOZMAN. Okay. I am sorry. I am sorry for insulting you.

[Laughter.]

Mr. BOOZMAN. My dad did 20——

Secretary NICHOLSON. No disrespect to the Marines.

Mr. BOOZMAN. Well, again, as a guy that understands. My dad did 20 years in the Air Force, so we look down on all of you.

[Laughter.]

Mr. BOOZMAN. But I appreciate the fact that you brought out that when you look at the record over the past 6 years, the VA spending has gone up dramatically. And in looking at the fiscal 2007 request when you were here and really got beat up pretty good about veterans' health and things, the reality is and the continued resolution, the numbers are the same, $25,512,000,000, on the total fiscal year 2007 request, $34,000,000,986. The House actually passed last year $35,024,000,000 and then we wound up in the continued resolution with $35 billion.

So I appreciate your leadership on that. We also had the opportunity of getting a vet center and we are very pleased with that. And that is much needed. And, you know, there was some comment and some concern, and I share the concern about the staffing, that we are able to do that.

But the reality is that staffing is not dependent on you. It is dependent on whether or not Congress gives you the funds to staff the center. Is that not right, if we are really——

Secretary NICHOLSON. Yes, sir. We would have to——

Mr. BOOZMAN. So, again, you know, we cannot have it both ways, you know.

I have got just a quick question for Admiral Cooper about the expert education system, the TEES Program. What level of funding is proposed? And I guess again, what are the milestones that you hope to accomplish with that? Is that something that you need to get back with me on or——

Admiral COOPER. I can get back to you with a full answer. The fact is that the TEES system is one that we are looking forward to, but it is in really an embryo stage. We are in the development part of it.

We have the different education programs and the goal is to be able to settle 90 percent of the claims without any hands-on. But we have a good ways to go, so let me get back to you with a more developed answer.

Mr. BOOZMAN. Very good. One other thing real quick, Admiral. The Independent Living Program. Right now, I guess my question is, if Congress removed the 2,500 limitation on the new entrance

into the program in the Independent Living, how many additional FTEs would you require? What would be the cost involved in doing that?

Admiral COOPER. The limitation is strictly on the number of people we can bring into the program per year. I do not think I would need more FTE in order to allow more people to come in, but it does present a problem over each year when more than 2,500 come in. So the limitation, I think, should be lifted, but I do not require, as I see it now, more FTE to execute that.

Mr. BOOZMAN. So that is something that you feel also that we ought to look at lifting the limitation?

Admiral COOPER. I think it is very important today to lift that, yes, sir.

Mr. BOOZMAN. Okay. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I apologize for responding to an e-mail, and I want to thank the Secretary for being here.

You know, as we look at the backlog of cases that are waiting a decision, I wonder how you can justify awarding five-figure bonuses to senior executives in VBA when there is such a rising backlog of cases.

Secretary NICHOLSON. Well, let me review the numbers a bit. I said that we had 806,000 new claimants in 2006, the highest number of claimants in 15 years. And that is an extraordinarily large amount of claims, especially once you know what is involved in dealing with each one of these. And they did almost 800,000 claims. They completed almost 800,000 claims. So they did pretty good yeoman work.

We are requesting another 500 people in anticipation of the continued growth in claims. We are going to make better use of the VETSNET technology and with that, we will drive that time down. But that is going to take constant command attention and a lot of work by trained people.

So I do not think it has been a shortcoming of theirs. It is not, I do not think, lack of diligence. It is just that it is a market phenomenon that people have really come in and we have worked outreach.

I was in San Antonio 2 weekends ago for the dedication of the new Center for the Intrepid and I did not know they were going to be here, but there was a very nice display of VA benefits with several VA employees there handing out materials to the thousands of servicemembers who will become veterans, acquainting them with what they are entitled to. They are the same people that work in our regional office in Houston.

So, you know, they are outreaching as well as processing. And it is just a matter of the dynamics of supply and demand and handling the demand, and we are driving down. And we will have it down to 145 days. So I would defend the compensation that we gave to those people.

Ms. BROWN-WAITE. Just a quick question on that. Is the criteria for the bonuses public information or is it arbitrary?

Secretary NICHOLSON. I guess I would refer to counsel. I am sure it is public. It is not secret.

Ms. BROWN-WAITE. Because you cannot find out what the bonuses are throughout the system unless you do a Freedom of Information request. So I just wanted to know if the information is available, what the criteria actually are for the bonuses.

Mr. HUTTER. Yes, ma'am. The criteria are what we call the executive core qualifications, and all bonuses are measured against an evaluation by a senior manager, most of whom are at this table, of how an executive has met these executive core qualifications. They measure how well they lead change, how well they lead, are they results driven, and so forth. And those are public.

Ms. BROWN-WAITE. Okay. If you would make sure that my office gets a copy of that. I have another question. I want to make sure that my time is not all used up.

The CHAIRMAN. If the gentle lady would yield. On behalf of the Committee, we want to ask for that information to get to Ms. Brown-Waite. The criteria and the amount of the bonuses——

Ms. BROWN-WAITE. Correct.

The CHAIRMAN [continuing]. All that information, please if you would get that to Ms. Brown-Waite.

[The information has been provided to Ms. Brown-Waite and the Subcommittee on Oversight and Investigations in preparation for a hearing on this subject being held on June 12, 2007.]

Ms. BROWN-WAITE [continuing]. The people who are enrolled in VA research. How long did it take to notify Congress? Was the data encrypted and was it password protected? And, you know, when did you find out because I know last year when we were here, it took so long for you to find out. I certainly hope you found out in an expedited manner. And I would like to know how soon Congress was notified.

Secretary NICHOLSON. First let me say that incident is still under active investigation, and I do not know the magnitude of it. And it may be larger than that. We just do not know at this point.

But I will say that the system that we put in place after the May incident worked and that the response was immediate. I found out immediately. The IG and FBI were brought into it immediately. Our team that we have organized for this went into effect.

Again, the IG is working with the subject and there is some sensitivity about how public they really wanted this to be because of the investigation. But virtually everybody knew this the next day that we——

Ms. BROWN-WAITE. Who is everybody?

Secretary NICHOLSON. Well, that is a good——

Ms. BROWN-WAITE. Who was everybody, sir?

Secretary NICHOLSON. That is a fair question. Everybody did not know. We did not want everybody to know it. We notified the Chairman. We called the four corners, the Chairman of this Authorizing Committee, the Appropriating Committee in the House and similarly in the Senate, both Majority and Ranking Members. I, of course, notified the White House that this had occurred. So the response to the notifications, I think, were timely this time.

Again, the whole thing is still under analysis, including forensic analysis of the devices. It appears it was not all encrypted. Some

of it was. All this is still under investigation. I would be happy to talk to you about it, I guess privately or in camera. But the IG has asked us to try to limit all we know.

The CHAIRMAN. Ms. Brown-Waite, I do want to say that the Secretary tracked me down right away, gave me that information, I believe in full public disclosure, not just to one person.

But the Secretary did convince me that a short time should be granted where the investigation could take place, and publication would harm that investigation. I took his advice on that, although the information eventually, you know, got out beyond that.

And then at that point, the Secretary did do a press release and availability on that. But he notified all the people. We talked to each other and agreed that he ought to have that time.

And I think the information through Birmingham got out faster than they would have wanted it, but we accepted the Secretary's judgment that some more time—I mean, it was not a matter of months or weeks. It was a matter of days or hours that they wanted more time.

We do need to get on to the second panel. Mr. Buyer, you asked for hopefully one question.

Mr. BUYER. Well, I have got a couple here briefly.

Mr. Hutter, as General Counsel, I want to thank you for the positive actions you took in the Regional Counsel's Office in Indianapolis following the security breaches, so thank you very much for getting hold of that one.

Next is to Under Secretary Tuerk. I would like for you to tell us about the National Shrine Program, where we stand with that.

With regard to General Howard, our CIO, Mr. Secretary, thank you for bringing him.

I note that for the IT account, you list $1.3 billion in nonpayroll and then $555 million in payroll because you now own these people. You have the personnel tail now. Does this include contractors? That is one of my questions.

The other is, there is an inclusion of $231.9 million for information security in accordance with section 902 of Public Law 109–461. What exactly is that number? What are you buying to become compliant?

And the last comment I had really is to you, Mr. Secretary. So as soon as I finish this comment, Mr. Secretary, if you can answer those questions.

Mr. Secretary, I want to thank you for a couple of your initiatives. One is your innovative Coming Home to Work Program whereby you reach out to the disabled veterans and you get them into work as they are doing their rehabilitation, tapping into hope. Thank you very much.

The other is the National Rehabilitative Special Events, your partnership with the United States Olympic Committee. Your contacts and your ties with the Olympic Committee have paid great dividends. You are giving great hope to a lot of disabled veterans and senior veterans as they participate in your events.

Now, with this partnership, it helps not only in the rehabilitation, but it allows them now to aspire to levels within those sports that they never ever dreamed would be possible. So I want to thank you for your innovation in both of those.

Mr. HOWARD. Sir, your first question regarding the money to pay for contractors, that money is in the nonpay area. The 555 pays for full-time equivalent of VA employees, but all of the pay of people, so to speak, as well as material and what have you is in the nonpay portion for contractors.

Mr. BUYER. I do not understand what that means.

Mr. HOWARD. In other words, we have many, many contracts, you know, throughout all of our facilities and some of them are for equipment. Some of them are for services. Some of them are for both.

Mr. BUYER. But you have control of that now?

Mr. HOWARD. Yes, sir.

Mr. BUYER. All right. Thank you.

Mr. TUERK. Thank you, Mr. Buyer. I am glad to speak to you about our National Shrine Commitment.

Through 2006, we had expended $99 million on projects with money that was discretely fenced off for National Shrine projects. In 2007, we intend to spend another approximately $16 million on National Shrine projects which will bring us up to $115 million.

Since the consultant's report came out in 2002, which identified some 928 projects that needed to be done with an estimated cost of some $280 million, through 2006, we had completed 269 of those projects.

In this budget request, we are requesting $9.1 million to be fenced in our operations and maintenance account for National Shrine projects, and an additional two million to be expended from our minor construction account for National Shrine projects.

I would also add, though, Mr. Buyer, that beyond the projects that are financed with National Shrine money specifically, everything we are doing in our maintenance activities, outside of money specifically fenced for National Shrine purposes, is geared toward improving the excellence of our cemeteries' appearance.

Furthermore, many of our other construction projects fold in National Shrine upgrades as part of a larger major or minor construction project. So the money that is fenced off specifically for National Shrine projects only tells part of the story of the progress we are making.

A number that we look at that tells us how we are doing relates to feedback from the public. And in 2006, 97 percent of the people we asked in a survey rated the appearance of our National cemeteries as excellent. We have now set a goal to achieve a 99 percent response of excellent to that question. But that summarizes where we have been and where we are headed and where we are right now.

Mr. BUYER. All right. Thank you, Mr. Chairman.

The CHAIRMAN. I thank the panel. And, Mr. Secretary, just one more followup to Ms. Brown-Waite's issue that she raised. I wanted to thank you for getting our relationship off to the kind of start that we talked about by your quick notification of us.

Again, we may not always agree on what should be public and what should not, but that communication is vital and I thank you. It turns out we were all at the same place, so the people you talked to were able to talk about it. But we appreciate the real rapid response.

You mentioned round tables. Several other people mentioned them. We are going to try on the Committee to have problem-solving sessions as opposed to hearings in which all the Members of the Committee, the stakeholders such as Veterans Service Organizations and, of course, the experts from your Administration would be around the same table trying to say, well, how do we solve the 600,000 claim backlog, how do we get to where we all want to be. And I hope that we can try that and it becomes productive.

Just lastly, as an introduction to the next panel also, just so the people who put together the Independent Budget and saw me waving it around for the last 5, 6 years or 8 years or 10 years, I am going to still wave it around even in this seat.

They asked, I think, for a reasonable amount of additional funding, and I think this Committee when we have to formalize our own budget submissions will be closer to this figure than the Administration's figure.

I know that does not pain you to get more money and I know you have to back the President's budget, but there were some questions raised, whether it is research or other areas that we think should be increased, and we will be getting our submission to the Budget Committee shortly.

Thank you again for being here all morning.

Secretary NICHOLSON. Thank you, Mr. Chairman.

The CHAIRMAN. The next panel may join us. I promised in the past that the VSOs would come first and let the VA wait for that, but we will do that in the future.

We want to thank the four groups that took the lead in putting together the Independent Budget for being here, Paralyzed Veterans of American, Disabled American Veterans, the Veterans of Foreign Wars, and AMVETS. Of course, we have The American Legion to give its thoughts on the budget and also the Vietnam Veterans of America will also do that.

Again, I thank you for your efforts. We have looked at the Independent Budget for years and years and it has been closer to the mark than other budget recommendations. And I think the Committee's advice to the Budget Committee that we have to do soon will be much closer to yours. I hope we endorse the Independent Budget.

I have Mr. Blake from Paralyzed Veterans as first, but however you have decided to do that.

STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Mr. Chairman. Mr. Chairman, Members of the Committee, on behalf of the four organizations who co-authored the Independent Budget, I would like to thank you for the opportunity to testify today on the healthcare recommendations for fiscal year 2008.

Before I begin, I would just like to mention that in the spirit of openness and cooperation, the IB VSOs extended an invitation last week to all the Committee staff and to all of the LAs for the Members of the Committee to come to a briefing where we could lay out the recommendations for the Independent Budget in advance of the President's budget release.

I feel like by doing that, it fosters more cooperation among us all. I feel like the only way we can really get to where we need to go is for us to work together to get there.

Unfortunately, even as we testify today, the Appropriations Bill for fiscal year 2007 has not been completed. Despite a positive outlook outlined in House Joint Resolution 20, the VA has been placed in a critical situation where it is cannibalizing dollars for other accounts to continue to provide medical services, jeopardizing not only the VA healthcare system but the actual healthcare of veterans.

For fiscal year 2008, the Administration has requested $34.2 billion for veterans' healthcare, about a $1.9 billion increase over the levels established in House Joint Resolution 20. Although we recognize this as another step forward, it still does not meet the recommendations of the Independent Budget.

For fiscal year 2008, we recommend approximately $36.3 billion, an increase of $4 billion over the 2007 level established in House Joint Resolution 20 and approximately $2.1 billion over the Administration's request.

For fiscal year 2008, the IB recommends approximately $29 billion for medical services. Our medical services' recommendation includes $26.3 billion for current services, $1.4 billion for the increase in patient workload, 105 million for additional FTE, and a $1.1 billion increase for policy initiatives.

For medical administration, the Independent Budget recommends approximately $3.4 billion and, finally, for medical facilities, the IB recommends approximately $4 billion.

This recommendation also includes an additional $250 million above the fiscal year 2008 baseline in order to begin to address the nonrecurring maintenance needs of the VA.

Although the Independent Budget healthcare recommendation does not include additional funding to provide for the healthcare needs of category eight veterans now being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision.

VA estimates that more than one and a half million category eight veterans will have been denied enrollment into the system by fiscal year 2008. Assuming a utilization rate of about 20 percent in order to reopen the system to these deserving veterans, the IB estimates that the VA will require about 366 million discretionary dollars.

Although not proposed to have a direct impact on veterans' healthcare, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug copayments from eight to fifteen dollars and an index enrollment fee based on veterans' incomes.

Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than one million veterans will choose not to enroll.

It is astounding that this Administration would continue to recommend policies that would push veterans away from the best healthcare system in the world. Congress has soundly rejected these proposals in the past and we urge you to do so once again.

For medical and prosthetic research, the Independent Budget is recommending $480 million. This represents a $66 million increase over the 2007 level in the continuing resolution and $69 million over the administration's request for fiscal year 2008.

We are very concerned that the medical and prosthetic research account continues to face a virtual flat line in its funding level. Research is a vital part of veterans' healthcare and an essential mission for our National healthcare system.

In closing, to address the problem of adequate resources provided in a timely manner, the Independent Budget has proposed funding for veterans' healthcare be removed from the discretionary process and be made mandatory.

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 equally important when it is going to get that money.

In the end, 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 continue to serve in harm's way.

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

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

The CHAIRMAN. Thank you, Mr. Blake.

Commander Morin of The American Legion needs to get a plane, so we will hear from you next. Thank you, sir.

STATEMENT OF PAUL A. MORIN
NATIONAL COMMANDER, THE AMERICAN LEGION

Mr. MORIN. Thank you, Mr. Chairman and Members of the Committee. Thank you for allowing me to testify before you today on the President's fiscal year 2008 budget request on behalf of The American Legion.

I will summarize and respectfully request that my complete statement be placed in the record.

I trust each of you share the frustration of the veterans community over the imperfect budget process that is currently in place. Today we are here to discuss the fiscal year 2008 VA budget. At the same time, Congress is still considering the fiscal year 2007 budget 4 months after the start of the fiscal year.

Operating on a continuing resolution makes it very difficult for the Department of Veterans Affairs to serve veterans in an optimal manner.

Praise of the VA healthcare delivery system continues to be expressed by medical experts and prestigious journals. However, across the country, VA officials are encouraged to try to outwit, outplay, and outlast the Federal budget process.

Who will get how much and when is hardly the best business practice for an industry leader in providing healthcare and conducting research.

The President's budget request for fiscal year 2008 calls for medical care funding at $36.6 billion, which is about $1.8 billion less than The American Legion's recommendation of $38.4 billion.

As the leader of America's largest veterans' organization, I want to express The American Legion's thanks to the President for recommending a level of funding similar to that of which we proposed for medical care. The major difference is that the President's budget request continues to offset the discretionary appropriations, its medical care collection fund goal of $2.4 billion, whereas The American Legion considers these funds as a supplement since they are for treatment of nonservice-connected medical conditions.

Mr. Chairman, as you are aware, the President's fiscal year 2008 budget has proposed enrollment fees which would require some veterans to pay from $250 to $750 each year for VA healthcare. The proposal would also increase co-payments for prescription drugs to $15.00. Congress rejected similar proposals last year and The American Legion urges you to do the same this year.

With respect to another issue of importance, The American Legion remains steadfastly in support of achieving adjudication of VA disability claims. As a nation at war, the expectation of increasing the number of new disability claims is obvious. The newest generation of wartime veterans rightly deserve timely adjudication of their claims.

Again, the Secretary, Congress, and the veterans community must work toward meaningful solutions to the ever-increasing backlog of veterans' disability claims. Increased funding and additional staffing is a solid first step toward change, and The American Legion appreciates the proposed increases in funding and additional personnel included in the President's budget.

The purpose of my being here is to discuss the President's budget, reaffirm The American Legion's budget recommendations, and continue to urge you and your colleagues to adequately fund the Nation's best healthcare delivery system, 7-year CARES construction plan, medical and prosthesis research, State Extended Care Grant Program, State Veteran Cemetery Grant Program, VA claims and adjudication process, and a national Cemetery Administration.

Each of these important areas is discussed in detail in our full statement. We are a Nation at war. Each of these budgetary concerns is clearly a part of the ongoing cost of war.

Since becoming The American Legion's National Commander in August, I have traveled across the Nation and overseas visiting with active-duty servicemembers, Reserve, and National Guard troops, veterans and their family. I am pleased to report that they all continue to do what this Nation expects of them. The men and women of the Armed Forces are truly dedicated professionals.

Veterans also continue to serve this Nation. You see them at burial details providing honors for their fallen comrades. You see them in the VA hospitals as volunteers. You see them responding to natural disasters to lend a helping hand. And you see them running programs that benefit children and youth of our country.

Mr. Chairman, we must never forget that the families also continue to serve. In many ways, their service is far more demanding both emotionally and physically. Many survive those who have made or will be making the ultimate sacrifice in uniform of this Nation.

The American Legion budget recommendations that I presented in September 2006 are based in large part on the findings of boots on the ground, visits to medical facilities. We have found that the quality of treatment and service remains impressive. But the timely access to care is inconsistent at best.

In addition, there are many deserving veterans locked out of the system because of the means test. They are categorized as priority eight veterans. These honorably discharged veterans, most, if not all, with the means of providing third-party reimbursement are prohibited from enrolling in the VA healthcare system. This includes, among others, military retirees and wartime veterans.

Welcoming the newest generation of wartime veterans into the VA healthcare system is the right thing to do, and The American Legion supports the legislation that will extend VA healthcare from 2 years to 5 years for returning servicemembers in the current Global War on Terrorism. However, denying this group of eligible veterans access to the system is wrong.

Mr. Chairman and Members of the Committee, I know you may question how would we pay for reopening access to all eligible veterans. One way is quite simple. It is widely reported that the cost of VA medical care is approximately $2,000 less per patient than that of Medicare. If so, VA could be annually saving Medicare approximately four billion in mandatory funding. Should additional Medicare eligible veterans be enrolled, the potential savings to Medicare would be increased as well.

Clearly allowing the VA to collect third-party reimbursements from Medicare is not only a cost savings measure, it is the right thing to do. The American Legion urges this Committee to explore the concept of Medicare reimbursement.

Mr. Chairman, as I mentioned at the beginning of my statement, the budget process is not working as it should. The American Legion strongly believes changing VA medical care funding from discretionary to mandatory funding would go a long way toward healing the currently crippled budget process. And as we submit to members the booklet put out by a majority of the Veterans Service Organizations on assured funding.

President Lincoln's words, to care for him who shall borne the battle, guided the efforts of more than 218,000 VA employees who are committed to providing the best possible medical care, benefits, social support, and lasting memorials to veterans and their dependents and recognition of honorable service to this Nation.

The American Legion looks forward to working with this Committee to ensure that these dedicated VA employees have the resources they need to carry out their important mission.

Thank you, Mr. Chairman, for this opportunity to comment on the President's fiscal year 2008 budget request for the Department of Veterans Affairs.

[The prepared statement of Mr. Morin appears on p. 82.]

The CHAIRMAN. Thank you, Commander, and thank you for what you do for your membership and our Nation's veterans.

Mr. Brian Lawrence from the DAV.

STATEMENT OF BRIAN LAWRENCE, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. LAWRENCE. Mr. Chairman, Members of the Committee, on behalf of the 1.3 million members of the Disabled American Veterans, thank you for the opportunity to present the recommendations of the 2008 Independent Budget and compare them to the President's proposed budget for veterans' programs.

As you know, the IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, Paralyzed Veterans of America, and the Veterans of Foreign Wars. Each organization has a principal responsibility for a major component of the budget. My testimony focuses on the Veterans Benefits Administration.

The President recommends that funding for VBA be increased by approximately $30 million. Obviously we are quite pleased that the President shares our perspective that increased funding is needed. Our recommendations for increases exceed the Administration's both in overall dollar amounts and numbers of employees. However, our differences are relatively minor compared with other areas of the Federal budget.

We hope that such minor differences can be resolved during the upcoming budget cycle in favor of disabled veterans who will rely on the services that VBA provides.

The IB recommendation for overall VBA funding is $1.9 billion as compared to the President's recommendation of $1.2. Differences in our recommendations are primarily due to the following reasons:

One, the IB anticipates a continuation of a high number of disability claims. We based these estimates on two factors, ongoing hostilities in Iraq and Afghanistan and an aging veterans population. The Administration also expects an inclined rate in the number of claims, but does not expect it to be as sharp as in past years.

The other reason for differences between the IB and the Administration's numbers is that we believe VA Rating Board personnel should concentrate more on making accurate decisions and less on producing high numbers. Therefore, our ratio of workers to claims is larger than the Administration's, resulting in a higher number of full-time employees.

Along with recommendations for funding levels, the IB makes several suggestions for policy improvements. Since I am running short on time, I am going to focus on just the recent enactment of the provision allowing attorneys into the claims process. We are deeply concerned about the negative impact this might have.

The VA claims system was designed to be open, informal, and helpful to veterans. It is reasonable to expect that the involvement of fee-charging lawyers and agents will impede productivity in the claims process and further bog down the system and eventually lead to the need for even more increases in staffing.

For example, VA will have the responsibility of oversight and administration of fee agreements under which the Secretary is to pay the attorney directly from past-due benefits awarded to the veteran. Added costs to do so are likely to be substantial without commensurate added advantages or benefits for either the VA or veterans.

We hope that such unintended consequences will be considered by the Committee and this provision would be repealed. Once again, we appreciate the Committee's interest in these issues and we appreciate the opportunity to testify today.

Thank you.

[The prepared statement of Mr. Lawrence appears on p. 93.]

The CHAIRMAN. Thank you. And the full statements of all will be entered into the record.

Mr. Cullinan.

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

Mr. CULLINAN. Thank you very much, Mr. Chairman and distinguished Members of the Committee. On behalf of the men and women of the Veterans of Foreign Wars and the constitute Members of the Independent Budget, I thank you for holding today's most important hearing. This is truly an essential component in doing the right thing by America's veterans.

Before I go into the construction budget, Mr. Chairman, I would like to again publicly thank you for restoring our joint hearings. We communicate with you and the various Members of this Committee and the Congress, all of us, the VFW, all of us do in a variety of ways directly, indirectly through hearings, through a lot of staff interaction, our grass roots. But these joint hearings are about more than just communication. They are very important, symbolic events for our membership to see their nationally elected leader present to you, the Congress.

And I think that this event is also emblematic of the special relationship that the veterans community has with Congress, so it reflects well on all of us. So, again, I just want to thank you for that.

I have a little aside on that matter too. The VFW's national commanders have been presenting over in the Senate for the past 3 years, and they have done a terrific job over there helping us out. But the truth be known, they do not have a room big enough for all of our people to fit into. So the prospect of being back in the caucus room again is again heartening. So I just thought I would mention that too.

Getting to the construction programs, the Department of Veterans Affairs construction budget for the past year has been dominated by the capital asset for enhanced services, CARES. Through the CARES process, the IB VSOs were greatly concerned with the underfunding of the construction budget.

Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final result of CARES. In past IBs, we warned against this, pointing out that there was a number of legitimate construction needs identified by local managers of VA facilities. A number of facilities were authorized, including the House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as a justification.

Within this context, while pointing to the fact that this is generally a very good budget, the President's budget, for VA, unfortunately, the construction portion is far from adequate.

Mr. Chairman, in constructing the IB, we looked to our in-house resources. We talked to experts outside of the veterans community. We use industry standards, things like the PricewaterhouseCoopers study. The Presidential Task Force's report on construction has been extremely important in helping us formulate our calculations on how much funding should be increased.

When we are looking at the condition of VA properties, the infrastructure, we will look at things like the facility construction assessment to come up with our general assessment of what needs to get done for VA. And I think our projections have been not only good but actually quite moderate through the years.

The PTF recommends a recapitalization rate about 5 to 8 percent. We are only asking for 4 percent. And, again, in this context, I think VA has been recapitalizing at something like half a percent a year, which means the average VA facility would have to stay functioning for 155 years. And that is just not going to happen.

So I would argue that our recommendations are indeed moderate. When I reflect back to 2004, when then Secretary Anthony Principi testified before this Committee, he said it would take a billion dollars a year to fund CARES, which was then just an element of the construction planning process, $1 billion a year.

Since that time, in 2004, they got about 750 million and every year after that, they have only gotten about half that much. So there is a real deficit there. There is a real problem.

The President's budget for medical care, not the entire, but the medical care portion of the construction is $511 million. The IB is asking for $1.4 billion. Again, that is about 4 percent of the capital value.

Clearly the President's recommendation, especially with everything that is going on now and the need to not only recapitalize, but there are urgent needs. We heard Mr. Baker speak earlier of what is going down in New Orleans. There is a lot of need for construction out there, and we have a lot of buildings that need help.

For example, last year, in the 2007 capital plan, only eight of the partially funded projects out of the top twenty got any consideration whatsoever. The cost of these, by the way, would have been about $700 million. That is eight out of twenty only got any kind of consideration at all.

In 2008, the $511 million that the President calls for in his budget would only fund six projects of the twelve partially funded projects. Six others are not funded at all. And that plan for 2008 for the scored projects—scored projects are those projects that have some degree of priority in the VA's overall scheme of things of what does and does not need to get built or done—none of the 27 would get any funding at all.

So the short form of what I am saying here is there is no funding for any new construction in this particular budget, and clearly that just will not do.

With respect to minor construction, the need for some 300 projects has been identified. I see I am going over my time here. I am sorry, sir. Has been identified. The IB is calling for a funding level of $450 million. The President's budget would only provide for about $180 million for VHA. It is not enough money.

The last point I will make, and it is an urgent one, with the initial planning process of CARES, they identified the need for $2 billion alone for minor construction.

With that, I will conclude. Thank you, Mr. Chairman. Sorry I went over.

[The prepared statement of Mr. Cullinan appears on p. 99.]

The CHAIRMAN. Thank you, sir.

And, Mr. Greineder, from AMVETS.

STATEMENT OF DAVID G. GREINEDER, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS)

Mr. GREINEDER. Thank you. Mr. Chairman, Members of the Committee, thank you for the opportunity to be here today.

As a co-author of the Independent Budget, AMVETS is pleased to give you our best estimates on the resources necessary to carry out a responsible National Cemetery Administration budget for fiscal year 2008.

I would first like to commend the committed NCA staff who provide the highest qualify of service to veterans and their families in times of tremendous grief. The devoted staff provides aid and comfort to hurting families in very difficult times, and we thank them for that.

The Administration requests approximately $166.8 million in discretionary funding for operations and maintenance of NCA, as well as $32 million for the State Cemetery Grants Program.

The Members of the Independent Budget recommend Congress provide $218.3 million for the operational requirements of the NCA, a figure that includes our national Shrine initiative. In total, our funding recommendation represents a $51.5 million increase over the Administration request.

The National Cemetery system continues to be seriously challenged. Though there has been noteworthy progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Therefore, we again recommend Congress establish a 5-year, $250 million National Shrine initiative to restore and improve the condition and character of NCA cemeteries. We recommend $50 million in fiscal year 2008 to begin this important initiative.

By enacting a 5-year program with dedicated funds and an ambitious schedule, the National Cemetery system can fully serve all veterans and their families with most dignity, respect, and compassion.

For funding the State Cemetery Grants Program, the Independent Budget recommends $37 million for fiscal year 2008. The State Cemetery Grants Program is an important component of the NCA. It has greatly assisted States to increase burial services to veterans, especially those living in less densely populated areas not currently served by a national veterans cemetery.

Many States have difficulty meeting the 170,000 veterans within 75 miles requirement for a national cemetery, which is why the State Grant Program is so important. Since 1978, the VA has more than doubled the acreage available and accommodated more than 100 percent increase in burials through these grants.

The Independent Budget also strongly recommends Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full cost of burial, they now only pay for just 6 percent of what they covered when the program started in 1973.

These recommendations are contained in my written testimony, but I would like to say our recommendations which represent a modest increase would restore the allowance to its original proportion of burial expense about 22 percent, and tell veterans that their sacrifice is given the appreciation it so well deserves.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.7 million soldiers who died in every war and conflict are honored by a burial in a national cemetery. Each Memorial Day and Veterans Day, we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than a final resting place; they are hallowed grounds to those who died in our defense and a memorial to those who served.

Mr. Chairman, this concludes my statement.

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

The CHAIRMAN. Thank you.

And, finally, the National President of the Vietnam Veterans of America, Mr. John Rowan.

STATEMENT OF JOHN ROWAN
NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Thank you, Mr. Chairman, Mr. Buyer, and the rest of the Members of the Committee.

VVA, of course, is interested, and we have seen you swap chairs. One of you moved over to the left, left to the right. But we hope that the Committee as always will continue to work on behalf of veterans, and I believe that in a bipartisan, nonpartisan, whatever you want to call it, we have hope that you will work together to help us do the best we can.

You have my statement, which will be added. I would also appreciate it if you could add into our official statement a report that was put out by Ms. Linda Bilmes from the Harvard University School, John F. Kennedy School of Government called "Soldiers Returning from Iraq and Afghanistan, the Long-Term Cost of Providing Veterans Medical Care and Disability Benefits." If we could have that added into the record as part of our statement——

The CHAIRMAN. Without objection, that will occur.

[The report by Linda Bilmes appears on p. 285.]

Mr. ROWAN. It is very clear from looking at that study of the new veterans that we also need to go back and get Congress to reauthorize, or it has been authorized, to get the VA to finally complete the Vietnam veterans longitudinal study because that, too, we believe, will show the problems of the VA long term in their fiscal needs to deal with the problems of veterans long after the war has been over.

It is within that regard that we talk about some of the—it is interesting. My five colleagues, one of them had to leave, we really appreciate a lot of the work done by the Independent Budget and group and go along with a lot of what they are saying. We just

think we need a little bit more than what, frankly, they are asking for.

And we are looking particularly in the medical services alone almost seven billion extra, and we believe it is needed for many different reasons, not the least of which is that we do not believe that the increase in demand that the VA was even considering when the VA developed their budgets in the last several years and including even the new one.

And it is not just the demand of the OIF or OEF new veterans coming out. It is the demand of the Vietnam veterans who are now coming to deal with the terms that they have received for having been exposed to Agent Orange, in my case 40 years ago. Many of us now are coming down with all of these conditions that are related to our service in Vietnam that are now causing us to go to the VA.

I would be very interested to see that 800,000 claim number broken down into who actually reported new claims. Who are they? Obviously I think the number that was mentioned was 200 and something thousand of the new vets coming in by the Secretary. That means there has got to be about another 500,000 older veterans, coming into the system for the first time many of them. And we are coming in with our diabetes and our prostate cancer and all of these other issues.

And to get back to the priority eights question, many of those people would be seven and eights because they have never had any problems until now all of a sudden they face these problems as they get them again in their later years.

And even in the sevens, the zero percent disability people, it is interesting how many of them get a hundred percent, for example, prostate cancer and then drop back down to zero when they go through treatment. But they have to be monitored for the rest of their lives. They should be monitored in the VA system and not be forced to go out to the outside system if they have their own healthcare.

So that is part of it. Again, part of our assessment of why we need additional money, in the budget, supposed budget savings the last time around, the so-called management efficiencies, they were not management efficiencies. They were staff deficiencies, because often when you go out to the VISN levels, you found that these people were cutting staff to accommodate their budget.

And that is one of the reasons why we see a lot of places where they are having difficulty finding enough doctors, enough nurses, getting the people to get into those clinics, why we are seeing times being dragged on again with people not getting clinic appointments in reasonable time frames.

And there are a whole bunch of other things that we think is just medical inflation. They do not keep up with it. We also think they use wrong formulations in the fact that they do not take into consideration we are not like the general population.

Again, going back to the Vietnam veterans issues and even to some of the newer veterans, we have more healthcare issues than the general public does and we are coming down with them as we get older and, unfortunately, because of our exposures, either in Vietnam or in the Gulf War, to whatever was out there.

And one of the things on a smaller note, we would like to see the 300 million go back in to restore the services for Agent Orange exposed veterans. We want to bring these veterans into the system, many of them for the first time. They have just never gone there. Some of them, you know, just again what is a disabled veteran?

If you got out of the war and you managed to walk away from Vietnam and you did not get shot and you did not get hurt and you figure I am safe, I am good to go, you come home and 30 years later, you have got prostate cancer or you have got diabetes and you have got neuropathy and all of these other things are hitting you, and you read in the paper, well, it is because everybody has got diabetes or prostate cancer is now on television, everybody has got it, I am just getting old. No. You got it probably because you stepped foot in Vietnam 40 years ago and that is why you got it.

We have a presumption of it. You are entitled to compensation for it. And if you are not in the system and you are not getting treated by the VA and even sometimes when you are treated by the VA, the doctors there do not know that you are entitled to compensation for some of these things.

So we would urge you to take a look at all of that and particularly to deal with these newer veterans with some of their mental issues too. We do not believe anywhere near enough money is going to the mental health questions, to dealing with their PTSD problems or other problems when they come home.

And, again, I just look forward to working with the new Committee and its new reconstruction, but, really old friends on the Committee on both sides of the aisle. And as we go forward, we are looking forward to seeing your working groups that you are talking about having.

Thank you.

[The prepared statement of Mr. Rowan appears on p. 105.]

The CHAIRMAN. Thank you. Thank all of you.

John, you used the phrase "step foot in Vietnam." Did you do that explicitly because there is some concern over those who were in the Navy that maybe have been affected and did not step foot and, therefore, are not entitled to——

Mr. ROWAN. Well, there is a lot of discussion about stepping foot in a lot of places. Unfortunately, the law says now you had to step into the place.

And there is an issue with regards to the Navy. There is also an issue with regards to people in other places. We are finally seeing more and more recognition of Korea, for example. We are finding out about all kinds of other exposures even in the stateside places.

There is a real question somebody brought up to me one time. I forget what islands it was now. It was either Marshall's or some place where again they stored this stuff while it was in transit and some of them are saying that they have been exposed to it there.

The key question I believe is in the Vietnam veterans longitudinal studies. If we went back to that study and completed that study, we may find out a lot more information. If we look at our colleagues in Australia who have done a tremendous amount of work on this stuff, we would see that, not only for the Vietnam veterans but for their family members.

One of the things that still bothers us is that, you know, we only have spina bifida as the only example of an issue of secondary problems with relation to exposure to Agent Orange. Talking to a lot of our Vietnam veterans, we believe there is a lot more out there in that regard for a lot of other child illnesses that ought to be covered.

The CHAIRMAN. Thank you.

I would yield to Mr. Michaud.

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

A question for anyone from the Independent Budget. Looking at the number the Secretary gave us this morning of the $1.7 billion to restore priority eights compared to what the Independent Budget gives for a number, why such a disparity in the numbers?

Mr. BLAKE. The $1.7 billion, I assume, includes the total amount for collections that would be received from that group of veterans that come in. The $366 million that we project is actual discretionary dollars.

We have done some analysis to determine what we believe the total cost would be if the amount that would be received in collections from those veterans were brought into the system. We projected about $1.1 or $1.2 billion, but for real discretionary dollars for that group of veterans, we estimate about $366.

Mr. MICHAUD. A question for Mr. Blake. You had mentioned that the enrollment fees will drive veterans out of the system. These enrollment fees and co-pays are different than what were presented in previous budgets.

Do you really think that if someone is making $200,000, if they have to pay a $750 enrollment fee, it is going to drive them out of the system?

Mr. BLAKE. Well, I would probably say that if somebody is making $200,000, I would believe that they probably have other healthcare to begin with. But that is not necessarily the case. To be perfectly honest with you, I believe this is a question that we are going to have to address this year.

Kind of addressing what Mr. Buyer had brought up about this earlier, I think this is a case of where the Independent Budget just principally disagrees with the idea that these fees and co-pays should be increased or added. I would say that our response to the idea that it is an equalization with the retirees, 20- and 30-year retirees, that that question—our answer to that would be, well, if you want to equalize it, then remove the fees for those 20- and 30-year retirees, and then they are still equal. It is just a different way to accomplish, I guess, the same thing.

And I am not certain that I believe the idea that it is strictly for a government management tool. I mean, I still believe that there is obvious budget implications that go along with these. So we recognize that this is an issue that is going to have to be addressed.

I have to say from my perspective I find it not amusing, but quite interesting that the VA chose the method that they did to—they made it easy for Congress to reject these co-pays and fees because they do not have any immediate impact on the discretionary budget of the VA healthcare system.

So I think they recognize the will of Congress with this issue and, yet, they continue to push the issue, and it concerns us that

ultimately it would still force people to leave the system. I do not believe they have factored into that 200,000 who would leave the system, that does not necessarily include the higher-income veterans.

There are a lot of veterans who are on the margin who would probably fall into that category of veterans that would leave the system. But we do not have an exact analysis of how that would impact it. It would be kind of interesting to see maybe how that would play out over time.

Mr. MICHAUD. And if we could, Mr. Chairman, request from the VA, I would be interested in finding out, since they did break it out to under $50,000, between $50,000 and $74,999, the number of veterans falling in those categories because I do not believe it is going to drive them out, if they are making $200,000, of the system.

My next question is, and I know Mr. Lawrence brought it up, on attorney fees, and I know the VSOs are split on allowing attorneys to get involved into the system, how often do you think attorneys will get involved in the system? Do you think there is going to be a huge influx of attorneys or do you think it might be on an occasional basis?

I guess I will ask those who are against them, and I guess the veterans who are in favor of the attorneys being involved in the system exactly how do you think the attorneys will be involved in the system?

Mr. LAWRENCE. Well, their money, their funding comes from retroactive payments that the veteran would get, and there are some sizable retroactive benefits. And some of them, I mean, they would cherry pick. That is one of our concerns. You know, an attorney is not going to represent somebody that they do not see, you know, a payout at the end.

We represent everybody and, you know, we provide a service. And I can see attorneys not doing that, cherry picking through the system, abusing the system, maybe even delaying claims longer so that the retroactive amount is larger.

And, you know, it is conceivable that it would come to the point where people would feel they needed an attorney to accomplish something that should not require an attorney. As I stated, it is an open and simple system. And I just do not see how adding attorneys to that process would improve it.

Mr. CULLINAN. Mr. Michaud, the VFW is also in the against them camp, so I would like to speak to that next. I mean, along with the prospect of individual abuse, the concern, of course, is what effect will the introduction of attorneys have on the system. Will it make it more adversarial? Will it compel our service officers to play a more litigious approach to, you know, pursuing veterans' claims.

The other thing I would like to talk about, though, is the prospect of an underlining irony. You know, in tort claims actions, you will have firms that are set up and they will come in representing various individuals in the courts, and oftentimes they have their own boards of expert witnesses. And I know there are a couple of examples of this where they are actually getting involved with veterans' law. I think it is in Missouri that Joe was talking about.

And what they are doing is they will bring on—its tinnitus. There is a type of severe tinnitus. This firm, I think it is in Ne-

braska, has their own audiologist on board. And they are representing veterans with a severe form of tinnitus and, sure enough, their allowance rate is extraordinarily high.

Now, by extension, I could see this applying to all sorts of other things. Take individual unemployability. For example, you could suddenly have attorneys getting very successful at representing lots of veterans before VA where suddenly I, you who might not have—and it costs the government then. And the consequences that could have for the survival of the system are a little bit daunting.

Mr. GREINEDER. Mr. Michaud, AMVETS is also against the attorney bill that passed back in December. We join our colleagues at the DAV and VFW against it. And we actually passed a national resolution at our convention in August against the bill.

One of our concerns is that any good lawyer entering the VA system will use the system to their advantage and, you know, causing more delays. We are already at a 600,000 backlog, so we are concerned about entrance of lawyers, what that will do to the system.

Mr. ROWAN. We take the exact opposite opinion, I guess, from my colleagues. We have been always in favor of Vietnam Veterans of America bringing lawyers into the system. We think that veterans are entitled to legal representation like anybody else.

And one only has to look at the Social Security system where lawyers have been brought in and nothing disastrous has occurred, and we have not seen people running amuck. In fact, what we have seen is people finally getting their due.

Having been service rep and done claims work, anybody who says that system is not adversarial, boy, I tell you, it seemed to be very adversarial.

And the other thing is, when you are filing claims and doing all that claims work, anything beyond the simplest claim and the most presumptive claims, for example, you are getting into some very interesting areas where you are writing briefs. Really good service reps who have been out there are practically parallels. They have to read law. They have to read sections of Title 38. They have got to quote things all over the place.

We are really looking at, when we get into the appeals level of things, when you are up to the Board of Veterans Appeals, you are talking to attorneys all the time. In the Court of Veterans Appeals, you have got to be an attorney. I mean, who are we kidding here? I mean, attorneys are all over this place. They are all over the VA. They are the ones who are writing half the Title 38 in the first place. So attorneys are everywhere in the system except on our side of the table most of the time.

The other thing is, you know, the gentleman just said what happens if we get all of these unemployability claims. Well, they are not going to get accepted unless they have got some legitimacy. Just because a lawyer goes in and brings the claim does not mean we are going to win.

And if they are winning all these claims that they deserve, then that only means the system undeservedly kept veterans out from getting their due.

So, you know, I think it needs to be watched, monitored very clearly. The Bar Association has to get involved, and these lawyers

cannot just be any lawyer. They need to go through some kind of training. We think that they ought to have that. But they would end up having some sort of practicality like Social Security lawyers.

I had to go unfortunately through a process with my son who had a problem when he crushed his foot in a motorcycle accident and had to go on Social Security Disability, and we had to bring the lawyers into the system because there is no other way to beat that system. They just beat you down with all the legal aspects of it.

And so, you know, unfortunately, the adversarial manner of the VA at certain levels, when you get into certain types of claims, you may very well have to have somebody able to write a really good legal brief to get past them. And so we are in favor of it. We do not think it is going to clog the system or make it any worse than it already is.

The CHAIRMAN. Thank you. This is a subject we have not exhausted yet.

Mr. Buyer.

Mr. BUYER. Thank you.

It is unfortunate The American Legion Commander had to leave to catch a plane. I think this was the first time in 15 years that I have been on this Committee that an American Legion Commander has testified at a budget hearing, and so I want to thank The American Legion Commander for coming.

Up until the last Congress, Mr. Rowan, is the first time VVA had ever been invited to sit at the table. And therein lies part of the challenge this Committee has had. You have got the Independent Budget. We try to go through this budgetary process, but there are many Military Service Organizations and other organizations that get excluded and they do not get to this table.

So, Mr. Cullinan, therein lies the huge difference between a philosophical approach. You choose theater over substance. Now, I understand as a military man the importance of a military parade. I am going to put on my uniform here in about 10 days, so I understand what a military parade can do, discipline, command and control, all those things are important.

But to this Committee, the most important thing is for us to get timely input. And if you think that your input is the only input—actually, I do not think you believe that. But right now that is all we get. We just get the Independent Budget, The American Legion, and yours. And there is a whole bunch of other input that we need.

But, yet, what is going to happen? We do not get that input until much later and it is going to be done in theater whereby the Commander then plays to his audience, i.e., the Members. We sit there and listen as the Commander plays to his audience, and then they give us input. But the input is now after the budget process has already been done, so now you have been relegated to the back bench and all you can do is play the part of the critic.

And you cheer that. You say that is wonderful. That is great. I get my theater. I get to be a critic. No. I want you to participate substantively in the process, not just you, but the 20 VSOs and MSOs. The Military Service Organizations have been excluded from this process. And I am stunned now. I put together a process to bring them in and now they are being silenced.

I mean, let me just say this. In the 2 years that I chaired this Committee, here are the individuals that actually came into my office to work with me. It was not anyone from the big four. It was not anyone sitting at this table. It was not your organizations. It was General Matz with NAUS. It was Admiral Ryan with MOAA. It was Mr. Rowan with VVA. It was Rolling Thunder and the Patriot Guard Riders. That is who would come into my office and see me.

The only time the commanders of the big four ever came in to see me is because they wanted to have their joint hearings back. No one even picked up the phone. No one even came to see me personally on any substantive issue in the 2 years which I chaired this Committee. I think that is stunning. I think America needs to know that.

And so what did I have to do? I had to then put together a process on how to get their timely input. The best of all worlds, Mr. Cullinan, would have been to have done joint hearings prior to our budget views and estimates. I proposed that. That does not work because you want to do them at a time when you do your spring conferences when you bring all your Members out. So I understand all that, and we just could not get it worked out.

Mr. Lawrence, I need some help. Where did you come up with FTE productivity being 100 claims per year? Where do you get that, because that is nine fewer than VBA? So where do you get that?

Mr. LAWRENCE. That is just the formula that the IB has used.

Mr. BUYER. Say again.

Mr. LAWRENCE. We want claims workers to be able to concentrate more on quality rather than numbers. So logically that is going to require them to have a fewer number of claims, and the estimate that the IB has traditionally used is 100 per worker, 100 claims per worker.

Mr. BUYER. So it is an arbitrary number?

Mr. LAWRENCE. No more arbitrary than 109 for the VA. Sir, I would also like to add—maybe I did not make a great impact on you when we did meet—but I personally met with you in a handful of meetings over the course of the last year.

Mr. BUYER. I am referring to commanders. I am referring to commanders.

Mr. LAWRENCE. You said nobody at this table.

Mr. BUYER. Nobody at this table who represents national organizations.

Mr. LAWRENCE. All right.

Mr. BUYER. I apologize. Thank you for correcting me.

Let me ask a question on burial details. Are your organizations getting the resources they need for burial details, ammunition necessary, upgrading of weapons? Can anybody answer that question?

Mr. CULLINAN. I know that it has gotten better. There was a real problem for a while. For one thing, there was a type of per diem which was not made available unless certain uniform members. And that has been corrected, so that has helped quite a bit.

You know, we would really have to poll our membership, though, to find out how well it is actually going. We are not getting a lot of complaints about it, and I know that that change in law really

made a difference for our people. And a lot of our people who volunteer for these assignments, they are not wealthy by any stretch of the imagination. This money was coming out of their own pockets. So that change helped a lot.

Mr. BUYER. All right. Please go back and look at that a little bit further. If there are things that we need to do from our standpoint or communicate with the Armed Services Committee because for this increase the Secretary talked about with regard to burials, we are going to be responsive to you. Okay?

Thank you.

Mr. BLAKE. Mr. Buyer, can I make one statement real quick?

Mr. BUYER. Yes, sir.

Mr. BLAKE. I think I made clear last year that if I know I am not the subject matter expert on a particular issue, I will be glad to forward the question along or bring that person with me the next time.

With regards to your question about the 100 claims per FTE, I would suggest maybe submit that question to us in writing because if you look inside the IB, there are a number of people involved in the writing. And I know who the individual is. I am pretty certain who the individual is who is responsible for that section and I am sure he would be glad to give you a better explanation of your question there.

Mr. BUYER. Gentlemen, your answers, I think, coincide with the task force, that we want to make sure we get the best qualified people to adjudicate these claims. And I do not even know what the number would be if I were an adjudicator. But thank you.

The CHAIRMAN. I want to thank you all. I want to personally thank everyone at the table for helping educate me over the last decade about your organizations. I think the Independent Budget is a tremendous job. As I said, I am going to recommend that we follow it in our own budget deliberations.

I also want to make sure, everybody, again, thank you for agreeing to participate. On Monday, at one o'clock, all the Members of the Committee, Mr. Buyer, are invited to participate in what I am calling a summit, not a round table, but a square table, to, in fact, put in writing the agenda that we are going to pursue as a Committee over the next year.

And we look forward to your participation in that, and we look forward to working with you. I love commanders, but I love you all too. And I appreciate that you all will be helping us as we progress.

Mr. BUYER. Will the gentleman yield?

The CHAIRMAN. I yield to Mr. Buyer.

Mr. BUYER. As a gentleman from California, you recognize the challenges for Members to get back for those votes at 6:30, so as we do these round tables, I think it is a great idea to just recognize that Members are returning on these Mondays. So it makes it challenging for attendance.

The CHAIRMAN. I appreciate hearing that, and I complained about that as a Californian for a long time. So we will make sure that that is taken into account.

This meeting is adjourned, and we thank you all for participating.

[Whereupon, at 1:30 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bob Filner
Chairman, Full Committee on Veterans' Affairs

Welcome everyone to the hearing on the Fiscal Year 2008 Budget Submission of the Department of Veterans Affairs.

Secretary Nicholson on Monday characterized the VA's FY 2008 budget as a "landmark" budget.

I applaud the VA for submitting a budget that calls for an increase for veterans' medical care, unlike the budget it submitted 2 years ago, and I believe it presents us a framework from which to begin our analysis as to whether the VA's budget submission will meet the needs of veterans in the coming fiscal year. Our job as a Committee is to make sure that as we follow this "landmark" we are not led off course and lose our way.

The VA has requested an increase for VA medical care of $1.9 billion over the level provided for in the joint funding resolution. This represents a 6 percent increase. The amount we provided this fiscal year is 12 percent more than we provided in FY 2006. The Independent Budget and The American Legion both recommend more than a 12 percent increase for FY 2008. The Vietnam Veterans of America recommend substantially more. I look forward to your explanations as to why you believe your 6 percent increase will suffice.

Your budget submission states that $1.4 billion of your increase for medical care is attributable to inflation. Once this is factored in, your recommended increase leaves precious few dollars to meet the increasing needs of veterans.

Although the waiting list for new enrollees has indeed declined, and I applaud you for that, I believe that no veteran should have to wait for a healthcare appointment simply because the VA does not have the resources to care for that veteran. Can you assure this Committee that your budget request has the dollars you need to address this problem?

Last year, your budget request claimed an additional $197 million in "efficiencies" for FY 2007, for a total of $1.1 billion. This year's budget submission also claims clinical and pharmacy "cost avoidance." This Committee would like to know whether you believe you will achieve these "efficiencies" for FY 2007, and what exactly are your dollar estimates as to your "efficiencies" in these two areas for FY 2008.

In the area of mental health, I see that you are requesting an additional $56 million for a total of $360 million for your Mental Health Initiative. Your budget submission also claims that the VA plans to spend $3 billion for mental health services. The GAO has reported in November that you failed to fully allocate the resources you pledged in FY 2005 and FY 2006 for your Mental Health Initiative.

In light of this report, will the VA fully allocate the $306 million for this initiative in FY 2007, and the $360 million for FY 2008? Does the VA currently have the resources it needs to address the mental healthcare needs of our veterans, especially our veterans returning from Iraq and Afghanistan?

I must note that I am disappointed that you have once again brought forward legislative proposals as part of your FY 2008 submission. Instituting enrollment fees and increasing pharmacy co-payments have been rejected year after year by Congress. Last year you claimed that enactment of these proposals would reduce your need for discretionary healthcare dollars. This year, your proposals are deemed "mandatory" spending and are taken out of your overall mandatory spending.

I would like you to explain to this Committee why you have offered these proposals again, and the policy reasons for deeming the proposed receipts from these proposals mandatory dollars.

The VA is facing an ever-greater claims processing crisis. In light of this I would expect your FY 2008 budget submission to aggressively request additional dollars to address this growing problem. But I see that your request for General Operating Expenses, which funds claims processors, is close to $9 million less than the amount provided for in the joint funding resolution. What steps are you taking to meet this

challenge, and why has the VA not requested a sizable increase in this account in order to address the claims processing backlog?

Your VA research request seeks less than you will receive under the joint funding resolution. You should be requesting at least an $18 million increase just to keep pace with inflation. This is especially true when once again you are seeking more resources from other Federal sources and the budget for the National Institutes for Health promises to be static.

I look forward to a full explanation of your Information Technology request, including transfers from other accounts. We must ensure that the VA is moving in the right direction in IT and that the funding level you receive in FY 2008 will lead to better security, more innovation, and fewer incidences like the one that occurred in Birmingham, Alabama last week.

I note that you seek increases in both Major and Minor construction. I know this Committee will be interested in learning how the VA selected the projects included in the FY 2008 request.

There is much work to be done to ensure that the VA has the funding it needs in the coming fiscal year, and to ensure that the VA spends the resources it receives diligently. Mr. Secretary, we look forward to hearing from you this morning, and to working closely with you to make sure that the needs of our veterans, those returning from Iraq and Afghanistan, and the veterans from our previous conflicts, are met.

Prepared Statement of Hon. Steve Buyer
Ranking Republican Member, Full Committee on Veterans' Affairs

Thank you. Mr. Chairman, good morning. I'd also like to welcome everyone to our first hearing of the 1st Session of the 110th Congress.

Mr. Secretary, I am glad you can be with us today to share with the Committee the President's proposed budget for 2008. I commend you for yet again embracing the challenge of improving the VA's budgeting process. Building on last year's progress, it appears that improving the integrity of the process has borne fruit with this budget.

Mr. Secretary, as you observe your second anniversary as chief steward of our nation's veterans we can look back and note that it has been a year of challenges and successes. I thank you for your willingness to squarely meet the challenges and commend you on those successes.

Since this time last year, we passed a major legislative initiative—Public Law 109–461—the Veterans Benefits, Health Care, and Information Technology Improvement Act of 2006. This bill was the result of a bipartisan effort led by this Committee in concert with our colleagues in the Senate. We listened to 20 VSOs and MSOs and incorporated many of their suggestions. We authorized 24 major construction projects in 15 states, approved continued leasing of 8 medical facilities and required VA to explore options for construction of a new medical facility in San Juan, Puerto Rico. With regard to our returning Iraq and Afghanistan veterans, we added $65M to increase the number of clinicians treating post traumatic stress disorder and improve their training. It further authorizes spending for collaboration in PTSD diagnosis and treatment between VA and DoD. We authorized more funding for additional blind rehabilitation specialists and increased the number of facilities where these specialists will be located. We expanded eligibility for Dependents Education Assistance to the spouse or child of a servicemember hospitalized or receiving outpatient care before the servicemember's discharge for a total and permanent service-connected disability. The intent here was to help enhance the spouse's earning power as early as possible before discharge of the servicemember.

We made chapter 35 more flexible for spouses and dependents, we restored the entitlements for members of the National Guard and Reserves who are called to active duty during the school year, we extended work study provisions to ensure a veteran didn't lose a job during the school year, and we required VA to report ways to streamline administration of the GI Bill to shorten the time to get that first check.

Some expressed concerns about veterans ability to afford a home so we authorized VA to guarantee co-op housing units which are often the most affordable housing in many areas.

Many asked us to help veteran, especially service-disabled veteran-owned businesses, so we gave VA the tools to increase the amount of business they do with veterans by giving service-disabled veteran-owned businesses preference over all other set-aside groups and ensuring the survivors of veteran businessowners who acquire ownership continue their veteran-owned status with VA.

Service organizations also expressed the need to revitalize the veterans employment programs at the Veterans Employment and Training Service. So, we made

several changes to strengthen mandatory training for DVOPs and LVERs, revised the incentive program to make it more effective, and established a pilot licensing and credentialing program. And VVA especially, noted that DOL needed to develop regulations to implement the Jobs for Veterans Act. We did that too.

Since this time last year, we have seen the Department embrace the idea of centralizing its IT under the VA's CIO. I believe that this innovation will be seen as part of your legacy to the Department of Veterans Affairs. As part of our work on IT, we engaged in a bipartisan fashion to increase data security in order to protect our nation's veterans. We have also worked through the complexities of the Charleston model, forging an exciting new way to approach hospital design and construction.

It is our job to preserve those arenas of excellence and to work together in a bipartisan fashion to ensure every service the Department provides meets the highest standards.

One of the most important services remains the determination and awarding of benefits. As you know, Mr. Secretary, the claims backlog has reached an all-time high. To help lead the way ahead, I organized a Compensation and Benefits Accountability Task Force in December 2005. After almost 1 year, they provided me a powerful work product with numerous recommendations. I want to commend those who spent many hours working on this valuable product—Blake Ortman, the Associate Legislative Director of PVA, James Doran, the National Service Director for AMVETS, Rick Weidman the National Legislative Director for Vietnam Veterans of America, John Lopez, the Chairman for the Association of Service Disabled Veterans, and Steve Smithson the Assistant Director, National Veterans Affairs and Rehabilitation Commission, the American Legion. Gentlemen, thank you for your good work. Mr. Secretary, I look forward to sharing this with you, as well as the Members of this Committee as we tackle this serious problem.

It's worth noting that again this year, the President has proposed substantial increases in the budgets of agencies focused on fighting the war on terror—the Department of Defense and the Department of Homeland Security. I am pleased that again this year, the Department of Veterans Affairs—an agency focused on caring for those who have borne the battle—has also received a substantial increase of approximately 8 percent over the level contained in H.J. Res. 20. At a time when much of the rest of government received a 2.2 percent increase, I believe this reflects the commitment of this Administration to care for our nation's veterans during time of war.

As you know Mr. Secretary, a budget is much more than numbers. In the end, it must translate into real actions on the ground that has a positive affect on America's veterans. As I look at this budget, I view it in light of my top three priorities, which remain:

- Caring for veterans who have service-connected disabilities, those with special needs, and the indigent.
- Ensuring a seamless transition from military service to the VA.
- And providing veterans every opportunity to live full, healthy lives.

We have an obligation to those who bear the burdens of war and of military service—and to their survivors. Our work must move us toward the fulfillment of that obligation.

Therefore I want to judge this budget not just by the numbers, but for what it does for America's veterans. When you send us a budget of this magnitude, Mr. Secretary, I expect to also find those outcomes you seek for success. The Congress is not a blank check. We will be looking for accountability. Generally, I think this is a good budget. But as we look at desired outcomes, I want to review what we learned from the 20 VSOs and MSOs at last September's "look back, look ahead hearing." At that time, the issues most frequently cited as concerns were: (1) VBA and the claims backlog, (2) seamless transition, mental healthcare, and healthcare funding, and (3) improving the GI Bill. Mr. Secretary, I'd ask you to explain how this budget addresses each of these issues and improves the lives of our veterans.

Mr. Secretary, I applaud you for the direct and forthright budgeting process that you have used in developing this year's budget. There appear to be none of the gimmicks that were used in years past.

That said, there are some concerns in the budget before us today: Mr. Secretary, last year you brought us a similar request for enrollment fees and increased co-pays. I personally agree that it is appropriate to ask for cost-sharing of veterans without service-connected disabilities. I applaud the fact that these legislative proposals do not reduce the discretionary medical care appropriations. However, I am concerned that this year, any funds collected under these proposals go directly to the U.S. Treasury.

Further, VA's projects nearly 2.8 billion dollars in collections, 7 percent above last year's projected collections. Given the agency's track record, this appears to be overly optimistic.

I am also concerned with your answer to the claims backlog. Simply throwing more money at the problem, is not the answer. I am troubled by what I would characterize as an insufficient use of technology and instead, the status quo—throw more people at the problem. We'll continue this discussion throughout the year, Mr. Secretary, but I want you to know up front, I am not pleased.

Budgets, systems, and programs are, after all, about service to *veterans*. As you mentioned in your opening remarks Mr. Secretary, you and I, along with Dr. Boozman and Mr. Salazar, traveled last year to Iraq and traced the path of wounded military personnel back through Germany to state-side military treatment facilities and ultimately to the VA hospitals. For me, this experience brought into sharp focus the issues facing today's veterans. These brave men and women have sacrificed everything for this nation and we owe them our energy and diligence in making them whole again.

Mr. Secretary, I thank you for appearing here today and look forward to your testimony. I also look forward to hearing from our second panel—those VSOs representing the Independent Budget and the American Legion.

Mr. Chairman, I yield back.

Prepared Statement of Hon. Henry E. Brown, Jr.

Mr. Chairman and Ranking Member Buyer, thank you for calling this hearing to examine the Administration's budget request for Fiscal Year 2008. I look forward to hearing from Secretary Nicholson on our first panel and from representatives from many of our nation's veterans service organizations later in the day.

As past chair of both the Health and former Benefits Subcommittees, I am pleased that this budget continues the hard work our Committee and the Administration embarked upon just a few short years ago. In 2001, we had a VA that was receiving just over $20 billion for medical care. In the budget proposal we are discussing today, VA is in line to receive upward of $36 billion for veterans' medical care. This accomplishment would not have been possible had it not been for the commitment made by this Committee, the Administration, and so many others in and out of Congress to our nation's veterans.

As the Congress and this Committee looks at the Administration's current budget proposal, I am hopeful that we will do so in a way that focuses on the bipartisan concern we all have for the wellbeing of our nation's veterans. The work done in our VA medical centers is of such importance, not only to veterans, but also for our entire nation. From developing new treatments to leading the world in the use of electronic medical records, the work of the VA truly is world class.

That said, as with any organization, especially one as large as the VA, there is room for improvement. I am especially glad to see that this budget includes something that this Committee has called for the VA to do for a very long time. The centralized management of information technology (IT) systems and security contained in this budget will lead to improved security for the personal information of our nation's veterans as well as provide the VA with the ability to improve service from the top down.

In addition, I want to praise Secretary Nicholson and the Department of Defense for coming together under the banner of common sense to develop a joint medical records system for our service personnel and veterans. This will go a long way toward achieving the goal of seamless transition that this Committee has so actively pursued.

In closing, Mr. Chairman, while I certainly have concerns with this budget and some of the funding decisions made by the Administration within certain accounts, overall I believe it sets a very solid starting point for Congress to build upon. I look forward to that process in the coming months. Again, Mr. Chairman, thank you for the time, which I now yield back.

Prepared Statement of Hon. Jeff Miller

Thank you, Mr. Chairman for holding this hearing to discuss the fiscal year 2008 funding for the Department of Veterans Affairs.

I am committed to our responsibility to ensure that the budget we adopt will continue to meet both the complex needs of our new generation of younger veterans as well as maintain and improve the quality of services for our older veterans.

I want to thank the Secretary for his appearance before the Committee today and I thank you for your leadership. I also want to commend the manner in which you and your staff have responded to the emergent challenges in taking care of our veterans.

I also appreciate the Veterans Service Organization representatives for participating in our hearing today. Your outlook on funding recommendations for veterans programs and input into the budget is of great value to me in this process.

It is satisfying to see that after this Committee uncovered weaknesses in the process VA used to develop its healthcare budget in 2005, the budget request for fiscal year 2008 is more transparent. The Department proposes $36.6 billion for VA healthcare—the largest amount ever requested by any Administration.

However, I would be remiss in not expressing my concern about the inclusion of legislative proposals to establish fees and increases in pharmacy co-payments for certain veterans without service-connected conditions similar to requests that Congress has rejected year after year.

Having chaired the Subcommittee on Disabilities and Memorial Affairs last year, I am cautiously encouraged that the budget includes increased funding to reduce compensation processing time and improve accuracy.

In the State of Florida, the VA patient workload is among the highest in the Nation and the demand for VA healthcare continues to grow, especially in Okaloosa County, the center of my Congressional District.

Three years ago, the Capital Asset Realignment for Enhanced Services (CARES) Commission identified this Florida Panhandle region as underserved for inpatient care. In fact, it is the only market area in the VISN, VISN 16, without a medical center.

The absence of a VA inpatient facility continues to be one of the biggest concerns of veterans who live in this area. Currently, many of these veterans have to drive to Mississippi to receive inpatient care.

Bringing a full service VA hospital to the first district is something I have been fighting for. I look forward to working with the Department in support of VA's overall capital construction program to address the issue of providing timely access to inpatient healthcare for veterans living in and around Okaloosa County.

Collectively, we share the same goal of providing exceptional service to those who have served in our Armed Forces and sacrificed so much for our freedom.

I hope that our hearing this morning will point the way toward close cooperation among all of us as advocates of our Nation's veterans to respond to their evolving needs and those of their families.

Prepared Statement of Hon. Gus M. Bilirakis

Mr. Chairman, I want to commend you for scheduling this timely hearing on the Administration's Fiscal Year 2008 budget request for the Department of Veterans Affairs. I would also like to take a moment to welcome VA Secretary, Jim Nicholson, and our other witnesses to the Committee this morning.

As a new Member of the Committee, I am anxious to hear directly from Secretary Nicholson on the Administration's overall budget request for the upcoming fiscal year and how it addresses the needs of our nations' veterans. I am also looking forward to hearing the recommendations of the authors of the Independent Budget as well as those of the other veterans' service organizations (VSOs) testifying today. The VSOs often provide us with valuable insight into the day-to-day operations of the VA and its needs.

There are a number of issues in the budget which are of specific interest to me, but rather than spending time to raise them now, I will wait until the question and answer period to discuss them. However, I do have some concerns regarding the legislative proposals that were included in the Administration's budget request.

As I understand these proposals, they would implement annual enrollment fees and increased prescription drug co-payments for Priority 7 and 8 veterans. I know that the Administration has made similar proposals in the past which Congress has rejected. I am very concerned about the impact these proposals would have on our nation's veterans. As the Representative of a district with a large veterans' population, I strongly believe that we must do everything we can to repay the great debt that we owe the men and women who answered the call to duty, and I hope that the Committee will carefully review these proposals before taking any action on them.

Mr. Chairman, I look forward to working with you and the other Members of our Committee to ensure that our veterans receive the benefits they earned through their service to our country.

Prepared Statement of Hon. Ginny Brown-Waite

Thank you, Mr. Chairman,

First, I would like to thank Secretary Nicholson for testifying before the Committee today. I have a great deal of respect for the work you have done since taking office, and am confident that you will continue to serve our nation's veterans well.

I am pleased that the President's budget request would provide $86.75 billion for the Department of Veterans Affairs—a nearly 8 percent increase from the previous year. Having said that, I do have concerns about this budget. Once again, the President has included a proposal establishing an enrollment fee and increased prescription drug co-payments for category 7 and 8 veterans. I have always said that Congress should not impose any new fees without expanding access to care. In fact, I recently introduced legislation, H.R. 92, to ensure that veterans receive timely access to healthcare. Too many veterans are waiting too long for care, or worse, shut out of the VA's system altogether. The President submits this proposal year after year, and every time I vehemently oppose it. This year will be no different.

Some are saying that this budget does not provide adequate funding to the VA. I want to make certain that this budget will adequately meet the needs of those veterans seeking benefits and medical care. With increasing numbers of our brave men and women returning from Iraq and Afghanistan, the VA will face a significant strain for the near future. As Members of Congress, we have an obligation to ensure that those who served are receiving the care they need. Therefore, it is essential that Congress continue to direct funds and resources to areas in need, while bringing greater efficiency to the VA.

Once again, thank you to all of today's witnesses. I look forward to working with my colleagues in the 110th Congress to ensure that our nation's veterans receive the care and support to which they are entitled.

Prepared Statement of Hon. John T. Salazar

Mr. Chairman, Monday I visited with four soldiers from Colorado at the Walter Reed Army Medical Center. Monday also happens to be the day the President released his budget proposal for 2008.

While at Walter Reed, I sat with a young man who took a shot gun blast at point blank range.

Then I spent some time with a 25-year-old double amputee.

The third soldier, a native of the Colorado plains, was recently fitted with a prosthetic left leg.

And the fourth is a Lt. Col recovering from a bullet shattered right leg.

These brave soldiers are representatives of the thousands of injured men and women of the U.S. Armed Forces that have returned from Afghanistan and Iraq.

Over 50,000 troops have sustained serious injuries in this war. Yet the President is proposing an increase in VA health funding that fails to adequately fund the basic necessities of our future generation of war veterans.

The President says his budget meets the growing healthcare needs of our Nation's Veterans, yet fails to adequately fund medical care for Colorado's 400,000 veterans, and troops returning from Iraq and Afghanistan.

The President claims he's expanding the Department's ability to provide mental healthcare, yet this proposed budget fails the thousands of servicemembers returning from war with PTSD and other psychological traumas of war.

With the President's proposed budget, the Veteran's Administration will be forced to shift resources from the care of our aging veteran population to address the needs of our most severely injured veterans returning from combat today.

Mr. Chairman, the cost of this war must not be shouldered solely by the brave men and women who have fought for our freedoms. It is *our* responsibility to guarantee that our veterans get the benefits that they were promised the day they signed up for service.

Prepared Statement of Hon. Doug Lamborn

Thank you, Mr. Chairman.

It is an honor to be here in my first Veterans' Committee hearing among veterans and their families, and those who have, in turn, dedicated themselves to serving these great patriots who have secured our nation's very freedoms.

Mr. Buyer, thank you for your service as Ranking Member of this Committee and for your confidence in this freshman. I assure you that my service will be marked by energy, and a focus to ensure our veterans, their families, and their survivors that we have a system that makes timely and accurate decisions and efficiently delivers benefits to deserving beneficiaries.

Admiral Cooper, I was glad to have been able to visit with you briefly; this is a complex area and has profound impact on our veterans and their families.

These beneficiaries, we would all agree, shouldn't have to grapple with the complexities, laws, regulations, and pressures generated from one side of Washington to another. They are already grappling with the pressures of illness, injury, the need for a pension, some college tuition, perhaps a life insurance policy or a home loan.

No veteran should wait 6 months for a claims decision or years for an appeals decision. We must—and we will—work together in a bipartisan fashion and with you in the Administration to solve this problem.

We will welcome fresh ideas, make room for promising partnerships, and keep the end goal in mind: veterans who are well-served by their government.

Secretary Tuerk, I look forward to working with you. Your Administration has a reputation for efficiency and customer satisfaction. More must be done so that all of our national cemeteries meet shrine commitment standards.

As we expand the number of national and state cemeteries, we should preserve if not accelerate our progress toward this vital commitment, which has enjoyed the Committee's enduring support.

Much must also be done before we can offer our veterans a burial option in a national or state cemetery within a reasonable drive from their residence.

I look forward to the opportunity today to hear more on these and other issues of importance to our veterans and their families.

Mr. Chairman, I yield back my time.

Prepared Statement of Hon. Timothy J. Walz

Mr. Chairman, Members of the Committee and guests, let me express what a true honor it is for me to serve on this distinguished Committee. Having served 24 years in the Army National Guard and having deployed to Europe in support of Operation Enduring Freedom, I understand the need to keep our promise to America's veterans. These brave men and women have admirably served their country with unflinching courage and valor. Crafting policy that serves their best interests is this Committee's chief goal, and so I sincerely express my eagerness to work with each of you to meet that important goal.

Today we turn our attention to the President's Fiscal Year 2008 budget requests for the Department of Veterans Affairs and I want to thank the Secretary and other Department officials for joining us here today. I also want to thank the leaders of the various veterans service organizations that are here today. Thank you for the work that you do on behalf of all of our nation's veterans.

I am eager to listen to today's testimony on the President's budget request. While I am pleased to see a 6 percent increase in requested funding for VA medical care, a significant jump from the .4 percent increase requested for FY2006, I am concerned with some of the President's proposals. The President's request to increase pharmaceutical co-payments and to impose an enrollment fee on priority 7 and 8 veterans presents serious concerns. Furthermore, the President has proposed a cut to VA Medical and Prosthetic Research, a far cry from increases drastically needed by NIH and requested by the Independent Budget. Finally, while the size and increasing workload of the Department of Veterans Affairs would seem to require considerable funding increases for the Office of the Inspector General, the President's budget has instead proposed only slight increases for oversight.

In conclusion, this budget request leaves me with important questions and concerns. I look forward to today's testimony and to the opportunity to work with each of the Members of this Committee on the problems facing America's veterans.

Thank you.

Prepared Statement of Hon. Corrine Brown

Chairman Filner, thank you for holding this hearing and inviting the Secretary to discuss the budget of the Department of Veterans Affairs.

I would like to thank all the groups here today to speak on the VA budget. The groups that authored the Independent Budget: AMVETS, DAV, PVA and VFW; you

have continued to serve your country with this budget. Showing the inadequacies of veterans funding, whether Democrat or Republican, is important to the advancement of veterans rights.

Mr. Secretary, thank you for coming today to discuss this budget. I do not agree with most of it, and there is much that I would change.

First, I would like to thank you for all the building that will be going on in my district. I see there is money for the Orlando VA Medical Center and the Jacksonville cemetery. And yesterday the announcement of a new vet center to be built in Gainesville.

Next, however, are the proposals that hurt individual veterans, the men and women who have served their country and have paid into THEIR system with their blood and sweat.

Every year you include drug co-pays and enrollment fees. Every year, you do what you can to drive veterans out of the VA system. By your own estimate, enrollment fees would drive out over 200,000 veterans from the healthcare system they built and deserve. You still do not allow new Priority 8 veterans into the system.

Every year, the Congress, Members of both the Republican and Democratic parties, reject co-pays and enrollment fees.

And this year, you are balancing the budget on the backs of veterans even more blatantly than ever. The money raised with this tax on veterans' health would go directly into the U.S. Treasury.

How dare you use budget gimmicks and tricks to fund tax cuts for the wealthy?

I cannot believe you are cutting VA medical and prosthetic research when ever more young men and women are coming back from Afghanistan and Iraq without limbs. We are doing remarkable things for these soldiers and to cut funding at this time says to current and future soldiers to not get hurt, because you will be on your own.

And what about information security? Recently a portable computer hard drive, potentially containing personal information on veterans, was reported missing from a VA facility in Birmingham, AL. We held hearing after hearing last year about the loss of veterans' data, obviously to no effect.

Tell me, Mr. Secretary, what is going on with the data security promises you gave last year?

Once again I am reminded of the words of the first President of the United States, **George Washington**:

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country."

Prepared Statement of Hon. Cliff Stearns

Mr. Chairman, thank you for holding this hearing today on the Fiscal Year 2008 budget for the Department of Veterans Affairs, and I thank Secretary Nicholson and our Veterans Service Organizations for being here.

First I would like to take a moment to compliment the Secretary for the Department's handling last year of the data breach incident. The Department responded quickly and effectively to the crisis to protect the identities of many veterans, averting what could have been an even greater breach of privacy.

I would also like to say that we have worked well in the past with the Secretary on issues that are critical to veterans, increasing the number of clinics and working to bring a new veteran's cemetery to the Jacksonville area. I am *very* pleased that one of your three highest priorities you have mentioned previously is to "ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines." I was very pleased that the President authorized six new VA cemeteries Veterans' Day 2004, including my over-a-decade-old bill for a VA cemetery in North Central Florida.

I am pleased with the progress we have made on these issues, and look forward to more opportunities for collaboration. Florida is a premier retirement area for our nation's veterans, with one of the highest numbers of veterans in its population, so naturally I am very interested in hearing suggestions for improvements from Secretary Nicholson.

Mr. Secretary, I am greatly concerned about the claims backlog that is inhibiting the ability of veterans to receive benefits. It is an issue that we have worked on in the past, and it is my hope that we will accomplish much in this area through close collaboration with your Department in the coming year.

I stand firmly behind the President in his strengthening of the VA for today's veterans. Taking care of veterans disabled by their service, and without other means, is a national commitment we must honor.

I appreciate our veterans that are here today. I know that many of you travel great distances to come before us, and we are grateful to see you.

Thank you again, Chairman Filner for the opportunity to hear our panelists, and examine the budget.

Prepared Statement of Hon. R. James Nicholson
Secretary, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, good morning. I am pleased to be here today to present the President's 2008 budget proposal for the Department of Veterans Affairs (VA). The request totals $86.75 billion—$44.98 billion for entitlement programs and $41.77 billion for discretionary programs. The total request is $37.80 billion, or 77 percent, above the funding level in effect when the President took office.

The President's requested funding level will allow VA to continue to improve the delivery of benefits and services to veterans and their families in three primary areas that are critical to the achievement of our mission:

- to provide timely, high-quality healthcare to a growing number of patients who count on VA the most—veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;
- to improve the delivery of benefits through the timeliness and accuracy of claims processing; and
- to increase veterans' access to a burial option in a national or state veterans' cemetery.

Ensuring a Seamless Transition from Active Military Service to Civilian Life

The President's 2008 budget request provides the resources necessary to ensure that service members' transition from active duty military status to civilian life continues to be as smooth and seamless as possible. We will continue to ensure that every seriously injured or ill serviceman or woman returning from combat in Operation Iraqi Freedom and Operation Enduring Freedom receives the treatment they need in a timely way.

Earlier this week I announced plans to create a special Advisory Committee on Operation Iraqi Freedom/Operation Enduring Freedom Veterans and Families. The panel, with membership including veterans, spouses, and parents of the latest generation of combat veterans, will report directly to me. Under its charter, the Committee will focus on the concerns of all men and women with active military service in Operation Iraqi Freedom or Operation Enduring Freedom, but will pay particular attention to severely disabled veterans and their families.

We will expand our "Coming Home to Work" initiative to help disabled service members more easily make the transition from military service to civilian life. This is a comprehensive intergovernmental and public-private alliance that will provide separating service members from Operation Iraqi Freedom and Operation Enduring Freedom with employment opportunities when they return home from their military service. This project focuses on making sure service members have access to existing resources through local and regional job markets, regardless of where they separate from their military service, where they return, or the career or education they pursue.

VA launched an ambitious outreach initiative to ensure separating combat veterans know about the benefits and services available to them. During 2006 VA conducted over 8,500 briefings attended by more than 393,000 separating service members and returning reservists and National Guard members. The number of attendees was 20 percent higher in 2006 than it was in 2005 attesting to our improved outreach effort.

Additional pamphlet mailings following separation and briefings conducted at town hall meetings are sources of important information for returning National Guard members and reservists. VA has made a special effort to work with National Guard and reserve units to reach transitioning service members at demobilization sites and has trained recently discharged veterans to serve as National Guard Bureau liaisons in every state to assist their fellow combat veterans.

Each VA medical center and regional office has a designated point of contact to coordinate activities locally and to ensure the healthcare and benefits needs of returning service members and veterans are fully met. VA has distributed specific guidance to field staff to make sure the roles and functions of the points of contact and case managers are fully understood and that proper coordination of benefits and services occurs at the local level.

For combat veterans returning from Iraq and Afghanistan, their contact with VA often begins with priority scheduling for healthcare, and for the most seriously wounded, VA counselors visit their bedside in military wards before separation to assist them with their disability claims and ensure timely compensation payments when they leave active duty.

In an effort to assist wounded military members and their families, VA has placed workers at key military hospitals where severely injured service members from Iraq and Afghanistan are frequently sent for care. These include benefit counselors who help service members obtain VA services as well as social workers who facilitate healthcare coordination and discharge planning as service members transition from military to VA healthcare. Under this program, VA staff provide assistance at 10 military treatment facilities around the country, including Walter Reed Army Medical Center, the National Naval Medical Center Bethesda, the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg.

To further meet the need for specialized medical care for patients with service in Operation Iraqi Freedom and Operation Enduring Freedom, VA has expanded its four polytrauma centers in Minneapolis, Palo Alto, Richmond, and Tampa to encompass additional specialties to treat patients for multiple complex injuries. Our efforts are being expanded to 21 polytrauma network sites and clinic support teams around the country providing state-of-the-art treatment closer to injured veterans' homes. We have made training mandatory for all physicians and other key healthcare personnel on the most current approaches and treatment protocols for effective care of patients afflicted with brain injuries. Furthermore, we established a polytrauma call center in February 2006 to assist the families of our most seriously injured combat veterans and service members. This call center operates 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members.

In addition, VA has significantly expanded its counseling and other medical care services for recently discharged veterans suffering from mental health disorders, including post-traumatic stress disorder. We have launched new programs, including dozens of new mental health teams based in VA medical facilities focused on early identification and management of stress-related disorders, as well as the recruitment of about 100 combat veterans as counselors to provide briefings to transitioning service members regarding military-related readjustment needs.

Medical Care

We are requesting $36.6 billion for medical care in 2008, a total more than 83 percent higher than the funding available at the beginning of the Bush Administration. Our total medical care request is comprised of funding for medical services ($27.2 billion), medical administration ($3.4 billion), medical facilities ($3.6 billion), and resources from medical care collections ($2.4 billion).

Legislative Proposals

The President's 2008 budget request identifies three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a small share of the cost of their healthcare.

The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family Income	Annual Enrollment Fee
Under $50,000	None
$50,000–$74,999	$250
$75,000–$99,999	$500
$100,000 and above	$750

The second legislative proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from $8 to $15 for a 30-day supply of drugs. And the last provision would eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans.

While our budget requests in recent years have included legislative proposals similar to these, the provisions identified in the President's 2008 budget are markedly different in that they have no impact on the resources we are requesting for VA medical care. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, high-quality medical services that set the national standard of excellence in the healthcare industry. Unlike previous budgets, these legislative proposals do not reduce our discretionary medical care appropriations. Instead, these three provisions, if enacted, would generate an estimated $2.3 billion in mandatory receipts to the Treasury from 2008 through 2012.

Workload

During 2008, we expect to treat about 5,819,000 patients. This total is more than 134,000 (or 2.4 percent) above the 2007 estimate. Patients in Priorities 1–6—veterans with service-connected conditions, lower incomes, special healthcare needs, and service in Iraq or Afghanistan—will comprise 68 percent of the total patient population in 2008, but they will account for 85 percent of our healthcare costs. The number of patients in Priorities 1–6 will grow by 3.3 percent from 2007 to 2008.

We expect to treat about 263,000 veterans in 2008 who served in Operation Iraqi Freedom and Operation Enduring Freedom. This is an increase of 54,000 (or 26 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for healthcare in 2007, and 108,000 (or 70 percent) more than the number we treated in 2006.

Funding Drivers

Our 2008 request for $36.6 billion in support of our medical care program was largely determined by three key cost drivers in the actuarial model we use to project veteran enrollment in VA's healthcare system as well as the utilization of healthcare services of those enrolled:

- inflation;
- trends in the overall healthcare industry; and
- trends in VA healthcare.

The impact of the composite rate of inflation of 4.45 percent within the actuarial model will increase our resource requirements for acute inpatient and outpatient care by nearly $2.1 billion. This includes the effect of additional funds ($690 million) needed to meet higher payroll costs as well as the influence of growing costs ($1.4 billion) for supplies, as measured in part by the Medical Consumer Price Index. However, inflationary trends have slowed during the last year.

There are several trends in the U.S. healthcare industry that continue to increase the cost of providing medical services. These trends expand VA's cost of doing business regardless of any changes in enrollment, number of patients treated, or program initiatives. The two most significant trends are the rising utilization and intensity of healthcare services. In general, patients are using medical care services more frequently and the intensity of the services they receive continues to grow. For example, sophisticated diagnostic tests, such as magnetic resonance imaging (MRI), are now more frequently used either in place of, or in addition to, less costly diagnostic tools such as x-rays. As another illustration, advances in cancer screening technologies have led to earlier diagnosis and prolonged treatment which may include increased use of costly pharmaceuticals to combat this disease. These types of medical services have resulted in improved patient outcomes and higher quality healthcare. However, they have also increased the cost of providing care.

The cost of providing timely, high-quality healthcare to our Nation's veterans is also growing as a result of several factors that are unique to VA's healthcare system. We expect to see changes in the demographic characteristics of our patient population. Our patients as a group will be older, will seek care for more complex medical conditions, and will be more heavily concentrated in the higher cost priority groups. Furthermore, veterans are submitting disability compensation claims for an increasing number of medical conditions, which are also increasing in complexity. This results in the need for disability compensation medical examinations, the majority of which are conducted by our Veterans Health Administration, that are more complex, costly, and time consuming. These projected changes in the case mix of our patient population and the growing complexity of our disability claims process will result in greater resource needs.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality healthcare. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class healthcare to veterans. For example, our record of success in healthcare delivery is substantiated by the results of the 2006 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School, the ACSI survey found that customer satisfaction with VA's healthcare system increased last year and was higher than the private sector for the seventh consecutive year. The data revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, or 10 points higher than the rating for inpatient care provided by the private-sector healthcare industry. VA's rating of 82 for outpatient care was 8 points better than the private sector.

Citing VA's leadership role in transforming healthcare in America, Harvard University recognized the Department's computerized patient records system by awarding VA the prestigious "Innovations in American Government Award" in 2006. Our electronic health records have been an important element in making VA healthcare the benchmark for 294 measures of disease prevention and treatment in the U.S. The value of this system was clearly demonstrated when every patient medical record from the areas devastated by Hurricane Katrina was made available to all VA healthcare providers throughout the Nation within 100 hours of the time the storm made landfall. Veterans were able to quickly resume their treatments, refill their prescriptions, and get the care they needed because of the electronic health records system—a real, functioning health information exchange that has been a proven success resulting in improved quality of care. It can serve as a model for the healthcare industry as the Nation moves forward with the public/private effort to develop a National Health Information Network.

The Department also received an award from the American Council for Technology for our collaboration with the Department of Defense on the Bidirectional Health Information Exchange program. This innovation permits the secure, real-time exchange of medical record data between the two departments, thereby avoiding duplicate testing and surgical procedures. It is an important step forward in making the transition from active duty to civilian life as smooth and seamless as possible.

In its July 17, 2006, edition, *Business Week* featured an article about VA healthcare titled "The Best Medical Care in the U.S." This article outlines many of the Department's accomplishments that have helped us achieve our position as the leading provider of healthcare in the country, such as higher quality of care than the private sector, our nearly perfect rate of prescription accuracy, and the most advanced computerized medical records system in the Nation. Similar high praise for VA's healthcare system was documented in the September 4, 2006, edition of *Time Magazine* in an article titled "How VA Hospitals Became the Best." In addition, a study conducted by Harvard Medical School concluded that Federal hospitals, including those managed by VA, provide the best care available for some of the most common life-threatening illnesses such as congestive heart failure, heart attack, and pneumonia. Their research results were published in the December 11, 2006, edition of the *Annals of Internal Medicine*.

These external acknowledgments of the superior quality of VA healthcare reinforce the Department's own findings. We use two primary measures of healthcare 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 the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 85 percent in 2008, or a 1 percentage point rise over the level we expect to achieve this year. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the prevention index will be maintained at our existing high level of performance of 88 percent.

Access to Care

With the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to healthcare—96 percent of primary care appointments will be scheduled within 30 days of patients' desired date, and 95 percent of specialty care appointments will be scheduled within 30 days of patients' desired date. We will minimize the number of new enrollees waiting for their first appointment. We reduced this number by 94 percent from

May 2006 to January 2007, to a little more than 1,400, and we will continue to place strong emphasis on lowering, and then holding, the waiting list to as low a level as possible.

An important component of our overall strategy to improve access and timeliness of service is the implementation on a national scale of Advanced Clinic Access, an initiative that promotes the efficient flow of patients by predicting and anticipating patient needs at the time of their appointment. This involves assuring that specific medical equipment is available, arranging for tests that should be completed either prior to, or at the time of, the patient's visit, and ensuring all necessary health information is available. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In addition, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

Funding for Major Healthcare Programs and Initiatives

Our request includes $4.6 billion for extended care services, 90 percent of which will be devoted to institutional long-term care and 10 percent to non-institutional care. By continuing to enhance veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day healthcare, home-based primary care, purchased skilled home healthcare, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2008 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to over 44,000. This represents a 19.1 percent increase above the level we expect to reach in 2007 and a 50.3 percent rise over the 2006 average daily census.

The President's request includes nearly $3 billion to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders. The resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. We estimate that about 80 percent of the funding for mental health will be for the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder (PTSD). An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our ongoing outreach to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, as well as increased readjustment and PTSD services.

In 2008 we are requesting $752 million to meet the needs of the 263,000 veterans with service in Operation Iraqi Freedom and Operation Enduring Freedom whom we expect will come to VA for medical care. Veterans with service in Iraq and Afghanistan continue to account for a rising proportion of our total veteran patient population. In 2008 they will comprise 5 percent of all veterans receiving VA healthcare compared to the 2006 figure of 3.1 percent. Veterans deployed to combat zones are entitled to 2 years of eligibility for VA healthcare services following their separation from active duty even if they are not otherwise immediately eligible to enroll for our medical services.

Medical Collections

The Department expects to receive nearly $2.4 billion from medical collections in 2008, which is $154 million, or 7.0 percent, above our projected collections for 2007. As a result of increased workload and process improvements in 2008, we will collect an additional $82 million from third-party insurance payers and an extra $72 million resulting from increased pharmacy workload.

We have several initiatives underway to strengthen our collections processes:

- The Department has established a private-sector based business model pilot tailored for our revenue operations to increase collections and improve our operational performance. The pilot Consolidated Patient Account Center (CPAC) is addressing all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes. The CPAC currently serves revenue operations for medical centers and clinics in one of our Veterans Integrated Service Networks but this program will be expanded to serve other networks.
- VA continues to work with the Centers for Medicare and Medicaid Services contractors to provide a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA healthcare services. We are working to include additional types of claims that will result in more accurate payments

and better accounting for receivables through use of more reliable data for claims adjudication.

- We are conducting a phased implementation of electronic, real-time outpatient pharmacy claims processing to facilitate faster receipt of pharmacy payments from insurers.
- The Department has initiated a campaign that has resulted in an increasing number of payers now accepting electronic coordination of benefits claims. This is a major advancement toward a fully integrated, interoperable electronic claims process.

Medical Research

The President's 2008 budget includes $411 million to support VA's medical and prosthetic research program. This amount will fund nearly 2,100 high-priority research projects to expand knowledge in areas critical to veterans' healthcare needs, most notably research in the areas of mental illness ($49 million), aging ($42 million), health services delivery improvement ($36 million), cancer ($35 million), and heart disease ($31 million).

VA's medical research program has a long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that are now being applied to clinical care include the discovery that vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles, development of a system that decodes brain waves and translates them into computer commands that allow quadriplegics to perform simple tasks like turning on lights and opening e-mail using only their minds, improvements in the treatment of post-traumatic stress disorder that significantly reduce trauma nightmares and other sleep disturbances, and discovery of a drug that significantly improves mental abilities and behavior of certain schizophrenics.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2008. Through a combination of VA resources and funds from outside sources, the total research budget in 2008 will be almost $1.4 billion.

General Operating Expenses

The Department's 2008 resource request for General Operating Expenses (GOE) is $1.472 billion. This is $617 million, or 72.2 percent, above the funding level in place when the President took office. Within this total GOE funding request, $1.198 billion is for the administration of non-medical benefits by the Veterans Benefits Administration (VBA) and $274 million will be used to support General Administration activities.

Compensation and Pensions Workload and Performance Management

VA's primary focus within the administration of non-medical benefits remains unchanged—delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizeable increase in workload. The volume of claims applications has grown substantially during the last few years and is now the highest it has been in the last 15 years. The number of claims we received was more than 806,000 in 2006. We expect this high volume of claims filed to continue, as we are projecting the receipt of about 800,000 claims a year in both 2007 and 2008.

The number of active duty service members as well as reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 55 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed nearly doubled during the last 4 years, reaching more than 51,000 claims in 2006. Almost one in every four original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also increases workload in other parts of the Department, including the Board of Veterans' Appeals.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Also, we are now required to review the claims at more points in the adjudication process.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member, from 98 in 2006 to 101 in 2008. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices. And fourth, we will ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible and further simplify and clarify benefit regulations.

Through a combination of management/productivity improvements and an increase in resources in 2008 to support 457 additional staff above the 2007 level, we will improve our performance in the area most critical to veterans—the timeliness of processing rating-related compensation and pension claims. We expect to improve the timeliness of processing these claims to 145 days in 2008. This level of performance is 15 days better than our projected timeliness for 2007 and a 32-day improvement from the average processing time we achieved last year. In addition, we anticipate that our pending inventory of disability claims will fall to about 330,000 by the end of 2008, a reduction of more than 40,000 (or 10.9 percent) from the level we project for the end of 2007, and nearly 49,000 (or 12.9 percent) lower than the inventory at the close of 2006. At the same time we are improving timeliness, we will also increase the accuracy of our decisions on claims from 88 percent in 2006 to 90 percent in 2008.

Education and Vocational Rehabilitation and Employment Performance

With the resources we are requesting in 2008, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 15 days during the next 2 years, falling from 40 days in 2006 to 25 days in 2008. During this period, the average time it takes to process supplemental claims will improve from 20 days to just 12 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,432,000 in 2008, or 4.8 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 75 percent in 2008, a gain of 2 percentage points over the 2006 performance level. The number of program participants will rise to about 94,500 in 2008, or 5.3 percent higher than the number of participants in 2006.

Our 2008 request includes $6.3 million for a Contact Management Support Center for our education program. These funds will be used during peak enrollment periods for contract customer service representatives who will handle all education calls placed through our toll-free telephone line. We currently receive about 2.5 million phone inquiries per year. This initiative will allow us to significantly improve performance for both the blocked call rate and the abandoned call rate.

The 2008 resource request for VBA includes about $4.3 million to enhance our educational and vocational counseling provided to disabled service members through the Disabled Transition Assistance Program. Funds for this initiative will ensure that briefings are conducted by experts in the field of vocational rehabilitation, including contracting for these services in localities where VA professional staff are not available. The contractors would be trained by VA staff to ensure consistent, quality information is provided. Also in support of the vocational rehabilitation and employment program, we are seeking $1.5 million as part of an ongoing project to retire over 650,000 counseling, evaluation, and rehabilitation folders stored in re-

gional offices throughout the country. All of these folders pertain to cases that have been inactive for at least 3 years and retention of these files poses major space problems.

In addition, our 2008 request includes $2.4 million to continue a major effort to centralize finance functions throughout VBA, an initiative that will positively impact operations for all of our benefits programs. The funds to support this effort will be used to begin the consolidation and centralization of voucher audit, agent cashier, purchase card, and payroll operations currently performed by all regional offices.

National Cemetery Administration

The President's 2008 budget request includes $166.8 million in operations and maintenance funding for the National Cemetery Administration (NCA). These resources will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment. We expect to perform nearly 105,000 interments in 2008, or 8.4 percent higher than the number of interments we performed in 2006. The number of developed acres (over 7,800) that must be maintained in 2008 will be 7.3 percent greater than last year.

Our budget request includes $3.7 million to prepare for the activation of interment operations at six new national cemeteries—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; southeastern Pennsylvania; and Sarasota County, Florida. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003.

The 2008 budget has $9.1 million to address gravesite renovations as well as headstone and marker realignment. These improvements in the appearance of our national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 84.6 percent in 2008, which is 4.4 percentage points above our performance level at the close of 2006. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2008, or 4 percentage points higher than the level of performance we reached last year.

Capital Programs (Construction and Grants to States)

VA's 2008 request includes $1.078 billion in appropriated funding for our capital programs. Our request includes $727.4 million for major construction projects, $233.4 million for minor construction, $85 million in grants for the construction of state extended care facilities, and $32 million in grants for the construction of state veterans cemeteries.

The 2008 request for construction funding for our healthcare programs is $750 million—$570 million for major construction and $180 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program, total funding for which comes to $3.7 billion over the last 5 years. CARES will renovate and modernize VA's healthcare infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Within our request for major construction are resources to continue six medical facility projects already underway:

- Denver, Colorado ($61.3 million)—parking structure and energy development for this replacement hospital
- Las Vegas, Nevada ($341.4 million)—complete construction of the hospital, nursing home, and outpatient facilities
- Lee County, Florida ($9.9 million)—design of an outpatient clinic (land acquisition is complete)
- Orlando, Florida ($35.0 million)—land acquisition for this replacement hospital
- Pittsburgh, Pennsylvania ($40.0 million)—continue consolidation of a 3-division to a 2-division hospital
- Syracuse, New York ($23.8 million)—complete construction of a spinal cord injury center.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical

services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Our 2008 request for minor construction funds for medical care and research will provide the resources necessary for us to address critical needs in improving access to healthcare, enhancing patient privacy, strengthening patient safety, enhancing research capability, correcting seismic deficiencies, facilitating realignments, increasing capacity for dental services, and improving treatment in special emphasis programs.

We are requesting $191.8 million in construction funding to support the Department's burial program—$167.4 million for major construction and $24.4 million for minor construction. Within the funding we are requesting for major construction are resources to establish six new cemeteries mandated by the National Cemetery Expansion Act of 2003. As previously mentioned, these will be in Bakersfield ($19.5 million), Birmingham ($18.5 million), Columbia-Greenville ($19.2 million), Jacksonville ($22.4 million), Sarasota ($27.8 million), and southeastern Pennsylvania ($29.6 million). The major construction request in support of our burial program also includes $29.4 million for a gravesite development project at Fort Sam Houston National Cemetery.

Information Technology

VA's 2008 budget request for information technology (IT) is $1.859 billion. This budget reflects the first phase of our reorganization of IT functions in the Department which will establish a new IT management structure in VA. The total funding for IT in 2008 includes $555 million for more than 5,500 staff who have been moved to support operations and maintenance activities. Prior to 2008, the funding and staff supporting these IT activities were reflected in other accounts throughout the Department.

Later in 2007 we will implement the second phase of our IT reorganization strategy by moving funding and staff devoted to development projects and activities. As a result of the second stage of the IT reorganization, the Chief Information Officer will be responsible for all operations and maintenance as well as development activities, including oversight of, and accountability for, all IT resources within VA. This reorganization will make the most efficient use of our IT resources while improving operational effectiveness, providing standardization, and eliminating duplication.

This major transformation of IT will bring our program under more centralized control and will play a significant role in ensuring we fulfill my promise to make VA the gold standard for data security within the Federal Government. We have taken very aggressive steps during the last several months to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information, launching an initiative to expeditiously upgrade all VA computers with enhanced data security and encryption, entering into an agreement with an outside firm to provide free data breach analysis services, initiating any needed background investigations of employees to ensure consistency with their level of authority and responsibilities in the Department, and beginning a campaign at all of our healthcare facilities to replace old veteran identification cards with new cards that reduce veterans' vulnerability to identify theft. These steps are part of our broader commitment to improve our IT and cyber security policies and procedures.

Within our total IT request of $1.859 billion, $1.304 billion (70 percent) will be for non-payroll costs and $555 million (30 percent) will be for payroll costs. Of the non-payroll funding, $461 million will support projects for our medical care and medical research programs, $66 million will be devoted to projects for our benefits programs, and $446 million will be needed for IT infrastructure projects. The remaining $331 million of our non-payroll IT resources in 2008 will fund centrally managed projects, such as VA's cyber security program, as well as management projects that support department-wide initiatives and operations like the replacement of our aging financial management system and the development and implementation of a new human resources management system.

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 $131.9 million for ongoing development and implementation of Health*e*Vet-VistA (Veterans Health Information Systems and Technology Architecture). This initiative will incorporate new technology, new or reengineered applications, and data standardization to improve the sharing of, and access to, health information, which in turn, will improve the status of veterans' health through more informed clinical care. This sys-

tem will make use of standards accepted by the Secretary of Health and Human Services 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 them and to all those authorized to provide care to veterans.

Until Health*e*Vet-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 $129.4 million in 2008 for the VistA legacy system. Funding for the legacy system will decline as we advance our development and implementation of Health*e*Vet-VistA.

In veterans benefits programs, we are requesting $31.7 million in 2008 to support our IT systems that ensure compensation and pension claims are properly processed and tracked, and that payments to veterans and eligible family members are made on a timely basis. Our 2008 request includes $3.5 million to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will, when fully deployed, receive application and enrollment information and process that information electronically, reducing the need for human intervention.

VA is requesting $446 million in 2008 for IT infrastructure projects to support our healthcare, benefits, and burial programs through implementation and ongoing management of a wide array of technical and administrative support systems. Our request for resources in 2008 will support investment in five infrastructure projects now centrally managed by the CIO—computing infrastructure and operations ($181.8 million); network infrastructure and operations ($31.7 million); voice infrastructure and operations ($71.9 million); data and video infrastructure and operations ($130.8 million); and regional data centers ($30.0 million).

VA's 2008 request provides $70.1 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide controls to better secure our IT architecture in support of all of the Department's program operations. Our request also includes $35.0 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a longstanding material weakness and will effectively integrate and standardize financial and logistics data and processes across all VA offices as well as provide management with access to timely and accurate financial, logistics, budget, asset, and related information on VA-wide operations. In addition, we are asking for $34.1 million for a new state-of-the-art human resource management system that will result in an electronic employee record and the capability to produce critical management information in a fraction of the time it now takes using our antiquated paper-based system.

Summary

Our 2008 budget request of $86.75 billion will provide the resources necessary for VA to:

- strengthen our position as the Nation's leader in providing high-quality healthcare to a growing patient population, with an emphasis on those who count on us the most—veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;
- improve the delivery of benefits through the timeliness and accuracy of claims processing; and
- increase veterans' access to a burial option by opening new national and state veterans' cemeteries.

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.

Prepared Statement of David G. Greineder
Deputy National Legislative Director, American Veterans (AMVETS)

Chairman Filner, Ranking Member Buyer, and Members of the Committee:

AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for

fiscal year 2008. My name is David G. Greineder, Deputy National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 21st year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled their resources together to produce a unique document, one that has stood the test of time.

The IB, as it has come to be called, is our blueprint for building the kind of programs veterans deserve. Indeed, we are proud that over 60 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decisionmakers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans should not have to wait for benefits to which they are entitled. Veterans must be ensured access to high-quality medical care. Specialized care must remain the focus of VA. Veterans must be guaranteed timely access to the full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

Today, I will specifically address the National Cemetery Administration (NCA), however, I would like to briefly comment on the Administration's budget request coming out of the Office of Management and Budget (OMB) just 3 days ago.

Everyone knows that the VA healthcare system is the best in the country, and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system can provide a wide array of specialized services to veterans like those with spinal cord injuries and blindness. This type of care is very expensive and would be almost impossible for veterans to obtain outside of VA.

Because veterans depend so much on VA and its services, AMVETS believes it is absolutely critical that the VA healthcare system be fully funded. It is important our nation keep its promise to care for the veterans who made so many sacrifices to ensure the freedom of so many. With the expected increase in the number of veterans, a need to increase VA healthcare spending should be an immediate priority this year. We must remain insistent about funding the needs of the system, and the recruitment and retention of vital healthcare professionals, especially registered nurses. Chronic under funding has led to rationing of care through reduced services, lengthy delays in appointments, higher co-payments and, in too many cases, sick and disabled veterans being turned away from treatment.

Looking at the Administration's budget, released on Monday, *The Independent Budget* recommends Congress provide $36.3 billion to fund VA medical care for fiscal year 2008. We ask you to recognize that the VA healthcare system can only bring quality healthcare if it receives adequate and timely funding.

One option, and we believe the best choice, to ensure VA has access to adequate and timely resources is through mandatory, or assured, funding. I would like to clearly state that AMVETS along with its *Independent Budget* partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. We recommend this action because the current discretionary system is not working. Moving to mandatory funding would give certainty to healthcare services. VA facilities would not have to deal with the uncertainty of discretionary funding, which has been inconsistent and inadequate for far too long. Most importantly, mandatory funding would provide a comprehensive and permanent solution to the current funding problem.

The National Cemetery Administration

The Independent Budget acknowledges the dedicated and committed NCA staff who continue to provide the highest quality of service to veterans and their families despite funding shortfalls, aging equipment, and increasing workload. The devoted staff provides aid and comfort to hurting veterans' families in a very difficult time, and we thank them for their consolation.

The NCA currently maintains more than 2.7 million gravesites at 124 national cemeteries in 39 states and Puerto Rico. At the end of 2007, 66 cemeteries will be open to all interments; 16 will accept only cremated remains and family members of those already interred; and 43 will only perform interments of family members in the same gravesite as a previously deceased family member.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national ceme-

teries, annual interments are projected to increase from approximately 102,000 in 2006 to 117,000 in 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

The NCA is responsible for five primary missions: (1) To inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a Presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

NCA Budget Request

The Administration requests $166.8 million for the NCA for fiscal year 2008. The members of *The Independent Budget* recommend that Congress provide $218.3 million and 30 FTE for the operational requirements of NCA, the National Shrine Initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed Forces.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

In accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a 5-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY2008 operations budget.

It should be noted that the NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a 5-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

The State Cemetery Grants Program

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials through this program.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $37 million for the SCGP for fiscal year 2008. The availability of this funding will help states establish, expand, and improve state-owned veterans' cemeteries.

Many states have difficulties meeting the requirements needed to build a national cemetery in their respective state. The large land areas and spread out population in these areas make it difficult to meet the "170,000 veterans within 75 miles" national veterans cemetery requirement. Recognizing these challenges, VA has implemented several incentives to assist states in establishing a veterans cemetery. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration.

Burial Benefits

There has been serious erosion in the value of the burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the Federal Government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. *The Inde-*

pendent Budget recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973.

In the 108th Congress, the burial allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. *The Independent Budget* recommends increasing the service-connected burial benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The non-service-connected burial allowance was last adjusted in 1978, and also covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the non-service-connected burial benefit from $300 to $1,270.

The NCA honors veterans with a final resting place that commemorates their service to this nation. More than 2.7 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans, they are hallowed ground to those who died in our defense, and a memorial to those who survived.

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

Statement of Paul A. Morin, National Commander, The American Legion

Mr. Chairman and Members of the Committee:

As The American Legion's National Commander, I thank you for this opportunity to present the views of its 2.7 million members on the President's Fiscal Year 2008 budget request.

The President's FY 2008 budget request is designed to allow VA to address its three highest priorities:

- *Provide timely, high-quality healthcare to veterans who need VA the most—those with service-connected disabilities, lower incomes, special healthcare needs, and service in Operation Iraqi Freedom and Operation Enduring Freedom.*
- *Address the significant increase in claims for compensation and pension.*
- *Ensure the burial needs of veterans and their eligible family members are met, and maintain veterans' cemeteries as national shrines.*

The American Legion will continue to work with the Secretary, Congress and the entire veterans' community to ensure that VA is indeed capable of providing the highest quality healthcare services "*... for him who shall have borne the battle and for his widow and his orphan*." In 1996, Eligibility Reform was enacted to reopen the VA healthcare system to all eligible veterans within existing appropriations. Therefore, the challenge faced is to make sure no veteran in need of healthcare is ever turned away from a VA medical care facility as a result of budgetary shortfalls.

There is no question that all service-connected disabled veterans and economically disadvantaged veterans must receive timely access to quality healthcare; however, their comrades-in-arms should also receive their earned benefit—enrollment in the VA healthcare delivery system. Rather than supporting legislative proposals designed to drive veterans from the world's best healthcare delivery system, The American Legion will continue to advocate new revenue streams to allow any veteran to receive VA healthcare.

Equally as important, The American Legion remains steadfastly in support of achieving timely adjudication of VA disability claims and pensions. As a nation at war, the expectation of an increase in the number of new disability claims is apparent. The newest generation of wartime veterans rightly deserve timely adjudication of their claims. Again, the Secretary, Congress and the veterans' community must work toward meaningful solutions to the ever-increasing backlog of veterans' disability claims. Increased funding and additional staffing is a solid first step toward change.

The American Legion fully supports the goals of the National Cemetery Administration. The addition of new national cemeteries and state veterans' cemeteries is critical in meeting the growing need.

With that in mind, The American Legion offers the following budgetary recommendations for selected discretionary programs within the Department of Veterans Affairs for FY 2008:

Program	FY06 Funding	President's Request	Legion's Request
Medical Care	**$30.8 billion**	**$36.6 billion**	**$38.4 billion**
Medical Services	$22.1 billion	$27.2 billion	$29 billion
Medical Administration	$3.4 billion	$3.4 billion	$3.4 billion
Medical Facilities	$3.3 billion	$3.6 billion	$3.6 billion
Medical Care Collections	($2 billion)	($2.4 billion)	$2.4 billion*
Medical and Prosthetics Research	$412 million	$411 million	$472 million
Construction			
Major	$1.6 billion	$727 million	$1.3 billion
Minor	$233 million	$233 million	$279 million
State Extended Care Facilities Grant Program	$85 million	$85 million	$250 million
State Veterans' Cemetery Grants Program	$32 million	$32 million	$42 million
National Cemetery Administration	$149 million	$166 million	$178 million
General Administration	$294 million	$274 million	$300 million
Information Technology	$1.2 billion	$1.9 billion	$1.9 billion

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

MEDICAL CARE

The Department of Veterans Affairs' standing as the nation's leader in providing safe, high-quality healthcare in the healthcare industry (both public and private) is well documented. Now VA is also recognized internationally as the benchmark for healthcare services:

- December 2004, RAND investigators found that VA outperforms all other sectors of the U.S. healthcare industry across a spectrum of 294 measures of quality in disease prevention and treatment;
- In an article published in the ***Washington Monthly*** (Jan/Feb 2005) "The Best Care Anywhere" featured the VA healthcare system;
- In the prestigious ***Journal of the American Medical Association*** (May 18, 2005) noted that VA's healthcare 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 ***U.S. News and World Report*** (Jul 18, 2005) issue included a special report on the best hospitals in the country titled "Military Might—Today's VA Hospitals Are Models of Top-Notch Care" highlighting the transformation of VA healthcare;
- ***The Washington Post*** (Aug 22, 2005) ran a front-page article titled "Revamped Veterans' Health Care Now a Model" that spotlights VA healthcare accomplishments;
- In 2006, VA received the highly coveted and prestigious "Innovations in American Government" Award from Harvard's Kennedy School of Government for its advanced electronic health records and performance measurement system; and
- Recently, in January 2007, the medical journal ***Neurology*** wrote: "The VA has achieved remarkable improvements in patient care and health outcomes, and is a cost-effective and efficient organization."

Although VA is considered a national resource, the Secretary of Veterans Affairs continues to prohibit the enrollment of any new Priority Group 8 veterans, even if they are Medicare-eligible or have private insurance coverage. This prohibition is not based on their honorable military service, but rather on limited resources provided to the VA medical care system. For 2 years following receiving an honorable discharge, veterans from Operations Enduring Freedom and Iraqi Freedom are able to receive healthcare through VA, but many of their fellow veterans and those of

other armed conflicts may very well be denied enrollment due to limited existing appropriations. This is truly a national tragedy.

As the Global War on Terrorism continues, fiscal resources for VA will continue to be stretched to their limits and veterans will continue to go to their elected officials requesting additional money to sustain a viable VA capable of caring for all veterans, not just the most severely wounded or economically disadvantaged. VA is often the first experience veterans have with the Federal Government after leaving the military. This nation's veterans have never let this country down; Congress and VA should do its best to not let veterans down.

The President's budget request for FY 2008 calls for Medical Care funding to be $36.6 billion, which is about $1.8 billion less than The American Legion's recommendation of $38.4 billion. The major difference is the President's budget request continues to offset the discretionary appropriations by its Medical Care Collection Fund's goal ($2.4 billion), whereas The American Legion considers this collection as a supplement since it is for the treatment of nonservice-connected medical conditions.

Medical Services

The President's budget request assumes the enrollment of new Priority Group 8 veterans will remain suspended. The American Legion strongly recommends reconsidering this "lockout" of eligible veterans, especially for those veterans who are Medicare-eligible, military retirees enrolled in TRICARE or TRICARE for Life, or have private healthcare coverage. Successful seamless transition from military service should not be penalized, but rather encouraged. This prohibition sends the wrong message to recently separated veterans. No eligible veteran should be "locked out" of the VA healthcare delivery system.

The VA healthcare system enjoys a glowing reputation as the best healthcare delivery system in the country, so why "lock out" any eligible veteran, especially those that have the means to reimburse VA for services received? New revenue streams from third-party reimbursements and co-payments can supplement the "existing appropriations," but sound fiscal management initiatives are required to enhance third-party collections of reasonable charges.

In FY 2008, VA expects to treat 5.8 million patients (an increase of 2.4 percent). According to the President's budget request, VA will treat over 125,000 more Priority 1–6 veterans in 2008 representing a 3.3 percent increase over the number of these priority veterans treated in 2007. Priority 7 and 8 veterans are projected to decrease by over 15,000 or 1.1 percent from 2007 to 2008. However, VA will provide medical care to non-veterans; this population is expected to increase by over 24,000 patients or 4.8 percent over this same time period. In 2008, VA anticipates treating 263,000 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, an increase of 54,000 patients, or 25.8 percent, over the 2007 level.

The American Legion supports the President's mental health initiative to provide $360 million to deliver mental health and substance abuse care to eligible veterans in need of treatment of serious mental illness, to include post-traumatic stress disorder.

The American Legion remains opposed to the concept of charging an enrollment fee for an earned benefit. Although the President's new proposal is a tiered approach targeted at Priority Groups 7 and 8 veterans currently enrolled, the proposal does not provide improved healthcare coverage, but rather creates a fiscal burden for the 1.4 million Priority Groups 7 and 8 patients. This initiative clearly projects further reductions in the number of Priority Groups 7 and 8 veterans leaving the system for other healthcare alternatives. This proposed vehicle for gleaning of veterans would apply to both service-connected disabled veterans as well as nonservice-connected disabled veterans in Priority Groups 7 and 8.

The American Legion also remains opposed to the President's proposed increase in VA pharmacy co-pays from the current $8 to $15 for enrolled Priority Groups 7 and 8 veterans. This proposal would nearly double current pharmacy costs to this select group of veterans.

The American Legion recommends $29 billion for Medical Services, $1.8 billion more than the President's budget request of $27.2 billion.

Medical Administration

The President's budget request of $3.4 billion is a slight increase in FY 2006 funding level. VA plans to transfer 3,721 full-time equivalents from Medical Administration to Information Technology in FY 2008. The American Legion applauds the President recommending this level of funding.

Medical Facilities

The President's budget request of $3.6 billion is about $234 million more than the FY 2006 funding level. The American Legion agrees with this recommendation to maintain VA existing infrastructure of 4,900 buildings and over 15,700 acres. In FY 2008, VA will transfer 5,689 full-time equivalents from Medical Facilities to Medical Services. It has been determined that the costs incurred for hospital food service workers, provisions and related supplies are for the direct care of patients which Medical Services is responsible for providing.

Medical Care Collection Fund (MCCF)

The Balanced Budget Act of 1997, Public Law 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 Federal Government. The American Legion supported legislation to allow VA to bill, collect, and reinvest third-party reimbursements and co-payments; however, The American Legion adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of the collected funds come from the treatment of non-service-connected medical conditions. Historically, these collection goals far exceed VA's ability to collect accounts receivable.

In FY 2006, VA collected nearly $2 billion, a significant increase over the $540 million collected in FY 2001. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans. Miscalculations of VA required funding levels result in real budgetary shortfall. Seeking annual emergency supplemental is not the most cost-effective means of funding the nation's model healthcare delivery system.

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 an 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.

The American Legion opposes offsetting annual VA discretionary funding by the arbitrarily set MCCF goal, especially since VA is prohibited from collecting any third-party reimbursements from the nation's largest Federally mandated health insurer—Medicare.

Medicare Reimbursement

As do most American workers, veterans pay into the Medicare system without choice throughout their working lives, including active-duty. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system, VA is prohibited from collecting any Medicare reimbursements for the treatment of allowable, nonservice-connected medical conditions. This prohibition constitutes a multi-billion 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 treatment of allowable, nonservice-connected medical conditions of allowable enrolled Medicare-eligible veterans.

As a minimum, VA should receive credit for saving the Centers for Medicare and Medicaid Services billions of dollars in annual mandatory appropriations.

MEDICAL AND PROSTHETICS RESEARCH

The American Legion believes that VA's focus in research should remain on understanding and improving treatment for conditions that are unique to veterans. The Global War on Terrorism is predicted to last at least two more decades. Service members are surviving catastrophically disabling blast injuries in Iraq, Afghanistan and elsewhere due to the superior armor they are wearing in the combat theater and the timely access to quality triage. The unique injuries sustained by the new generation of veterans clearly demands particular attention. There have been reported problems of VA not having the state-of-the-art prostheses, like DoD, and that the fitting of the prostheses for women has presented problems due to their smaller stature.

In addition, The American Legion supports adequate funding for other 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 DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $472 million for Medical and Prosthetics Research in FY 2008, $61 million more than the President's budget request of $411 million.

CONSTRUCTION

Major Construction

Over the past several years, Congress has kept a tight hold on the purse strings that control the funding needs for the construction program within VA. The hold out, presumably, is the development of a coherent national plan that will define the infrastructure VA will need in the decades to come. VA has developed that plan and it is CARES. The CARES process identified more than 100 major construction projects in 37 states, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over $7 million. Now that VA has a plan to deliver healthcare through the year 2022, it is up to Congress to provide adequate funds. The CARES plan calls for, among other things, the construction of new hospitals in Orlando and Las Vegas and replacement facilities in Louisville and Denver for a total cost estimate of well over $1 billion alone for these four facilities. VA has not had this type of progressive construction agenda in decades. Major construction money can be significant and proper utilization of funds must be well planned out. The American Legion is pleased to see six medical facility projects (Pittsburgh, Denver, Orlando, Las Vegas, Syracuse, and Lee County, FL) included in this budget request.

In addition to the cost of the proposed new facilities are the many construction issues that are virtually "put on hold" for the past several years due to inadequate funding and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. Hurricane Katrina taught a very real lesson on the unacceptable consequences of procrastination. The delivery of healthcare in unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much-needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable.

The American Legion believes that VA has effectively shepherded the CARES process to its current state by developing the blueprint for the future delivery of VA healthcare—it is now time for Congress to do the same and adequately fund the implementation of this comprehensive and crucial undertaking.

The American Legion recommends $1.3 billion for Major Construction in FY 2008, $573 million more than the President's budget request of $727 million to fund more pending "life-safety" projects.

Minor Construction

VA's minor construction program has suffered significant neglect over the past several years as well. The requirement to maintain the infrastructure of VA's buildings is no small task. Because the buildings are old, renovations, relocations and expansions are quite common. When combined with the added cost of the CARES program recommendations, it is easy to see that a major increase over the previous funding level is crucial and well overdue.

The American Legion recommends $279 million for Minor Construction in FY 2008, $46 million more than the President's budget request of $233 million to address more CARES proposal minor construction projects.

Capital Asset Realignment for Enhanced Services (CARES)

In March 1999, GAO published a report on VA's need to improve capital asset planning and budgeting. GAO estimated that over the next few years, VA could spend one of every four of its healthcare dollars operating, maintaining, and improving capital assets at its national major delivery locations, including 4,700 buildings and 18,000 acres of land nationwide.

Recommendations stemming from the report included the development of asset-restructuring plans for all markets to guide future investment decisionmaking, among other initiatives. VA's answer to GAO and Congress was the initiation and

development of the Capital Asset Realignment for Enhanced Services (CARES) program.

The CARES initiative is a blueprint for the future of VHA—a fluid work in progress, in constant need of reassessment. In May 2004, the long awaited final CARES decision was released. The decision directed VHA to conduct 18 feasibility studies at those healthcare delivery sites where final decisions could not be made due to inaccurate and incomplete information. VHA contracted Pricewaterhouse Cooper (PwC) to develop a broad range of viable options and, in turn, develop business plans based on a limited number of selected options. To help develop those options and to ensure stakeholder input, then-VA Secretary Principi constituted the Local Advisory Panels (LAPs), which are made up of local stakeholders. The final decision on which business plan option will be implemented for each site lies with the Secretary of Veterans Affairs.

The American Legion is dismayed over the slow progress in the LAP process and the CARES initiative overall. Both Stage I and Stage II of the process include two scheduled LAP meetings at each of the sites being studied with the whole process concluding on or about February 2006.

It wasn't until April 2006, after nearly a 7-month hiatus, that Secretary Nicholson announced the continuation of the services at Big Spring, Texas, and like all the other sites, has only been through Stage I. Seven months of silence is no way to reassure the veterans' community that the process is alive and well. The American Legion continues to express concern over the apparent short-circuiting of the LAPs and the silencing of the stakeholders. The American Legion intends to hold accountable those who are entrusted to provide the best healthcare services to the most deserving population—the nation's veterans.

Upon conclusion of the initial CARES process, then-Secretary Principi called for a "billion dollars a year for the next seven years" to implement CARES. The American Legion continues to support that recommendation and encourages VA and Congress to "move out" with focused intent.

STATE EXTENDED CARE FACILITY GRANTS PROGRAM

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes and contracts with public and private nursing homes. The reason for this is obvious; VA paid a per diem of $59.48 for each veteran it placed in State Veterans' Homes, compared to the $354 VA pays to maintain a veteran for 1 day in its own nursing home care units.

Under the provisions of title 38, United States Code, VA is authorized to make payments to states to assist in the construction and maintenance of State Veterans' Homes. Today, there are 109 State Veterans' Homes 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 healthcare needs of older veterans, it is essential that the State Veterans' Home Program be maintained as a viable and important alternative healthcare provider to the VA system. The American Legion opposes any attempts to place moratoria on new State Veterans' Home construction grants. 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 could result in cost overruns from increasing building materials costs and may result in states deciding to cancel these much-needed facilities.

The American Legion supports:

- increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans' Homes;
- the provision of prescription drugs and over-the-counter medications to State Veterans' Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and
- allowing 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 2008, $165 million more than the President's budget request. This additional funding will address more pending life-safety projects and new construction projects.

STATE CEMETERY GRANTS PROGRAM

The State Veterans' Cemetery Grant Program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated ceme-

teries can be used to establish, expand and improve on existing cemeteries. States are planning to open 24 new state veterans' cemeteries between 2007 and 2012. There are 60 operational cemeteries and two more under construction. Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $42 million for the State Cemetery Grants Program in FY 2008, $10 million more than the President's budget request.

NATIONAL CEMETERY ADMINISTRATION

The mission of the National Cemetery Administration is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to this Nation. The National Cemetery Administration's vision is to serve all veterans and their families with the utmost dignity, respect, and compassion. Every national cemetery should be a place that inspires visitors to understand and appreciate the service and sacrifice of this Nation's veterans.

National Cemetery Expansion

The American Legion supported P.L. 108–109, the National Cemetery Expansion Act of 2003, authorizing VA to establish new national cemeteries to serve veterans in the areas of: Bakersfield, Calif.; Birmingham, Ala.; Jacksonville, Fla.; Sarasota County, Fla.; southeastern Pennsylvania; and Columbia-Greenville, S.C. All six areas have veterans' populations exceeding 170,000, which is the threshold VA has established for new national cemeteries. By 2009, all six new national cemeteries should be open to serve veterans in these areas.

There are approximately 24 million veterans alive today. Nearly 688,000 veteran deaths are estimated to occur in 2008. The total number of graves maintained by VA is expected to increase from 2.8 million in 2006 to just over 3.2 million by 2012. The VA expects that at least 12 percent of these veterans will request burial in a national cemetery. Considering the growing costs of burial services and the excellent quality of service the NCA is providing, The American Legion foresees that this percentage will be much greater. By 2012, four more national cemeteries are expected to exhaust their supply of available, unassigned gravesites.

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

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. The American Legion supports NCA's goal of completing the National Shrine Commitment within 5 years. This commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this commitment.

The American Legion recommends $178 million for the National Cemetery Administration in FY 2008, $12 million more than the President's budget request.

INFORMATION TECHNOLOGY

The data theft that occurred in May of last year serves as a monumental wake up call to the nation. VA can no longer ignore IT security. The recovery of the laptop is indeed cause for optimism; however, we must not discount the possibility that every name on that list could still be subject to possible identity theft. The complete overhaul of VA IT is only in its beginning stages. Meanwhile, there are still unresolved security breaches within VA including the most recent theft of a laptop from a VA contractor. How many computers need to be stolen before veterans get some real assurances from the Federal Government that their information is not only safe, but that safeguards will be in place to help protect them against identity theft? The American Legion once again calls on VA and the Administration to keep its promise to veterans and provide free credit monitoring for 1 year. The American Legion is hopeful that the steps VA takes to strengthen its IT security will renew the

confidence and trust of veterans who depend on VA for the benefits they have earned.

Funding for the IT overhaul should not be paid for with money from other VA programs. This would in essence make veterans pay for VA's gross negligence in the matter. The American Legion hopes that Congress will not attempt to fix this problem on the backs of America's veterans and from scarce fiscal resources provided to the VA healthcare delivery.

VA has shown it can be a leader in the areas of care and service. Its accomplishments, from providing high quality medical care to leading the world in the development of electronic records, are indicators that VA can also be the nation's leader in IT security.

The American Legion believes that there should be a complete review of IT security governmentwide. VA isn't the only agency within the government that needs to overhaul its IT security protocol. The American Legion would urge Congress to exercise its oversight authority and review each Federal agency to ensure that the personal information of all Americans is secure.

The American Legion agrees with the President's budget request for $1.9 billion for Information Technology in FY 2008.

VA's LONG–TERM CARE MISSION

Historically, VA's Long-Term Care (LTC) has been the subject of discussion and legislation for nearly two decades. In a landmark July 1984 study, *Caring for the Older Veteran*, it was predicted that a wave of elderly veterans had the potential to overwhelm VA's long-term care capacity. Further, the recommendations of the Federal Advisory Committee on the Future of Long-Term Care in its 1998 report *VA Long-Term Care at the Crossroads*, made recommendations that serve as the foundation for VA's national strategy to revitalize and reengineer long-term care services. It is now 2006 and that wave of veterans has arrived.

Additionally, Public Law 106–117, the Millennium Act, enacted in November 1999, required VA to continue to ensure 1998 levels of extended care services (defined as VA nursing home care, VA domiciliary, VA home-based primary care, and VA adult day healthcare) in its facilities. Yet, VA has continually failed to maintain the 1998 bed levels mandated by law.

VA's inability to adequately address the long-term care problem facing the agency was most notable during the CARES process. The planning for the long-term care mission, one of the major services VA provides to veterans, was not even addressed in the CARES initiative. That CARES initiative is touted as the most comprehensive analysis of VA's healthcare infrastructure that has ever been conducted.

Incredibly, despite 20 years of forewarning, the CARES Commission report to the VA Secretary states that VA has yet to develop a long-term care strategic plan with well-articulated policies that address the issues of access and integrated planning for the long-term care of seriously mentally ill veterans. The Commission also reported that VA had not yet developed a consistent rationale for the placement of long-term care units. It was not for the lack of prior studies that VA has never had a coordinated long-term care strategy. The Secretary's CARES decision agreed with the Commission and directed VHA to develop a strategic plan, taking into consideration all of the complexities involved in providing such care across the VA system.

The American Legion supports the publishing and implementation of a long-term care strategic plan that addresses the rising long-term care needs of America's veterans. We are, however, disappointed that it has now been over 2 years since the CARES decision and no plan has been published.

It is vital that VA meet the long-term care requirements of the Millennium Health Care Act and we urge this Committee to support adequate funding for VA to meet the long-term care needs of America's Veterans. The American Legion supports the President's $4.6 billion funding recommendation for FY 2008.

HOMELESS VETERANS

VA has estimated that there are at least 250,000 homeless veterans in America and approximately 500,000 experience homelessness in a given year. Most homeless veterans are single men; however, the number of single women with children has drastically increased within the last few years. Homeless female veterans tend to be younger, are more likely to be married, and are less likely to be employed. They are also more likely to suffer from serious psychiatric illness.

Approximately 40 percent of homeless veterans suffer from mental illness and 80 percent have alcohol or other drug abuse problems. It cannot go unnoticed that the increase in homeless veterans coincides with the under-funding of VA healthcare, which resulted in the downsizing of inpatient mental health capabilities in VA hos-

pitals across the country. Since 1996, VA has closed 64 percent of its psychiatric beds and 90 percent of its substance abuse beds. It is no surprise that many of these displaced patients end up in jail, or on the streets. The American Legion applauds VA's recent plan to restore a good portion of this capacity. The American Legion believes there should be a focus on the prevention of homelessness, not just measures to respond to it. Preventing it is the most important step to ending it.

The American Legion has a vision to assist in ending homelessness among veterans, by ensuring services are available to respond to veterans and their families in need before they experience homelessness. Toward that objective, The American Legion in partnership with the National Coalition for Homeless Veterans created a Homeless Veterans Task Force. The mission of the Task Force is to develop and implement solutions to end homelessness among veterans through collaborating with government agencies, homeless providers and other veteran service organizations. In the last 2 years, 16 homeless veterans workshops were conducted during The American Legion National Leadership Conferences, National Convention and Mid-Winter Conferences. Currently, there are 51 Homeless Veterans Chairpersons within The American Legion who act as liaison to Federal, state and community homeless agencies and monitor fundraising, volunteerism, advocacy and homeless prevention activities within participating American Legion Departments.

The current Administration has vowed to end the scourge of homelessness within 10 years. The clock is running on this commitment, yet words far exceed deeds. While less than 9 percent of the nation's population are veterans, 34 percent of the nation's homeless are veterans and of those 75 percent are wartime veterans.

Homelessness in America is a travesty, and veterans' homelessness is disgraceful. Left unattended and forgotten, these men and women, who once proudly wore the uniforms of this nation's armed forces and defended her shores, are now wandering her streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending homelessness among America's veterans, there is much more that needs to be done. We must not forget them. The American Legion supports funding that will lead to the goal of ending homelessness in the next 10 years.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, P.L. 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

The American Legion strongly supports changing the Grant and Per Diem Program to be funded on a 5-year period instead of annually and a funding level increase to the $200 million level annually.

VETERANS BENEFITS ADMINISTRATION (VBA)

The VA has a statutory responsibility to ensure the welfare of the nation's veterans, their families, and survivors. Providing quality decisions in a timely manner has been, and will continue to be, one of the VA's most difficult challenges.

Workload and Claims Backlog

There are approximately 3.5 million veterans and beneficiaries currently receiving VA compensation and pension benefits. In 2006, VA added almost 250,000 new beneficiaries to the compensation and pension rolls. VA anticipates receiving about 800,000 claims a year in 2007 and 2008. The current staffing levels do not enable VA to reduce the pending claims inventory and provide timely service to veterans; therefore, the President is requesting an increase of 457 full-time equivalents compensation and pension personnel. The productivity of the additional staff will increase throughout 2008 and in subsequent years as these new employees receive training and gain experience. VA believes the additional staffing will enable VBA to improve claims processing timeliness, reduce appeals workload, improve appeals processing timeliness, and enhance services to veterans returning from the Global War on Terrorism.

The increasing complexity of VA claims adjudication continues to be a major challenge for VA rating specialists. Since judicial review of veterans' claims was enacted in 1988, the remand rate of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC) has, historically, been about 50 percent. In a series of precedent-setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, a number of longstanding VA policies and regulations have been invalidated because they were not consistent with statute. These court decisions immediately added thousands of cases to regional office workloads, since

they require the review and reworking of tens of thousands of completed and pending claims.

As of August 19, 2006, there were more than 389,000 rating cases pending in the VBA system. Of these, 92,047 (23.6 percent) have been pending for more than 180 days. According to the VA, the appeals rate has also increased from a historical rate of about 7 percent of all rating decisions being appealed to a current rate that fluctuates from 11 to 14 percent. This equates to more than 152,000 appeals currently pending at VA regional offices, with more than 132,000 requiring some type of further adjudicative action.

Staffing

Whether complex or simple, VA regional offices are expected to consistently develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner. The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VBA has lost much of its institutional knowledge base over the past 4 years, due to the retirement of many of its 30-plus year employees. As a result, staffing at most regional offices is made up largely of trainees with less than 5 years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their initial training.

Concern over adequate staffing in VBA to handle its demanding workload was addressed by VA's Office of the Inspector General (IG) in a report released in May 2005 (Report No. 05–00765–137, dated May 19, 2005). The IG specifically recommended, "in view of growing demand, the need for quality and timely decisions, and the ongoing training requirements, reevaluate human resources and ensure that the VBA field organization is adequately staffed and equipped to meet mission requirements." The Under Secretary for Benefits has conceded that the number of personnel has decreased over the last few years. And the congressionally mandated Veterans' Disability Benefits Commission is also closely looking at the adequacy of current staffing levels.

It is an extreme disservice to veterans, not to mention unrealistic, to expect VA to continue to process an ever increasing workload, while maintaining quality and timeliness, with less staff. Our current wartime situation provides an excellent opportunity for VA to actively seek out returning veterans from Operations Enduring Freedom and Iraqi Freedom, especially those with service-connected disabilities, for employment opportunities within VBA. To ensure VA and VBA are meeting their responsibilities, The American Legion strongly urges Congress to scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

GI BILL EDUCATION BENEFITS

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. We believe this is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average 4-year public institution as a commuter student during the 1999–2000 academic year was nearly $9,000. On October 1, 2005, the basic monthly rate of reimbursement under MGIB was raised to $1,034 per month for a successful 4-year enlistment and $840 for an individual whose initial active duty obligation was less than 3 years. The current educational assistance allowance for persons training full-time under the MGIB Selected Reserve is $297 per month.

The Servicemen's Readjustment Act of 1944, P.L. 78–346, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that act. Consequently, these former service members made a substantial contribution not only to their own careers, but also to the economic wellbeing of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that

the government actually made a profit, because veterans who had graduated from college generally earned higher salaries and, therefore, paid more taxes.

Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also making a greater contribution to their community, state, and nation.

The American Legion recommends the 110th Congress make the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify;
- The educational cost index should be reviewed and adjusted annually;
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package;
- Enrollment in the MGIB shall be automatic upon enlistment; however; benefits will not be awarded unless eligibility criteria have been met;
- The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated;
- If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans;
- If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB;
- Separating service members and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device;
- Eligible veterans shall have an unlimited number of years after discharge to utilize MGIB educational benefits;
- Eligible veterans should have the right to transfer their earned benefits to their spouse and dependents; and
- Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years after their date of separation to use MGIB educational benefits.

VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICE (VR&E)

The mission of the VR&E program is to help qualified, service-disabled veterans achieve independence in daily living and, to the maximum extent feasible, obtain and maintain suitable employment. The American Legion fully supports these goals. As a nation at war, there continues to be an increasing need for VR&E services to assist Operations Iraqi Freedom and Enduring Freedom veterans in reintegrating into independent living, achieving the highest possible quality of life, and securing meaningful employment. To meet America's obligation to these specific veterans, VA leadership must focus on marked improvements in case management, vocational counseling, and—most importantly—job placement.

The successful rehabilitation of our severely disabled veterans is determined by the coordinated efforts of every Federal agency (DoD, VA, DoL, OPM, HUD, etc.) involved in the seamless transition from the battlefield to the civilian workplace. Timely access to quality healthcare services, favorable physical rehabilitation, vocational training, and job placement play a critical role in the "seamless transition" of each and every veteran, as well as his or her family.

Administration of VR&E and its programs is a responsibility of the Veterans Benefits Administration (VBA). Providing effective employment programs through VR&E must become a priority. Until recently, VR&E's primary focus has been providing veterans with skills training, rather than providing assistance in obtaining meaningful employment. Clearly, any employability plan that doesn't achieve the ultimate objective—a job—is falling short of actually helping those veterans seeking assistance in transitioning into the civilian workforce.

Vocational counseling also plays a vital role in identifying barriers to employment and matching veterans' transferable job skills with those career opportunities available for fully qualified candidates. Becoming fully qualified becomes the next logical objective toward successful transition.

Veterans Preference in Federal hiring plays an important role in guiding veterans to career possibilities within the Federal Government and must be preserved. There are scores of employment opportunities within the Federal Government that educated, well-trained, and motivated veterans can fill—given a fair and equitable

chance to compete. Working together, all Federal agencies should identify those vocational fields, especially those with high turnover rates, suitable for VR&E applicants. Career fields like information technology, claims adjudications, debt collection, etc., offer employment opportunities and challenges for career-oriented applicants that also create career opportunities outside the Federal Government.

GAO has also cited exceptionally high workloads for a limited number of staff members at VR&E offices. This increased workload hinders the staff's ability to effectively assist individual veterans with identifying employment opportunities. In April 2005, the average caseload of a typical VR&E counselor approached 160 veterans. The American Legion is pleased that an additional number of 150 full-time equivalents will be hired and we applaud the President's budget request for $159.5 million in FY 2008. It is vital that Congress approve this request to adequately address the expected increase of veterans needing assistance.

HOME LOAN GUARANTY PROGRAM

VA's Home Loan Guaranty program has been in effect since 1944 and has afforded nearly 17 million veterans the opportunity to purchase homes. The Home Loan programs offer veterans a centralized, affordable and accessible method of purchasing homes in return for their service to this nation. The program has been so successful over past years that not only has the program paid for itself but has also shown a profit in recent years. The American Legion believes that it is unfair for veterans to pay high funding fees of 2 to 3 percent, which can add approximate $3,000 to $11,000 for a first time buyer. The VA funding fee was initially enacted to defray the costs of the VA guaranteed home loan program. The current funding fee paid to VA to defray the cost of the home loan has had a negative effect on many veterans who choose not to participate in this highly beneficial program. Therefore, The American Legion strongly recommends that the VA funding fee on home loans be reduced or eliminated for all veterans whether active duty, reservist, or National Guard.

Specially Adapted Housing

The American Legion believes that with the increasing numbers of disabled veterans returning from Iraq and Afghanistan, the need for specially adapted housing is paramount. Therefore, The American Legion strongly recommends that the current $50,000 grant for specially adapted housing be increased to $55,000 and special home adaptations be increased from $10,000 to $12,300. Specially adapted housing grants are available for the installation of wheelchair ramps, chair lifts, modifications to kitchens and bathrooms and other adaptations to homes for veterans who cannot move about without the use of wheelchairs, canes or braces or who are blind and suffer the loss or loss of use of one lower extremity. Special home adaptation grants are available for veterans who are legally blind or have lost the use of both hands.

SUMMARY

Mr. Chairman and Members of the Committee, The American Legion appreciates the strong relationship we have developed with this Committee. With increasing military commitments worldwide, it is important that we work together to ensure that the services and programs offered through VA are available to the new generation of American service members who will soon return home. You have the power to ensure that their sacrifices are indeed honored with the thanks of a grateful nation.

The American Legion is fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to healthcare, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the nation's call to arms.

Thank you for allowing me the opportunity to appear before you today.

Statement of Brian Lawrence
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the Disabled American Veterans (DAV), which is one of the four member organizations of *The Independent Budget* (IB). We appreciate the opportunity to present the recommendations of the fiscal

year (FY) 2008 IB and compare them to the President's proposed FY 2008 budget for veterans' programs. As you know, the IB is a budget and policy document that sets forth the collective views of the DAV, AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW). Each organization has a principal responsibility for a major component of the budget. My testimony focuses on Department of Veterans (VA) benefit programs, which are administered by the Veterans Benefits Administration (VBA). VBA is further divided into the following services: Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), Education, Loan Guaranty, and Insurance. VBA and its constituent departments are funded under the General Operating Expenses (GOE).

The level of funding sought in the President's FY 2008 budget for VBA is approximately $1.2 billion, an increase of $30 million over last year's level. This amount falls far short of the IB assessment, which anticipates that VBA will require more than $1.9 billion to meet the needs of disabled veterans. The difference between the Administration's and the IB proposals is more than $700 million.

C&P Service

With the Administration's proposed budget, C&P Service would be authorized total 9,559 FTE, which is a total increase of 114. This recommendation does not appear to be aligned with the Administration's stated goal to decrease the number of backlogged compensation claims. For nearly a decade, C&P has struggled to find a way to address claims processing problems and establish a viable long-term claims process. Despite its ongoing efforts, the backlog remains unacceptably high, and disabled veterans and their families suffer the consequences. While a number of factors play a role, the backlog has persisted primarily because of inadequate resources compounded by higher claims volumes. The disability claims workload from returning war veterans and veterans of previous periods has steadily increased since 2000. The IB anticipates that this trend will continue, considering the ongoing hostilities in Iraq and Afghanistan, as well as an aging veteran population. However, the VA perspective is that a slight decrease in the number of claims receipts will occur during 2007 and 2008. This prediction is somewhat troubling, considering that the VA funding shortfall that occurred in 2005 was attributed to error in estimating the number of future claims receipts.

During both FY 2005 and FY 2006, the total number of compensation, pension, and burial claims increased by an average annual rate of 4.5 percent. During this same period, the number of pending claims increased by a total of more than 33 percent. With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, it is reasonable to expect a continuation of inclined rates. Assuming the annual percentage rate of growth remains the same as in preceding years, VA can expect 874,136 claims for C&P in FY 2007. Further complicating this issue is legislation requiring VA to invite veterans in six states to request review of past claims decisions and disability ratings. It is estimated that this outreach project will produce 56,000 additional claims. Given past claims processing times, much of this workload will carry over into FY 2008, making the new total more than 930,000 claims in FY 2008. Clearly, VA will require more resources just to keep the backlog from growing, and it will require a significant increase in resources to fulfill the President's goal to reduce and eventually eliminate the claims backlog.

In its budget submission for FY 2007, VA projected production based an output of 109 claims per direct program FTE. *The Independent Budget* Veterans Service Organizations have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, resulting in compromised quality, higher error and appeal rates, and even more overload on the system, and adding to the claims backlog. The IB asserts a more reasonable estimate of accurate productivity is 100 claims per FTE. With an estimated 930,000 claims in FY 2008, that would require 9,300 direct program FTE. With the FY 2007 level of 1,375 support FTE added, this would require C&P to be authorized 10,675 total FTE for FY 2008.

The IB estimates for the numbers of FTE do not accommodate the kinds of demands that may arise as a consequence of Congressional injection of attorneys into the claims process. The VA claims system was designed to be open, informal, and helpful to veterans. It is reasonable to expect that the involvement of fee-charging lawyers and agents will negatively impact productivity in the claims adjudication process and further bog down the system and eventually lead to the need for even more increases in C&P staffing. For example, VA will have the responsibility of oversight and administration of fee agreements under which the Secretary is to pay the attorney directly from past-due benefits awarded on the basis of the claim. We

believe this leaves open the possibility for abuse. Allowing fee-charging lawyers and agents into the system will profoundly change the administrative claims process to the detriment of veterans and other claimants. We believe there is a potential for wide-ranging unintended consequences that will be beneficial for neither claimants nor the government. Beyond the cost to veterans, added administrative costs for VA are likely to be substantial, without commensurate added advantages or benefits for either.

In addition to recommending additional resources, the IB has identified two other critical areas that VA must address before it can reach its goal to reduce the backlog. First, it must continue to establish and improve training programs to enable newly hired C&P personnel to absorb the tremendous volume of information contained in the laws, regulations, and court decisions pertaining to veterans' benefits claims. This is a monumental task in itself, and it is understandable that newly hired FTE require a considerable 'ramp-up' period before they are able to make accurate claims decisions. As you know, the DAV maintains a National Service Officer (NSO) corps of approximately 260 employees who represent and assist disabled veterans and their dependents throughout the claims process. Each NSO goes through a mandatory training period that lasts anywhere from 16 to 26 months before they are allowed to conduct unsupervised work. A similar extensive training program for VA claims personnel would help to reduce errors along with the number of appeals that are accumulating into a mountainous backlog.

Second, C&P personnel must be accountable for the quality of work they produce. In the past, focus has primarily been on productivity. But producing a high number of claims decisions is detrimental if a significant number of them have to be reworked during an appeals process that adds months or years to the amount of time disabled veterans must wait for the benefits to which they are entitled. C&P personnel who consistently make errors and fail to improve despite remedial training must not be retained in a position where their numerous poor decisions impact disabled veterans.

VA must establish a long-term strategy focused principally on attaining quality and not merely achieving production quotas in claims processing, or emphasizing how well and efficient it deals with the needs of new veterans of current wars. It must obtain supplementary resources for VBA, and it must invest these in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can VBA proceed in a way that veterans' needs are addressed timely with the effects of disability alleviated by prompt delivery of appropriate benefits.

VR&E

For VR&E Service, the President's budget seeks funding for 1,260 FTE. The IB recommends 1,375 FTE for this business line. VR&E's workload is expected to continue to increase primarily as a consequence of the war in Iraq and ongoing hostilities in Afghanistan. Also, given its increased reliance on contract services, VR&E needs additional FTE dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA Vocational Rehabilitation and Employment Task Force recommended in its March 2004 report creation and training of new staff positions for this purpose. Other new initiatives recommended by the Task Force also require an investment of personnel resources. To implement reforms to improve the effectiveness and efficiency of its programs, the Task Force recommended that VA should add new FTE positions to the VR&E workforce. The FY 2007 total of 1,125 FTE for VR&E should be increased by 250, to 1,375 total FTE.

Education Service

For Education Service, the President's budget seeks funding for 894 FTE. While we appreciate the additional support, we believe the President's recommended staffing level for Education Service falls short of what is needed. As it has with its other benefit programs, VA has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during recent years, direct program FTE were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2008. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTE at the end of FY 2003 in relation to the workload at that time, VBA must increase direct program staffing in its Education Service in FY 2008 to 873 FTE,

149 more direct program FTE than authorized for FY 2007. With the addition of the 160 support FTE as currently authorized, Education Service should be provided 1,033 total FTE for FY 2008.

Other Suggested Benefit Improvements

The benefit programs are effective for their intended purposes only to the extent VBA can deliver benefits to entitled veterans and dependents in a timely fashion. However, in addition to ensuring that VBA has the resources necessary to accomplish its mission in that manner, Congress must also make adjustments to the programs from time to time to address increases in the cost of living and needed improvements. The IB makes a number of recommendations to adjust rates and improve the benefit programs administered by VBA. Some of those recommendations are:

- Establish cost-of-living-adjustments (COLAs) for compensation, dependency and indemnity compensation (DIC).
- Reject extension of provisions for rounding down compensation COLAs and allow current temporary provisions to expire.
- Increase specially adapted housing grants and provide for automatic annual COLAs.
- Increase automobile and adaptive equipment grants and provide for automatic annual COLAs.
- Establish a grant to cover the costs of home adaptations for veterans who replace their specially adapted homes with new housing.
- Increase rates of payment to veterans who are housebound or in need of regular aid-and-attendance due to service-connected disabilities.
- Establish presumption of service connection for hearing loss and tinnitus for veterans whose military duties involved high level noise exposure or combat.
- Protect veterans' benefits against awards to third parties in divorce actions.
- Eliminate remaining offset between career military retirement pay and VA compensation.
- Eliminate offset between DIC and the Survivor Benefit Plan.
- Increase DIC for survivors of military personnel who died on active duty.
- Lower age requirement for reinstatement of DIC to re-married survivors of service-connected veterans, from 57 to 55 years of age.
- Repeal funding fees for VA home loan guaranty.
- Update premium schedule for SDVI to reflect current mortality tables.
- Increase maximum protection of SDVI policies to at least $50,000.
- Increase maximum protection of Veterans' Mortgage Life Insurance from $90,000 to $150,000.
- Reject recommendations to compensate service-connected disabilities through payment of lump-sum settlements to veterans.

We invite the Committee's attention to the section of the IB addressing the Benefit Programs for details on these and other IB recommendations for improvement.

Another important component of our system of veterans' benefits is the right to appeal VA's benefits decisions to an independent court. The IB includes recommendations to improve the processes of judicial review in veterans' benefits matters. Again, we invite the Committee's attention to the IB for the details of these recommendations. In addition, the IB recommends that Congress enact legislation to authorize and fund construction of a courthouse and justice center for the United States Court of Appeals for Veterans Claims.

Closing

In preparing the IB, the four partners draw upon their extensive experience with the workings of veterans' programs, their firsthand knowledge of the needs of America's veterans, and the information gained from their continual monitoring of workloads and demands upon, as well as the performance of, the veterans' benefits system. Historically, this Committee has acted favorably on many of our recommendations to improve services to veterans and their families, and we hope you will give our recommendations full and serious consideration again this year.

Statement of Carl Blake
National Legislative Director, Paralyzed Veterans of America

Mr. Chairman and Members of the Committee, as one of the four co-authors of *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) healthcare system for FY 2008.

PVA, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, is proud to come before you this year marking the beginning of the third decade of *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, healthcare costs and healthcare demand to reach its recommended levels. This year, the document is endorsed by 53 veterans' service organizations, and medical and healthcare advocacy groups.

Last year proved to be a unique year for reasons very different from 2005. The VA faced a tremendous budgetary shortfall during FY 2005 that was subsequently addressed through supplemental appropriations and additional funds added to the FY 2006 appropriation. For FY 2007, the Administration submitted a budget request that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again.

Unfortunately, even as we testify today, Congress has yet to complete the appropriations bill more than one-third of the way through the current fiscal year. Despite the positive outlook for funding as outlined in H.J. Res. 20, the FY 2007 Continuing Resolution, the VA has been placed in a critical situation where it is forced to ration care and place freezes on hiring of much needed medical staff. Waiting times have also continued to increase. Furthermore, the VA has had to cannibalize other accounts in order to continue to provide medical services, jeopardizing not only the VA healthcare system but the actual healthcare of veterans. It is unconscionable that Congress has allowed partisan politics and political wrangling to trump the needs of the men and women who have served and continue to serve in harm's way.

For FY 2008, the Administration has requested $34.2 billion for veterans' healthcare, a $1.9 billion increase over the levels established in H.J. Res. 20, the continuing resolution for FY 2007. Although we recognize this as another step forward, it still falls well short of the recommendations of *The Independent Budget*. For FY 2008, *The Independent Budget* recommends approximately $36.3 billion, an increase of $4.0 billion over the FY 2007 appropriation level yet to be enacted and approximately $2.1 billion over the Administration's request.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA healthcare funding level. For FY 2008, *The Independent Budget* recommends approximately $29.0 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

	(Dollars in Thousands)
Current Services Estimate	$26,302,464
Increase in Patient Workload	$ 1,446,636
Increase in Full-time Employees	$ 105,120
Policy Initiatives	$ 1,125,000
Total FY 2008 Medical Services	$28,979,220

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 5-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 5.5 percent increase in workload. This projected increase reflects the historical trend in the workload increase over the last 5 years. The policy initiatives include $500 million for improvement of mental health services, $325 million for funding the fourth mission (an amount that nearly matches current VA expenditures for emergency preparedness and homeland

security as outlined in the 2007 Mid-Session Review), and $300 million to support centralized prosthetics funding.

For Medical Administration, *The Independent Budget* recommends approximately $3.4 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $4.0 billion. This recommendation includes an additional $250 million above the FY 2008 baseline in order to begin to address the non-recurring maintenance needs of the VA.

Although *The Independent Budget* healthcare recommendation does not include additional money to provide for the healthcare needs of category 8 veterans now being denied enrollment into the system, we believe that adequate resources should be provided to overturn this policy decision. VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA healthcare system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million. *The Independent Budget* veterans service organizations (IBVSO) believe the system should be reopened to these veterans and that this money should be appropriated in addition to our Medical Care recommendation.

Although not proposed to have a direct impact on veterans' healthcare, we are deeply disappointed that the Administration chose to once again recommend an increase in prescription drug co-payments from $8 to $15 and an indexed enrollment fee based on veterans' incomes. These proposals will simply add additional financial strain to many veterans, including PVA members and other veterans with catastrophic disabilities. Although the VA does not overtly explain the impact of these proposals, similar proposals in the past have estimated that nearly 200,000 veterans will leave the system and more than 1,000,000 veterans will choose not to enroll. It is astounding that this Administration would continue to recommend policies that would push veterans away from the best healthcare system in the world. Congress has soundly rejected these proposals in the past and we call on you to do so once again.

For Medical and Prosthetic Research, *The Independent Budget* is recommending $480 million. This represents a $66 million increase over the FY 2007 appropriated level established in the continuing resolution and $69 million over the Administration's request for FY 2008. We are very concerned that the Medical and Prosthetic Research account continues to face a virtual flatline in its funding level. Research is a vital part of veterans' healthcare, and an essential mission for our national healthcare 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.

The Independent Budget recommendation also recognizes a significant difference in our recommended amount of $1.34 billion for Information Technology versus the Administration's recommended level of $1.90 billion. However, when compared to the account structure that *The Independent Budget* utilizes, the Administration's recommendation amounts to approximately $1.30 billion. The Administration's request also includes approximately $555 million in transfers from all three accounts in Medical Care as well as the Veterans Benefits Administration and the National Cemetery Administration. Unfortunately, these transfers are only partially defined in the Administration's budget justification documents. Given the fact that the veterans' service organizations have been largely excluded from the discussion of how the Information Technology reorganization would take place and the fact that little or no explanation was provided in last year's budget submission, our Information Technology recommendation reflects what information was available to us and the funding levels that Congress deemed appropriate from last year. We certainly could not have foreseen the VA's plan to shift additional personnel and related operations expenses.

Finally, we remain concerned that the Major and Minor Construction accounts continue to be underfunded. Although the Administration's request includes a fair increase in Major Construction from the expected appropriations level of $399 million to $727 million, it still does not go far enough to address the significant infrastructure needs of the VA. Furthermore, the actual portion of the Major Construction account that will be devoted to Veterans Health Administration infrastructure is only approximately $560 million. We also believe that the Minor Construction request of approximately $233 million does little to help the VA offset the rising tide of necessary infrastructure upgrades. Without the necessary funding to address minor construction needs, these projects will become major construction problems in short order. For FY 2008, *The Independent Budget* recommends approximately $1.6 billion for Major Construction and $541 million for Minor Construction.

In closing, to address the problem of adequate resources provided in a timely manner, *The Independent Budget* has proposed that funding for veterans' healthcare

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 healthcare funding mandatory would not create a new entitlement, rather, it would change the manner of healthcare 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.

In the end, 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.

Statement of Dennis M. Cullinan, National Legislative Director
Veterans of Foreign Wars of the United States

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW), this nation's largest combat veterans' organization, I would like to thank you for the opportunity to testify today on the Fiscal Year 2008 budget for the Department of Veterans Affairs (VA).

The VA construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a system-wide, data-drive assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, *The Independent Budget* veterans' service organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

- 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
- 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
- 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
- 2004—February: VA Secretary receives CARES Commission recommendations.
- 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES website, www.va.gov/cares. As of December 2006, only ten of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES Decision document and its established priorities, or with the findings of the CARES review commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and Members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past *Independent Budgets* we warned against this, pointing out that there were a number of legitimate construction needs identified by the local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note this year that both Veterans' Committees have considered legislation that would authorize resumption of VA major medical facility construction projects, but with the breakdown of the appropriations process, these projects died with the end of the 109th Congress.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in fiscal year 2007, the Administration recommended a paltry $399 million for major construction.

After that 5-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for construction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

Category	**Funding (Dollars in Thousands)**
CARES	1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
TOTAL	$1,602,000

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its 5-year capital plan in fiscal year 2008.

Category	Funding (Dollars in Thousands)
CARES/Non-CARES	450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
TOTAL	$ 541,000

Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for our Nation's veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that healthcare can be provided in safe and functional facilities long into the future.

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Price Waterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the lifespan of VA's facilities. Examples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under the Medical Care account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for healthcare, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.

VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget veteran's service organizations (IBVSOs) continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73

critical VA facilities that, based on FEMA definitions, are at a "moderately high" or greater risk of seismic incident. Twenty-four of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of healthcare and services as well as for cost-effectiveness, it also results in higher up front project costs, which would require an increase in the construction budget.

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections.

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

The Independent Budget veteran's service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities, for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified need, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program and a more comprehensive examination as part of a master plan later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of these important programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The Commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."

Moreover, the Commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

We also concur with the CARES Commission's recommendations that VA take action to ensure consistent availability of mental health services across the system to include mental healthcare at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental healthcare services, especially with the unprecedented current need for these services, and the likely tremendous long-term need of our returning service members.

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect of everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

VA should develop a plan for addressing its excess space in non-historic properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/spinal cord disorders.

With the largest healthcare system in the U.S., VA has an advantage in its ability to develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designer, clinician, staff, and management during the design process. These design guides, which are viewable on the Facilities Management webpage, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in over a decade, despite the massive transition of the VA healthcare system from an inpatient-based system. *The Independent Budget* veterans' service organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at spinal cord injury/dysfunction (SCI/D) centers. It is important that these guides be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

The Department of Veterans Affairs' extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These

structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget veterans' service organizations recommend that VA establish partnerships with other Federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108–422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage, and encourage its use.

VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the Committee may have.

Statement of John Rowan
National President, Vietnam Veterans of America

Chairman Filner, Ranking Member Buyer and distinguished Members of the Committee, on behalf of all of our officers, Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify regarding the President's fiscal year 2008 budget request for the Department of Veterans Affairs today. I am pleased to welcome so many new and returning Members onto the Committee this year. VVA looks forward to working with all of you to address the needs of the unique system created to serve our nation's veterans.

I particularly wish to thank you, Mr. Chairman, for your impassioned and erudite speech to the Majority caucus that resulted in $3.6 billion being added to the continuing resolution for healthcare at the Veterans Health Administration. Your willingness to take a strong stand when it was not yet the conventional wisdom once again helped America, particularly America's veterans and our families. VVA thanks you for your strong leadership, and salutes your lifelong willingness to "speak truth to power."

Mr. Chairman, several years ago, Vietnam Veterans of America developed a White Paper in support of the need for assured funding for the veterans healthcare system, which I know you have read and shared with others. I also know you have been a long-time supporter of legislation to achieve assured funding. You have always understood the need for such a mechanism to correct the problems in the current system of funding. As we have this discussion in regard to the FY '08 budget for VA, the readily apparent need for this legislation has never been more pressing. We look forward to working with you to ensure its enactment.

VVA does wish to recognize that this year's request from the President for the VA Budget, while lacking in many other respects, is relatively free of budget gimmicks that have so plagued discussions in the past. VVA believes that this is due to the strong efforts of Secretary Nicholson in doing battle to strip out the favorite gimcrackery of that permanent staff over at the Office of Management and Budget (OMB). VVA commends the Secretary of Veterans' Affairs in this regard for seeking to have an honestly presented budget proposal.

Veterans Health Administration

VVA is recommending an increase of $6.9 billion to the expected fiscal year 2007 appropriation for the medical care business line. We recognize that the budget rec-

ommendation VVA is making this year is extraordinary, but with troops in the field, years of underfunding of healthcare organizational capacity, renovation of an archaic and dilapidated infrastructure, and updating capital equipment and several cohorts of war veterans reaching ages of peak healthcare utilization, these are extraordinary times. It's past time to meet these needs.

In contrast to what is clearly needed, we believe the Administration's fiscal year 2008 request for $2 billion more than the expected 2007 appropriation in the continuing resolution is inadequate. Unfortunately, we still are unsure of the bottom line for fiscal year 2007. While we certainly appreciate that the Congress is planning to restore funding for veterans healthcare in the continuing resolution (and it is essential that it does so to ensure the Department's ability to meet ongoing obligations), the fact that VA is still uncertain about the amount of funding it will receive a third of the way through the fiscal year does, in and of itself, make the case for assured funding.

The $2 billion increase the Administration has requested for medical care may almost keep pace with inflation, but it will not allow VA to enhance its healthcare or mental healthcare services for returning veterans, restore diminished staff in key disciplines like clinicians needed to care for hepatitis C, restore needed long-term care programs for aging veterans, or allow working-class veterans to return to their healthcare system. VVA's recommendation does accommodate these goals, in addition to restoring eligibility to veterans exposed to Agent Orange for the care of their related conditions.

I need not tell you about the many successes of the Department of Veterans Affairs in recent years. The veterans' service organizations are often seen as critics of the Department. While we sometimes take exception to its policy decisions, we are also its most stalwart champions. Over the last decade the Veterans Health Administration (VHA) at VA has taken steps to become a higher quality, more accessible healthcare system. It has demonstrated great efficiency by almost doubling the number of veterans it treats while holding per capita costs relatively constant. It has developed hundreds of Community Based Outreach Clinics (CBOC). VHA has received many prestigious awards for excellence and innovation. While VVA remains extremely concerned about recent breaches that compromised veterans' personal data, VVA appreciates the fact that VA has put together a computerized system of medical records that sets the standard for modern healthcare delivery. These achievements are to be celebrated.

Yet these advances have not come without cost. For years, the veterans' healthcare system has been falling behind in meeting the healthcare needs of some veterans. At the beginning of 2003, the former Secretary of Veterans Affairs made the decision to bar so-called priority 8 veterans from enrolling. In most cases, these veterans are not the well-to-do—they are working class veterans or veterans living on fixed incomes whose incomes are as little as $28,000 a year. It's not uncommon to hear about such veterans choosing between getting their prescription drug orders filled and paying their utility bills. The decision to bar these veterans is still standing, and it is still troubling to thoughtful Americans.

In addition to the current bar on healthcare enrollment, in recent years VA has sent Congress a budget that requires more cost sharing from veterans, and eliminates options for their care—particularly long term care. We appreciate that VA's proposal this year has not presumed enactment of some of the cost-sharing legislative proposals Congress has opposed in the past. This may allow Congress more leeway to augment its request in concrete ways rather than merely filling deficits left by the Administration presuming that revenues and savings from these unpopular initiatives will be realized.

Congress is to be commended for turning back many legislative requests for enrollment fees and outpatient cost increases, which would have jeopardized hundreds of thousands of veterans' access to healthcare. Hard-fought Congressional add-ons, such as the $3.6 billion for fiscal year 2007 currently being debated as part of the continuing resolution, have kept the system afloat. The budget recommended by VVA in addition to the enactment of some assured funding mechanism will enable a robust healthcare system to meet the needs of all eligible veterans—now and in the future.

Medical Services

For medical services for fiscal year 2008, VVA recommends $34.5 billion including collections. This is approximately $5 billion more than the Administration's request for fiscal year 2008. VVA is making its budget recommendations based on re-opening access to the millions of veterans disenfranchised by the Department's policy decision of early 2003, that was supposed to be "temporary." The former Ranking Member of this Committee, Lane Evans, discovered that a quarter million priority

8 veterans had applied for care in fiscal year 2005. Similar numbers of veterans have likely applied in each of the years since their enrollment was barred. Our budget allows 1.5 million new priority 7 and 8 veterans to enroll for care in their healthcare system. While this may sound like too great a lift for the system, use rates for priority 7 and 8 veterans are much lower than for other priority groups. Based on our estimates, it may yield only an 8% increase in demand at a cost of about $1.5 billion to the system for additional personnel, supplies and facilities.

The budget ax has fallen hard on long-term care programs in the VA. About a decade ago, there was a major policy shift throughout the healthcare industry including with VA, which encouraged programs to deliver as much care as possible outside of beds. In many cases this has been a productive policy. Veterans value the convenience of using nearby community clinics for primary care needs, for example.

However, the change took a great toll on the neuro-psychiatric and long-term care programs that housed and cared for thousands of veterans, often keeping them institutionalized for years. Instead of developing the significant community and outpatient infrastructures that would have been necessary to adequately replace the care for these most vulnerable veterans, the resources were largely diverted to other purposes.

Where have these vets gone? The fiscally challenged Medicaid program supports many of those who need long-term care, adding an additional burden to the states. State homes play an important role in remaining the only VA-sponsored setting that provides ongoing, rather than rehabilitative or restorative, long-term care. VA's mental health programs—some of the finest in the nation—as well as significant advances in pharmaceuticals continue to serve and allow many veterans to recover. However, what are in fact increasing waiting times for mental health programs and the lack of treatment options often contribute to incarceration and homelessness for the most vulnerable of these veterans. Sadly, we hear increasing numbers of stories of veterans of Iraq and Afghanistan whose inability to deal with readjustment post-deployment have lead them to the streets or even suicide.

Mr. Chairman, Vietnam Veterans of America's founding principle is: Never again will one generation of veterans abandon another. This is why we are imploring this Committee to ensure that VA has the imperative and the resources to bolster the mental health programs that should be readily available to serve our young veterans from Iraq and Afghanistan. Experts from within the Department of Defense estimate that as many as 17% of those who serve in Iraq will have issues requiring them to seek post-deployment mental health services and recent studies have shown that four out of five of the veterans who may need post-deployment care are not properly referred to such care. There is good reason to believe that even the rates forecast by DoD may be too low.

VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental healthcare. Its own internal champions—the Committee on Care of the Seriously Mentally Ill and the Advisory Committee on Post Traumatic Stress Disorder, for example, have expressed doubts about VA's mental healthcare capacity to serve these newest vets. As recently as last March, VHA's Undersecretary for Health Policy Coordination told one Commission that mental health services were not available everywhere, and that waiting times often rendered some services "virtually inaccessible." The doubts about capacity to serve new veterans have reverberated in reports done by the Government Accountability Office (GAO). In addition, one recent working paper by Linda Bilmes of the John F. Kennedy School of Government at Harvard University estimates that in a "moderate" scenario in 2008 VA will require $1.8 billion to treat the veterans returning from Iraq and Afghanistan—much of this funding would be used to augment mental healthcare to properly serve these veterans. VA has projected that approximately 260,000 Global War on Terrorism (GWOT) veterans will use the VA healthcare system in FY 2008. VVA and others believe that more than 300,000 "new" veterans will use the VHA system in FY 2008.

A further reason that VA has underestimated the need for medical services is that they continue to use the same formula that they use for CARES, which is a civilian-based model. Mr. Chairman, VVA has testified many times that the VHA must be a veterans' healthcare system and not a general healthcare system that happens to see veterans. The model VA uses was designed for middle-class people who can afford HMOs or other such programs. It projects only one to three "presentations" (things wrong with) patients as opposed to the five to seven that is the average at VHA for veterans. Obviously one using the VA model will continually underestimate overall resources needed to care for the veterans who come to the system by using this civilian formula. Further, VHA has been consistent in underestimating the number of GWOT returnees who will seek services from the system in each of the last 4 years. VVA has corrected these errors in our projections.

In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional billion dollars to assist VA in meeting the long term care and mental healthcare needs of all veterans. These funds should be used to develop or augment with permanent staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as PTSD teams and substance use disorder programs at VA Medical Centers and CBOC, which will be sought after as more troops (including demobilized National Guard and Reserve members) return from ongoing deployments. In addition, VA should be augmenting its nursing home beds and community resources for long term care, particularly at the State veterans' homes.

To assist in developing these programs and augmenting all areas of veterans' care, VVA recommends funding to approximate the staff-to-patient ratio VA had in place before so much of its neuro-psychiatric and long-term care infrastructure was dismantled. This would allow VA to better ensure timely access to care and services. Studies have shown that inadequate staffing—particularly of nurses involved in direct care—is correlated with poorer healthcare outcomes in all medical disciplines. To allow the staffing ratios that prevailed in 1998 for its current user population, VA would have to add more than 20,000 direct care employees—MDs and nurses—at a cost of about $2.2 billion.

The $2.2 billion funding for the staff shortfalls identified by VVA closely corresponds to the funding from unspecified so-called "management efficiencies" VA has had to shoulder throughout this Administration. It is important to realize that the effect of leaving these funding deficiencies unfulfilled is cumulative. That is, each year VA is forced to live with a greater hole in its budget. GAO has joined VSOs and Congress in questioning the extent to which VA has been able to identify and realize the so-called "savings" created by such proposed efficiencies. VA officials have advised GAO that the efficiencies identified in at least two recent budget proposals—FY 2003 and 2004—were developed to allow VA to meet its budget guidance rather than by detailed plans for achieving such savings (GAO–06–359R). In other words, the savings were justified only by the need to meet the Administration's "bottom line." I hope Congress agrees that this is no way to fund our veterans' healthcare system.

Finally, VVA believes Congress did a grave injustice to Vietnam-era veterans. For decades, veterans exposed to Agent Orange and other herbicides containing dioxin had been granted healthcare for conditions that were presumed to be due to this exposure. This special eligibility expired at the end of 2005 and, despite our request, Congress did not reauthorize it. Had Congress simply reauthorized existing authority, VA would have realized no new costs. Now we have heard that the Congressional Budget Office estimates that it will cost more than $300 million to restore this eligibility. Why this eligibility was allowed to expire seems more a matter of dollars than sense to VVA, given the ever mounting body of research that clearly points to conditions such as diabetes being linked to dioxin exposure. However, the pressing need now is to reinstate veterans with these conditions for the higher priority access to services that they deserve.

Medical Facilities

For medical facilities for fiscal year 2008, VVA recommends $5.1 billion. This is approximately $1.5 billion more than the Administration's request for fiscal year 2008. Maintenance of the healthcare system's infrastructure and equipment purchases are often overlooked as Congress and the Administration attempt to correct more glaring problems with patient care. In FY 2006, in just one example, within its medical facilities account VA anticipated spending $145 million on equipment, yet only spent about $81 million. (The rest of the funds went just to meet operating costs to keep the facilities open and operating.) However, these projects can only be neglected for so long before they compromise patient care, and employee safety in addition to risking the loss of outside accreditation. The remainder of the funding was apparently shifted to other more immediate priority areas (i.e., keeping facilities operating in the short run).

VA undertook an intensive process known as CARES (Capital Asset Realignment to Enhance Services) to "right size" its infrastructure, culminating in a May 2004 policy decision that identified approximately $6 billion in construction projects. While for the reasons noted above the VA has consistently underestimated future needs by using a fatally flawed formula, thus far Congress and the Administration have only committed $3.7 billion of this all-too-conservative needed funding.

We believe the CARES estimate to be extremely conservative given that the models projecting healthcare utilization for most services were based on use patterns in generally healthy managed care populations rather than veterans and that the patient population base did not include readmitting Priority 8 veterans, or significant casualties from the current deployments. Notwithstanding our concerns about the

methods used in CARES, very few of the projects VA agrees are needed have been funded since this time. Non-recurring maintenance and capital equipment budgets have also been grievously neglected as administrators have sought to shore up their operating funds.

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60% of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts with a minimum of remaining $2.3 billion.

Medical and Prosthetic Research

For medical and prosthetic research for fiscal year 2008, VVA recommends $460 million. This is approximately $50 million more than the Administration's request for fiscal year 2008. VA research has a long and distinguished portfolio as an integral part of the veterans' healthcare system. Its funding serves as a means to attract top medical schools into valued affiliations and allows VA to attract distinguished academics to its direct care and teaching missions.

VA's research program is distinct from that of the National Institutes of Health because it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing environmental hazard exposures, post-deployment mental health, traumatic brain injury, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

Further, VVA brings to your attention that VA Medical and Prosthetic Research is not currently funding a single study on Agent Orange or other herbicides used in Vietnam, despite the fact that more than 300,000 veterans are now service-connected disabled as a direct result of such exposure in that war. This is unacceptable.

Mr. Chairman, finally I urge this Committee to at long last urge your colleagues on the Appropriations Committee to use the power of the purse to compel VA to obey the law (Public Law 106–419) and conduct the long-delayed National Vietnam Veterans Longitudinal Study. VVA asks that you specifically request report language in the Appropriations bill for Military Construction, Veterans Affairs, and Related Areas that compels VA to advise the Appropriators and the Authorizers as to how VA plans to complete this study properly within 2 years, as a comprehensive mortality and morbidity study.

Assured Funding for Veterans Health Care

Once this Congress provides a budget that shores up VA medical services and facilities, it will need to ensure that VA continues to be funded at a level that allows it to provide high-quality healthcare services to the veterans that need them. That is where enactment of assured funding will come in. Once enacted, an assured funding mechanism will ensure that, at a minimum, annual appropriations cover the cost of inflation and growth in the number of veterans using VA healthcare. It will allow VA administrators some predictability in both how much funding it will receive and when it will be received resulting in higher quality and ultimately more cost-effective care for our veterans.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) is in even more acute need of additional resources and enhanced accountability measures now than they were a year ago. VVA recommends an additional 400 over and above the roughly 470 new staff members that are requested in the President's proposed budget for all of VBA.

Compensation & Pension

VVA recommends adding one hundred staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional $60 million dollars specifically earmarked for additional training for all of those who touch a veterans' claim, institution of a competency based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and state employees, and any others who might presume to at any point touch a veterans' claim.

Vocational Rehabilitation

VVA recommends that you seek to add an additional three hundred specially trained vocational rehabilitation specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. It is clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much, much greater accountability to the VA Vocational Rehabilitation process is absolutely essential if we as a nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

Accountability at VA

So much of what VVA and the Congress find wrong or disturbing at the VA revolves around the pervasive issue of little or no accountability, or imprecise fixing of authority commensurate with accountability mechanisms that are meaningful (and vice versa) in all parts of the VA.

Within the past year VA has finally made significant progress in meeting the minimum goal of at least 3% of all contracts and 3% of all subcontracts being let to service disabled veteran businessowners. Secretary Nicholson, and Deputy Secretary Mansfield, is to be commended on setting the pace for the Federal Government. It is instructive in this discussion, however, that the action directed by the Secretary to put achievement or substantial real progress toward meeting or exceeding the 3% minimum into the performance evaluation of each Director of the twenty-one Veterans Integrated Service Networks (VISNs) was a key element in VA to be the first large agency to reach the goal mandated by law. (Eighty-five percent of all VA procurement is through VHA, primarily through the VISNs) was the key element in this achievement.

All people (particularly people with a great deal of responsibility who work long hours) care about what they feel they have to care about. Putting it in the performance evaluations means that those managers who ignore a requirement do not get an outstanding or superior rating, and hence no bonus. VVA, and now the VA in at least this one instance, has always found that it is amazing how reasonable almost all people can be when you have their full attention.

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

Lastly, there is no excuse for the continuation of the practice of VHA to "lose" tens of millions (sometimes hundreds of millions) of taxpayer dollars that are appropriated to VHA for specific purposes, whether that purpose be to restore organizational capacity to deliver mental health services, particularly for PTSD and other combat trauma wounds, or to conduct outreach to GWOT veterans as well as demobilized National Guard and Reserves returnees from war zone deployments. There is a consistent pattern of VA, particularly VHA, to either really not know what happened to large sums of money given to them for specific reasons, or they are not telling the truth to the Congress and the public. In either case, it is unacceptable, and cannot be tolerated any longer.

In the proposed budget submittal, VVA struggled with accounting for the dollars footnoted in the President's submittal as "Adjusted for IT." We could not find an accurate accounting. When we asked in the 27 hours we had to prepare this submittal, it turns out that no one else that we have spoken to, including the VA officials, can fully explain at least $200(+) million of this "adjustment" either. And this is before they get their hands on the dollars. VVA urges this Committee and your colleagues on Appropriations to make this the year that this sloppy nonsense and dissembling is stopped once and for all. Accountability will only come about when the Congress absolutely demands that these folks be fully accountable for performance, and for accounting for each and every taxpayer dollar.

Thank you again, Mr. Chairman. We look forward to working with you and this distinguished Committee to obtain an excellent budget for VA in this fiscal year, and to ensure the next generation of veterans' wellbeing by enacting assured funding. I will be happy to answer any questions you and your colleagues may have.

PRE–HEARING QUESTIONS FOR THE RECORD

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Committee on Veterans' Affairs
Washington, DC
January 25, 2007

Honorable R. James Nicholson
Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Mr. Secretary:

In preparation for the Committee's consideration of the President's Budget for Fiscal Year 2008, we have developed the attached questions. If we do not get to all of them in the hearing, please respond in writing by February 16, 2007.

Sincerely,

BOB FILNER
Chairman

Enclosures

Benefits:

Question 1: The President has called for an increase in troops to Iraq. In light of the fact that the VA already has a 600,000 claims backlog, please describe in detail how the escalation of the war in Iraq will impair the VA's ability to provide benefits. Also, does the Administration's budget request for FY 2008 reflect this increased demand of VA services that will result from the additional troops serving in Operation Iraqi Freedom (OIF)? If yes, in what areas and in what amounts has the budget been altered to reflect the so-called "surge"?

Response: The 600,000 number referenced in your question represents total pending claims whether or not they require a disability rating decision. As of December 2006, there were 395,539 claims pending that required a rating decision.

The vast majority of the non-rating issues pending are not likely to be affected by the current escalation in the war since they primarily deal with maintenance of veterans' accounts that are already in receipt of benefits. Additionally many of these issues involve non-service connected disability and death pension. While we receive a high volume of non-rating issues, generally, they require minimal external development and are resolved quickly.

There are several factors relating to increasing the size of Operation Iraqi Freedom (OIF) forces that may affect our ability to handle claims volume resulting from any increase in the number of troops deployed as part of OIF. Included in these are the following:

1. The single strongest predictor of claim activity is the size of the active force. If the forces used for the "surge" are drawn from existing personnel serving on active duty, we believe that the downstream impact on claims will be less than if they are drawn from reserve component forces which would increase the size of the active force.
2. The number of deployments impact claims activity. Multiple deployments increase the likelihood a service member will suffer from combat related disabilities such as post traumatic stress disorder. Additionally, there is an increased incidence of non-combat related disabilities based on the mere fact that the service member is on active duty for a longer duration.
3. The duration of the deployment will also affect claim activity in the future. Lengthened tours expose soldiers to increased potential for injury.

The Department of Veterans Affairs' (VA) fiscal year (FY) 2008 budget submission does not reflect increased demand for benefits due to the surge since this strategy had not been decided when the budget was prepared. If the surge in forces in the combat theaters is drawing from existing active duty and already planned activation of Guard and reserve forces, we believe that we have already accounted for the surge in our 2008 projections. If not, we would anticipate some increase in claims receipts in FY 2008.

Question 2: Since the VA has previously failed to adequately predict the demand of services from returning veterans from OIF/Operation Enduring Freedom (OEF) what new methodology is the VA using to properly estimate need and services for these returning veterans? How does the FY 2008 budget reflect this new methodology?

Response: We believe that we have accurately projected disability claims receipts since the beginning of combat operations in Afghanistan and Iraq. The table below shows our projections and actual receipts.

Fiscal Year	Receipts	
	Projected	***Actual***
2004	767,051	771,115
2005	794,248	788,298
2006	811,947*	798,382*

*These figures reflect the core rating receipts and do not include estimated/actual receipts due to the six state outreach effort.

We believe that our current methodology is accurate. VA will be able to adjust its projections once the nature of the surge effort is known.

Question 3: Please provide data concerning the number of claims received from veterans who served in the theater of operations for OIF/OEF and their survivors and the disposition (grant, denial) of such claims for compensation, pension, DIC and death pension.

Response: Available data is based on a match between Department of Defense data on service members deployed in support of the Global War on Terrorism (GWOT) for the period September 11, 2001, through September 30, 2006, and VA data covering September 11, 2001, through August 30, 2006.

This data reflects summary counts of compensation and pension (C&P) benefit activity among veterans deployed overseas in support of GWOT. This data match only identifies deployed GWOT veterans who have also filed a VA disability claim *either prior to or following their GWOT deployment*. Many GWOT veterans had earlier periods of service, and had filed for and received VA disability benefits before being reactivated.

The Veterans Benefit Administration's (VBA) computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment.

For the period covered, 176,111 of nearly 634,000 GWOT veterans have filed a claim for disability benefits either prior to or following their GWOT deployment (approximately 28 percent). This includes survivors' claims for dependency and indemnity compensation (DIC) and death pension. VA has processed nearly 2,000 DIC claims for survivors of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) service members who died in service.

Question 4: With respect to question number three, what was the breakdown among Active Duty, Reservists and National Guard claimants? What percentages of claims were denied for each component? It has been reported that while 37% of Active Duty veterans have filed for service-related disability claims, only 20% of those in the National Guard or Reserves have filed similar claims. However, 18% of the claims filed by National Guard members and Reservists are denied, while only 8% of Active Duty claims are denied.

Response: The following chart displays the disposition of claims filed by all identified GWOT veterans.

Category	Reserves	Active Duty	Total
Deployed Servicemembers	371,974	952,445	1,324,419
Deployed Veterans	339,498	294,369	633,867

Category	Reserves	Active Duty	Total
Claims Filed	68,623	107,488	176,111
	20%	37%	28%
Claims Processed	50,953	85,343	136,296
	74%	79%	77%
Claims Granted	41,744	78,716	120,460
	82%	92%	88%
Claims Denied	9,209	6,627	15,836
	18%	8%	12%
Claims Pending	17,670	22,145	39,815
	26%	21%	23%

The following definitions are provided to assist in understanding this data:

- Claims Denied: None of the veterans' conditions meet eligibility requirements for service connection. This category includes a small number of veterans receiving nonservice-connected disability pension.
- Claims Filed: The sum of "Claims Granted," "Claims Denied," and "Claims Pending."
- Claims Granted: At least one claimed condition meets eligibility requirements for service connection. For veterans who filed for more than one condition, this category includes full grants of all conditions as well as all combinations of disabilities granted and denied. It includes grants of all service-connected disabilities, from 0 to 100 percent, regardless of whether the veteran receives monetary compensation.
- Claims Pending: VA is reviewing these veterans' claims for compensation or pension benefits. This category includes appeals.
- Claims Processed: The total of "Claims Granted" and "Claims Denied." This does not include "Claims Pending."

VA makes absolutely no distinctions in processing claims from active duty or reserve personnel. All claims are considered using the same laws and regulations to determine entitlement to benefits and disability evaluations, and our goal is to ensure all veterans receive the benefits they have earned in service to this nation. We continue to examine the differences in this data for active duty and reserve veterans. While we do not yet fully understand the differences, we believe a significant factor may be length of service. The majority of service-related disabilities are chronic diseases or disabilities that develop over time. Generally, reserve service is shorter than regular active duty service, resulting in a reduced likelihood that these veterans developed chronic service-related disabilities.

Question 5: With respect to individuals residing outside of the United States, please provide data concerning the number of claims received from veterans and their survivors and the disposition (grant, denial) of such claims for compensation, pension, DIC and death pension. Also, how many individuals living in the Philippines received VA benefits and what was the total amount? How many of these individuals do you expect to file for benefits in FY 2008 and what is the predicted amount?

Response: Claims for individuals residing outside the United States are processed based on their country of residence. The Houston Regional Office processes claims for those residing in Mexico, the Caribbean and Central and South America. Claims from residents of Canada are processed by the White River Junction, Vermont Regional Office. The Pittsburgh Regional Office processes claims from all other international claimants. VA does not separately maintain data on the number of claims received or the disposition of those claims for individuals residing outside the United States.

In January 2007, VA benefits totaling $12,655,000 were paid to 14,968 residents of the Philippines, during FY 2005, the last year for which data is available. VA

does not project numbers of expected claims or benefit amounts based on place of residence. Rather, budget projections are based on national projections of expected workload and other factors.

Question 6: Please provide the breakdown of each insurance program under the jurisdiction of the VA. How many of these programs are self funded through premiums? What insurance programs and at what percent and amount derive funds from the Servicemembers Group Life Insurance (SGLI) program?

Response: The insurance program administers six life insurance programs and supervises two additional programs for the benefit of servicepersons, veterans, and their beneficiaries.

Self-Supporting Insurance Programs—The United States Government Life Insurance (USGLI), National Service Life Insurance (NSLI), Veterans' Special Life Insurance (VSLI) and Veterans' Reopened Insurance (VRI) are fully self-supporting programs with the exception of a small amount of funding in the NSLI program which is paid from appropriated funds for the costs of claims traceable to the extra hazards of service in the armed forces. *Appropriated funds were $886,000 in 2006*. These programs are no longer open to new issues and were established to meet the insurance needs of veterans at the time of their service. Each of these funds is operated in basically the same manner. Obligations are financed from offsetting collections and redemption of investments in U.S. Treasury securities. Expenses associated with the administration of each of these programs are financed from excess revenues of each fund.

Service-Disabled Insurance Programs—The Service-Disabled Veterans' Insurance (S–DVI) and Veterans' Mortgage Life Insurance (VMLI) require annual subsidies to support these programs. The S–DVI program requires a subsidy because it provides life insurance protection to veterans with service-connected disabilities at standard premium rates and is, therefore, not self-supporting. Similarly, the VMLI program requires a subsidy because it provides mortgage protection life insurance at standard premium rates to disabled veterans who have received a grant for specially adapted housing. *The subsidy required from appropriated funds for the S–DVI program in 2006 was $37.2 million. The VMLI program required $7.8 million of appropriated funds in 2006*.

Service Members' Group Life Insurance (SGLI)—The SGLI program provides low cost group life insurance protection to persons on active duty and reservists in the military service. Service personnel separated from active duty and the reserves have the right to convert their SGLI coverage to renewable term insurance coverage offered by the VGLI program. SGLI also offers Family Service Members' Group Life Insurance coverage for a service member's spouse and children if the service member is on active duty or in the reserves. Maximum coverage for spouses is $100,000, or the amount of the service member's SGLI, whichever is less. All dependent children are insured for $10,000 at no charge. The SGLI program is supervised by VA and administered, under a contractual agreement, by Prudential Financial through the Office of Service Members' Group Life Insurance (OSGLI). The SGLI program is entirely self-supporting, except for any costs resulting from excess mortality traceable to the extra hazard of duty in the uniformed services. *The extra hazard costs are reimbursed to the SGLI program by the Department of Defense (DoD). Extra hazard costs received from DoD were $405.2 million in 2006*.

Traumatic Injury Protection TSGLI—TSGLI is a traumatic injury protection rider under SGLI that provides for payment between $25,000 and $100,000 (depending on the type of injury) to any member of the uniformed services covered by SGLI who sustains a traumatic injury resulting in certain severe losses. The premium charged for this coverage is $1 per month from each service member insured under SGLI. This premium covers only the civilian incidence of such injuries with any excess program costs above the premiums collected to be paid by DoD. Public Law 109–13 established the TSGLI program as a rider under the SGLI program effective December 1, 2005. This law also contains a retroactive provision that provides a service member who suffered a qualifying loss on or after October 7, 2001, through and including November 30, 2005, with a benefit under TSGLI if the loss was a direct result of a traumatic injury incurred in OEF or OIF. *DoD reimbursed the TSGLI program $202.7 million dollars in 2006, which was comprised of $28.0 million in start-up funds for the TSGLI program, $157.6 for retroactive TSGLI claims, and $17.1 million for prospective TSGLI claims*.

Question 7: Last year, Congress required that Vet Centers provide bereavement counseling to "all" immediate family members of a member of the Armed Forces who dies while on Active Duty. Will this new requirement significantly impact the VA?

Does the VA need to hire additional bereavement counselors to handle this increased mission requirement?

Response: VA has addressed the need for Vet Center support in anticipation of OIF/OEF requirements.

Since the inception of the Vet Center bereavement program in FY 2004, the families of over 900 military casualties have received bereavement services. Of these 900 cases, almost 75 percent of the casualties were from Operation Enduring Freedom and Operation Iraqi Freedom. The number of visits provided to families is approximately 6,500 and the cost for the services is approximately $600,000. The capacity for the increase in current workload was factored into the current budget. The VA is providing these services; increases were anticipated and included in the current Vet Center budget estimate.

In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers have hired additional staff and opened new centers. In February 2004, 50 global war on terrorism (GWOT) veterans were hired to augment the Vet Center existing staff. VA authorized a new 4-person Vet Center in Nashville, Tennessee in November 2004. An additional 50 GWOT veterans were hired in April 2005 to further enhance services to veterans returning from combat in Afghanistan and Iraq. VA established two new Vet Centers (Atlanta, Georgia and Phoenix, Arizona) in April 2006.

In February 2007 a major expansion of the Vet Center program was announced, 23 new vet centers have been announced to be located in Montgomery, Alabama; Fayetteville, Arkansas; Modesto, California; Grand Junction, Colorado; Orlando, Fort Myers, and Gainesville, Florida; Macon, Georgia; Manhattan, Kansas; Baton Rouge, Louisiana; Cape Cod, Massachusetts; Saginaw and Iron Mountain, Michigan; Berlin, New Hampshire; Las Cruces, New Mexico; Binghamton, Middletown, Nassau County and Watertown, New York; Toledo, Ohio; Du Bois, Pennsylvania; Killeen, Texas: and Everett, Washington.

Question 8: Pursuant to section 5313 of title 38, the VA limits the amount of VA compensation that may be paid to a veteran who is incarcerated in a "Federal, State or local penal institution" for more than 60 days for conviction of a felony. In FY 2006, what was the total amount of funds withheld under this statute? This statute was amended last year to include penal facilities run by private entities. What total amount of funds is the VA expected to withhold because of this change in law in FY 2008?

Response: VA does not track funds withheld. We track overpayments, which are the amounts erroneously paid to beneficiaries who are incarcerated. For FY 2005, overpayments from the prison match with Social Security totaled approximately $23,786,000. Data is not yet available for FY 2006.

VA does not separately track overpayments resulting from incarcerations in penal facilities run by private entities. However, VA withheld benefits, even prior to this legislation, if the privately operated penal facility was under contract to a governmental entity. We do not believe this change in law will significantly impact the amount of withholdings or overpayments due to incarceration in FY 2008.

Question 9: Please provide for FY 2005 through 2006, the number of claims processed in each regional office in each year for each separate program: compensation (provide separate data concerning the number of claims involving 8 or more issues and 7 issues or less); dependency and indemnity compensation (DIC); disability pension; pension based upon age and death pension.

Response: The attached spreadsheets contain the data requested. Disability pension includes veterans who have established eligibility based on age. VA does not track separately disability and age-based pension recipients. The specific claim types reported are:

- Original compensation claims with one to seven issues
- Original compensation claims with eight or more issues
- Reopened compensation claims
- All other rating related claims
- Original pension claims
- Reopened pension claims
- Claims for death pension
- Claims for dependency and indemnity compensation (DIC)

Question 10: Please provide for each regional office and the Appeals Management Center the number of remanded appeals pending as of September 30, 2006,

the date the Notice of Disagreement was filed, the date of each remand by the Board of Veterans Appeals and the current status of the claim.

Response: VBA and the Board of Veterans Appeals are currently gathering the data to respond to this request. We will provide this information when it becomes available.

Question 11: Please provide the methodology and rationale for allocating resources to the six regional offices with the highest ratio of pending claims to full time employee equivalents (FTEE) and the six regional offices with the lowest ratio of pending claims to FTEE. Please include data on the number and type of FTEE at these offices, the number of pending claims and the total number of new claims (by type, compensation, pension, DIC, and death pension) for each such office in FY 2006.

Response: VBA's compensation and pension resource allocation model does not allocate staffing based on pending work, or on the ratio of pending work to full time employee equivalents (FTEE) levels. Doing so would have the undesirable consequence of rewarding offices who are unable to reduce their pending inventories. Rather, the model is based on the following four factors: (1) receipts of incoming work, (2) accuracy, (3) timeliness, and (4) appellate work. Receipts are given the greatest weight as the single most important factor driving staffing requirements in regional offices and the factor least under an office's control. The use of accuracy and timeliness measures balance one another, ensuring that staffing decisions are based on both output and accuracy. However, additional FTE is distributed to ROs who demonstrate high levels of quality and productivity. The appellate factor is derived from both output and timeliness measures, rewarding offices that effectively manage their appellate workload. To minimize large variations in staffing allocations from year to year, the model employs a 2-year average for each of these factors.

The methodology is intended to allocate more resources to offices that receive a greater share of the workload, and process claims more efficiently and accurately. However, it is not viewed as an absolute standard for final staffing decisions. VBA leaders use the model as a guide, but then make some adjustments for special circumstances or unique missions performed by a regional office. To assist regional offices experiencing workload difficulties, VBA brokers claims that are ready for a decision to designated resource centers and to offices with higher capacity to finalize claims.

Question 12: Please provide information concerning the number of FTEE assigned to the Board of Veterans Appeals and the Group 7 staff assigned to represent the Secretary at the Board and the ratio of staff to pending appeals at the Board and the Court respectively.

Response: The Board of Veterans' Appeals (Board) will be authorized 437 FTEE in FY 2007 upon passage of the FY 2007 Military Construction and Veterans Affairs and Related Agencies Appropriations Act. Under the third continuing resolution for FY 2007, the Board is authorized 427 FTEE. On September 30, 2006, there were 40,265 appeals pending before the Board. The number of appeals pending before the Board includes the number of appeals physically at the Board (31,707), plus those appeals still in the field that the field offices have identified as ready for a Board hearing (8,558). Accordingly, the ratio of staff to pending appeals at the Board is 1 to 92.1, based on 437 FTEE, and 1 to 94.3, based on 427 FTEE. There are 97 FTEE, in the Office of General Counsel, currently assigned to Professional Staff Group VII (PSG VII), the Veterans Court Appellate Litigation Group. During FY 2006, PSG VII received a total of 4,906 new cases. That number was comprised of 3,656 new appeals from Board decisions, 79 new petitions for extraordinary relief, and 1,171 new applications for attorney fees under the Equal Access to Justice Act. During the first quarter of FY 2007, PSG VII received an additional 1,942 new cases, which consisted of 1,555 new appeals from Board decisions, 18 new writ petitions, and 369 new applications for attorney fees. As of December 31, 2006, the latest date for which we have complete data, there were 5,183 cases pending before the Veterans Court. Accordingly, the ratio of staff (97) to pending cases (5,183) is approximately 1 to 53 at the moment.

Lowest Ratio of Pending Claims to Full Time Employee Equivalents (FTEE)										
Station	**Ratio of Pending Claims to FTE**	**Division Level Managers**	**DRO**	**RVSR**	**VSR/Claims Examiner/ Supervisory VSR**	**LIE/FE**	**Clerk/ Claims Asst.**	**Original Compen-sation Claims Received**	**Original Pension Claims Received**	**Initial Death/DIC Claims Received**
Salt Lake City	22.29	1	2	48	53	2	19	10,686	281	112
Jackson	23.93	2	5	26	57	6	15	2,689	527	398
Muskogee	25.29	2	8	62	100	11	28	4,344	574	856
Columbia	26.78	3	3	47	101	9	28	4,057	990	586
Fargo	31.15	1	2	7	19	2	2	1,060	173	90
Sioux Falls	32.53	1	1	8	16	3	5	812	167	90
Highest Ratio of Pending Claims to Full Time Employee Equivalents (FTEE)										
Station	**Ratio of Pending Claims to FTE**	**Division Level Managers**	**DRO**	**RVSR**	**VSR/Claims Examiner/ Supervisory VSR**	**LIE/FE**	**Clerk/ Claims Asst.**	**Original Compen-sation Claims Received**	**Original Pension Claims Received**	**Initial Death/DIC Claims Received**
Atlanta	68.76	2	12	43	128	11	40	6,838	1,358	1,024
New York	68.91	2	6	27	58	10	24	3,395	735	418
Montgomery	75.37	3	8	30	91	7	28	4,600	1,575	809
Detroit	78.23	2	10	33	85	8	30	5,404	811	463
Chicago	84.07	2	10	33	85	8	30	5,404	877	463
Des Moines	85.13	1	4	10	31	3	12	2,354	670	200

Question 13: Please provide a list of the number of cases in which the Secretary requested more than one extension of time for the same specific filing (such as record on appeal, brief or motion) in the United States Court of Appeals for Veterans Claims for cases which were filed in FY 2006.

Response: Our data reflect that the Secretary sought more than one extension of time for a specific pleading in a total of 1,527 cases during FY 2006. It is worthy to note, however, that under the Court's Rules of Practice and Procedure a party is not permitted to seek more than 45 days of extension time for a specific pleading, absent extraordinary circumstances. Thus, even when the Secretary sought more than one extension of time, the total extension time for that pleading rarely consumed more than 45 days. The Secretary filed a total of 27,238 pleadings during FY 2006, or an average of approximately 2,270 pleadings per month.

Question 14: Please provide an update to the National Cemetery Administration's strategic plan concerning national cemetery repair and maintenance efforts, including costs for activities completed in Fiscal Year 2006 and cost estimates for activities anticipated for Fiscal Year 2008.

Response: The Millennium Act Report to Congress (Volume 2, National Shrine Commitment), issued in August 2002 provides a comprehensive assessment of the condition of VA's national cemeteries. This information is used in the National Cemetery Administration's (NCA) planning process to assist in prioritizing national shrine projects over a multi-year period. The report identified the need for 928 repair projects at an estimated cost of $280 million to ensure a dignified and respectful setting appropriate for each national cemetery. NCA is using the information and data provided in the report to plan and accomplish the repairs needed at each cemetery. Through FY 2006, NCA completed work on 269 projects, and initiated work on additional projects, with an estimated cost of $99 million. These projects account for about 44 percent of the deficiencies identified in the Millennium Act report.

Repairs to address repair/maintenance needs are addressed in a variety of ways. Gravesite renovation projects to raise, realign, and clean headstones and markers and to repair sunken graves are addressed through NCA's operations and maintenance (O/M) account. Infrastructure improvements to buildings, roads, irrigation systems, and historic structures are addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff are used to complete some repairs.

The 2008 budget includes $9.1 million in NCA's O/M account and $2 million in the minor construction request for national shrine projects. Future budget requests tied specifically to the shrine commitment will be prioritized within the context of Departmental priorities. For example, critical gravesite expansion projects require our immediate focus in order to keep existing cemeteries open and to ensure continued service to our nation's veterans and their families.

In addition to specific national shrine projects, a commitment to enhancing the appearance of the national cemeteries underlies all NCA activities. Over 30 percent of NCA's operating budget is used for routine tasks such as mowing, trimming, and other maintenance work. These functions are equally critical to providing an enduring memorial to those we serve.

NCA has also established an organizational assessment and improvement (OAI) program to ensure regular and consistent assessment of performance against established standards. Each national cemetery will be evaluated through site visits conducted on a cyclical basis. A total of 47 national cemeteries have been reviewed under OAI since the program's inception in 2004. In addition, NCA has developed additional performance metrics that will be used to improve the appearance of its national cemeteries. Baseline data was collected in 2004 for three new performance measures designed to assess the condition of individual gravesites, including the cleanliness and proper alignment of headstones and markers. With this baseline data, NCA has identified the gap between current performance and the strategic goal for each measure.

Question 15: Please provide data concerning the State Cemetery Grant Program, including the number of grants awarded in fiscal year 2006, total grant amounts, average grant amounts, and award locations.

Response: In FY 2006, VA spent $17.8 million for grants associated with four projects to establish, expand, or improve State veterans cemeteries. The average grant award was $4.4 million. Grant funding was provided at the following locations:

Anderson, South Carolina ($5.2 million—New Cemetery)
Radcliff (Ft. Knox), Kentucky ($8.5 million—New Cemetery)
Redding, California ($300,000—New Cemetery)
Wrightstown, New Jersey ($3.8 million—Cemetery Expansion)

The FY 2007 and 2008 budget requests include $32 million for this program in each year. There is sufficient State interest in the grant program to use these funds.

Question 16: For fiscal years 2006 and 2007, the VA's Education Service was allocated $19 million from the Readjustment Benefits Account to enter into contracts with State Approving Agencies for purposes of approving courses of education under the Montgomery GI Bill and other related activities. Per section 301 of P.L. 103–330 at the end of fiscal year 2007, the SAA funding will decrease to $13 million. Does the VA plan to request resources to maintain funding at the fiscal year 2007 levels?

Response: VA does not plan to request resources to maintain funding at FY 2007 level.

Question 17: If not why not, and what is the Education Service's plan to maintain program and outreach services, as well as fraud prevention and general oversight over the Montgomery GI Bill programs without the full complement of SAA personnel?

Response: VA deeply values the outreach services performed by the State Approving Agencies (SAA). SAA's are able to travel to many institutions across the United States and fulfill outreach efforts as well as their supervisory and approval functions.

VA will assume their outreach duties, but has not yet had an opportunity to truly evaluate the impact of the reduction in SAA program funding. VA will evaluate the impact in the coming months if it becomes apparent that some necessary outreach is not being accomplished, we will reallocate resources.

Question 18: Does the VA expect to hire additional Education Service staff?

Response: In FY 2007, 32 direct FTEE are added for the Education program and another 14 FTEE will be added in FY 2008.

Question 19: What are the current pending claim workloads for the following Montgomery GI Bill education programs: Ch. 30, Ch. 1606, Ch. 1607 and Ch. 35?

Response: As of the end of January 2007, the numbers were as follows:

Chapter 30:	33,620
Chapter 1606:	10,734
Chapter 1607:	3,213
Chapter 35:	11,807

Question 20: Please provide FTEE data with respect to all of VBA's business lines, including any projected plans to increase or decrease in fiscal year 2008.

Response: The table below depicts VBA FTEE data for 2006–2008 for our five business lines: (1) compensation & pensions (C&P) including burial, (2) education, (3) vocational rehabilitation & employment, (VR&E) (4) housing, and insurance. Increases to direct C&P, Education, and VR&E FTE levels will allow us to better address increasing workload and improve timeliness of claims processing.

2006 FTE Levels (Actuals)						
	C&P	**Edu**	**VR&E**	**Hsg**	**Ins**	**VBA**
Direct	7,858	726	948	747	397	10,676
IT	439	73	44	147	30	732
Support	989	91	119	148	55	1,402
Totals	9,286	889	1,110	1,042	482	12,810

2007 FTE Levels (Projected)						
	C&P	**Edu**	**VR&E**	**Hsg**	**Ins**	**VBA**
Direct	7,863	758	1,063	762	422	10,868
IT	488	66	44	102	30	730
Support	1,094	106	148	107	51	1,506
Totals	9,445	930	1,255	971	503	13,104

2008 FTE Levels (Requested)						
	C&P	**Edu**	**VR&E**	**Hsg**	**Ins**	**VBA**
Direct	8,320	772	1,102	762	408	11,364
IT	154	621	14	32	0	221
Support	1,085	101	144	99	51	1,506
Totals	9,559	894	1,260	893	459	13,065

Note: In the 2008 budget request, 509 information technology (IT) FTEE have been transferred to the IT appropriation.

Question 21: Please provide the Committee with any relevant data concerning fines, sanctions, penalties or fees assessed, pending or in negotiation thereof with a contractor concerning the Loan Guaranty Service's property management program.

Response: On December 19, 2006, VA notified Ocwen Loan Servicing LLC, VA's property management service provider, of the intention to impose a penalty for deficiencies in performance during three different quarters. The penalty being assessed is in the amount of $1,322,001.43. Ocwen is filing an appeal of the proposed penalty; this appeal process is authorized by the contract. VA will consider the appeal and issue a decision upon completing its review of the documentation provided by Ocwen.

Question 22: Please provide the total number of VR&E participants for each of the last three fiscal years, including the Independent Living program; additionally, please provide the VR&E caseload for each Regional Office for each of the last 3 fiscal years; and finally, what is the amount needed to fully implement the VR&E Five Track Program throughout all the Regional Offices?

Response: The table below represents the number of participants in the VR&E program, which represents all veterans actively involved in the program at the end of each fiscal year. The participants can be in any of the following case statuses: applicant, evaluation planning, extended evaluation, independent living, rehabilitation to employability, job ready status, and interrupted.

Fiscal Year	Number of Participants
2006	89,791
2005	92,703
2004	94,851

The following table illustrates the average caseload for VR&E counselors at each of the regional offices (RO) for the last 3 fiscal years. These figures do not reflect any impact of contractor support, which varies from RO to RO. A VR&E counselor's workload may vary among ROs depending on their use of contractors for specialized services.

Station Number	Station Name	FY04 Average Caseload	FY05 Average Caseload	FY06 Average Caseload
340	Albuquerque Regional Office, NM	170	206	137
463	Anchorage VAMROC, AK	148	168	242
316	Atlanta Regional Office, GA	210	133	122
313	Baltimore Regional Office, MD	150	149	164
301	Boston Regional Office, MA	135	124	118
307	Buffalo Regional Office, NY	179	165	207
328	Chicago Regional Office, IL	203	166	131
325	Cleveland Regional Office, OH	160	158	142
319	Columbia Regional Office, SC	159	161	137
339	Denver/Cheyenne Regional Office, CO	141	146	135
333	Des Moines Regional Office, IA	94	181	136
329	Detroit Regional Office, MI	149	172	150
437	Fargo VAMROC, ND	107	129	139
436	Fort Harrison VAMROC, MT	91	94	96
308	Hartford Regional Office, CT	168	310	226
459	Honolulu VAMROC, HI	116	112	103
362	Houston Regional Office, TX	204	217	145
315	Huntington Regional Office, WV	174	189	147
326	Indianapolis Regional Office, IN	212	254	173
323	Jackson Regional Office, MS	173	171	179
334	Lincoln Regional Office, NE	259	277	198
350	Little Rock Regional Office, AR	200	161	158
344	Los Angeles Regional Office, CA	285	301	186
327	Louisville Regional Office, KY	198	154	167
373	Manchester Regional Office, NH	84	93	102
358	Manila Regional Office, Philippines	142	148	130
330	Milwaukee Regional Office, WI	123	111	108
322	Montgomery Regional Office, AL	145	128	110
351	Muskogee Regional Office, OK	139	135	110
320	Nashville Regional Office, TN	156	190	147
321	New Orleans Regional Office, LA	195	169	162
306	New York Regional Office, NY	175	164	141
309	Newark Regional Office, NJ	314	197	194
343	Oakland Regional Office, CA	206	228	201
310	Philadelphia Regional Office, PA	145	154	145
345	Phoenix Regional Office, AZ	151	163	198
311	Pittsburgh Regional Office, PA	114	131	131

Station Number	Station Name	FY04 Average Caseload	FY05 Average Caseload	FY06 Average Caseload
348	Portland Regional Office, OR	156	208	143
304	Providence Regional Office, RI	132	95	133
354	Reno Regional Office, NV	188	131	160
314	Roanoke Regional Office, VA	293	270	164
341	Salt Lake City Regional Office, UT	101	87	112
377	San Diego Regional Office, CA	167	171	137
355	San Juan Regional Office, PR	111	111	108
346	Seattle Regional Office, WA	122	151	137
438	Sioux Falls VAMROC, SD	167	184	150
331	St. Louis Regional Office, MO	121	169	149
335	St. Paul Regional Office, MN	245	192	143
317	St. Petersburg Regional Office, FL	163	155	119
402	Togas VAMROC, ME	148	347	221
349	Waco Regional Office, TX	90	185	147
372	Washington Regional Office, DC	194	247	152
405	White River Junction VAMROC, VT	79	69	79
452	Wichita VAMROC, KS	133	138	127
460	Wilmington VAMROC, DE	151	154	162
318	Winston-Salem Regional Office, NC	223	224	179

The VR&E Five-Track to Employment Model has been fully deployed and implemented throughout all the regional offices.

Health

Question 1: The VA has been operating under a continuing resolution since the start of the fiscal year on October 1, 2006. P.L. 109–383 (H.J. Res. 102) provided the VA with the legal authority to transfer up to $683,970,000 from other accounts to the Medical Services Account.

Question 1(a): On September 30, 2006, what unobligated funds were available to the VA? Please detail specific amounts for specific accounts. Please list unobligated balances at the start and end of FY 2006, FY 2005, and FY 2004 and please explain why the amounts available as unobligated were greater or less than the amounts from the previous two fiscal years.

Response: The chart below shows start of year and end of year unobligated balances for FY 2004–FY 2006 for the total of the three medical care appropriations.

Unobligated Balances	(Dollars in Thousands)		
	FY 2004	FY 2005	FY 2006
Start of Year	$823,282	$710,682	$1,149,225
End of Year	$710,682	$1,149,225	$590,611

- VA reported to Treasury (via the SF 133) that the FY06 EOY unobligated balance was $589,863, or 748K lower than the amount shown above; please verify that $590,611 is the correct amount and whether the first quarter FY07 SF 133 SOY balance will reflect the higher amount.

- The FY 2006 start of year unobligated balance was greater than FY 2004 and FY 2005 due to resources provided by the budget amendment (P.L. 109–54) and Hurricane supplemental received in late FY 2005 and increased collections.
- The FY 2006 end of year unobligated balance was less than FY 2004 and FY 2005 due to a higher level of expenditures supporting veterans' healthcare.

Question 1(b): As of September 30, 2006, please list all "carryover" funding available to the VA. Please detail specific amounts for specific accounts as well as listing which amounts were provided as 2-year funding as well as noting for which fiscal year amounts, or portions of these amounts, were first provided.

Response: The chart below lists all carryover funding available to the three medical care appropriations as of September 30, 2006.

Description	Dollars in Thousands
Medical Services:	
No-Year	$227,745
2-Year	$139,617
Hurricane Supplemental	$34,389
Total	$401,751
Medical Administration:	
2-Year	$145,543
Hurricane Supplemental	$5,924
Total	$151,467
Medical Facilities:	
No-Year	$1,227
2-Year	$3,592
Hurricane Supplemental	$32,574
Total	$37,393
Grand Total:	
No-Year	$228,972
2-Year	$288,752
Hurricane Supplemental	$72,887
Total	$590,611

Question 1(c): As of January 26, 2007, have you made any transfers pursuant to your authority under P.L. 109–383? Please provide detailed information if you have used this transfer authority, including from which accounts funds were transferred, and the amounts of any such transfers.

Response: As of January 26, 2007, no transfers have been made pursuant to VA's authority under Public Law 109–383.

Question 1(d): Does the VA anticipate using this authority between January 26, 2007 and February 5, 2007?

Response: The Department has not used and does not anticipate using this authority between January 26, 2007 and February 5, 2007.

Question 1(e): What consequences, by specific account, do you foresee operating under a continuing resolution will have on VA activities at the end of FY 2007 and the start of FY 2008?

Response: The proposed funding level of $32.7 billion approved by the House (H.J. Res. 20) on January 29, 2007, would fully fund medical care for veterans this fiscal year. If however, Congress were to hold us to the 2006 funding level VA would be short approximately $3 billion of the funding needed to meet the estimated demand for care in FY 2007. A shortage of this magnitude would have serious implications in all three accounts—existing employment levels could not be sustained, patient waiting times would increase dramatically, and healthcare operations could not be sustained at their current levels for the remainder of FY 2007.

Question 2: CBOCs—Please provide a detailed list regarding the number of Community-Based Outpatient Clinics (CBOCs) which were approved in FY 2006 and FY 2005, as well as those approved for FY 2007 through January 26, 2007. Please also provide a detailed list regarding the facilities approved and whether or not they have been activated. Of those activated, please provide detailed estimates as to the costs of each activation and the funding source, by account, of each activation.

Response: Table 1 below depicts the Community-Based Outpatient Clinics (CBOCs) approved and activated FY 2005 and FY 2006. Table 2 below depicts CBOCs approved and not yet activated. No CBOCs have been activated in FY 2007.

Table 1: CBOCs Approved and Activated FY 2005 and FY 2006

VISN	CBOC Name	City	State	Type of Clinic: Contract (C) or VA (VA)	Cost To Establish Clinic
FY 2005					
3	Eastern Dutchess	Pine Plains	NY	V	$247,490
4	Gloucester	Sewell	NJ	V	$54,525
4	Northampton County	Bangor	PA	V	$198,853
4	Warren	North Warren	PA	V	$183,438
4	Uniontown	Uniontown	PA	V	$6,000
4	Venango	Oil City	PA	V	$156,685
7	Goose Creek	North Charleston	SC	V	$101,087
8	The Villages/Sumter County	The Villages	FL	V	$500,000
9	Dupont	Louisville	KY	V	$0
9	Standiford Field	Louisville	KY	V	$0
9	Memphis-South Clinic	Memphis	TN	V	$1,050,717
9	Covington	Memphis	TN	V	$183,852
9	Vine Hill	Nashville	TN	V	$120,000
10	New Philadelphia	New Philadelphia	OH	V	$1,939,553
10	Marion	Marion	OH	V	$487,166
10	Ravenna	Ravenna	OH	V	$1,372,455
15	Hanson/Hopkins County	Hanson	KY	V	$71,539
16	Galveston County Site 1	Galveston Island	TX	C	$123,227
16	Galveston County Site 2	Galveston Island	TX	C	$123,277
18	Anthem/New River	Anthem	AZ	V	$114,117

Table 1: CBOCs Approved and Activated FY 2005 and FY 2006—Continued

VISN	CBOC Name	City	State	Type of Clinic: Contract (C) or VA (VA)	Cost To Establish Clinic
FY 2005					
19	Rock Springs	Rock Springs	WY	V	$250,000
21	Sail Bruno/North San Mateo County	San Bruno	CA	V	$597,258
7	Athens	Athens	GA	V	$1,222,893
16	Slidell	Slidell	LA	V	$260,000
16	LaPlace/St. John*	LaPlace	LA	V	$2,260,000
16	Hammond*	Hammond	LA	V	$2,260,000

Costs to establish a clinic include all non-recurring startup costs such as equipment, furniture, IT needs and any lease buildout or construction costs. The costs do not include annual expenditures such as salary.
*Startup costs are high due to having to purchase modular buildings.

Table 2: Approved and To Be Activated

VISN	CBOC Name	State
4	Dover	DE
6	Hickory	NC
6	Lynchburg	VA
6	Norfolk	VA
6	Franklin	NC
6	Hamlet	NC
7	Bessemer	AL
8	Eastern Puerto Rico	PR
9	Morehead City	KY
9	Hazard	KY
9	Morristown/Hamblen	TN
16	Eglin AFB	FL
17	Conroe	TX
17	NE Bexar	TX
18	Globe/Miami	AZ
18	NW Tucson	AZ
18	SE Tucson	AZ
18	Thunderbird	AZ
20	Metro East	OR

Table 2: Approved and To Be Activated—Continued

VISN	CBOC Name	State
20	Canyon County	ID
20	Central Washington	WA
20	Metro West	OR
21	American Samoa	HI
21	Fallon	NV
22	Orange City	CA
23	Bemidji	MN
23	Holdrege	NE
23	Spirit Lake	IA
23	Western Wisconsin	WI

Question 3: Non-Recurring Maintenance—Please list total expenditures for non-recurring maintenance from the Medical Facilities Account, by month, for FY 2006. Please explain any variance from spend-out rates from the previous two fiscal years.

Response: The table below presents non-recurring maintenance (NRM) expenditures, by month, for the past 3 fiscal years. The variance in first half of FY 2004 relates to the implementation of the new three-appropriation structure directed in the appropriations act. The other variances between months are due to execution timing of NRM projects.

NRM by Month (Cumulative) (Dollars in Millions)			
Month	**FY 2004**	**FY 2005**	**FY 2006**
Oct	$0	$5	$16
Nov	$0	$10	$20
Dec	$0	$18	$27
Jan	$0	$26	$35
Feb	$0	$37	$45
Mar*	$1	$49	$53
Apr	$14	$57	$68
May	$32	$73	$80
Jun	$67	$90	$93
Jul	$103	$102	$119
Aug	$154	$146	$168
Sep	$360	$475	$412

*Represents establishment of the three medical care appropriation accounting structure in FY 2004.

Question 4: Priority 8 Veterans—Please provide VA estimates as to the number of veterans affected by the Administration's decision in January 2003 to end enrollment of new Priority 8 veterans. Please provide a total number, as well as the number by fiscal year. Please also provide an estimate as to amount of resources required to lift the enrollment ban, as well as the estimated amount contributed to the Medical Care Collection Fund (MCCF) per Priority 8 veteran per fiscal year.

Response: The following table shows the impact of Priority 8 suspension on unique enrollment by fiscal year.

2003 Cumulative[1]	2004 Cumulative[2]	2005 Cumulative[3]	2006 Cumulative[4]	2006 Estimate[5]	2007 Estimate[5]	2008 Estimate[5]
Total	Total	Total	Total	Total	Total	Total
93,228	192,419	263,257	331,754	830,203	1,254,460	1,570,503

[1] Totals are cumulative and do not include enrollees who were initially denied enrollment and subsequently enrolled in an eligible priority.
[2] Does not include ineligible enrollees who died prior to FY 2004.
[3] Does not include ineligible enrollees who died prior to FY 2005.
[4] Does not include ineligible enrollees who died prior to FY 2006.
[5] FY 2006–2008 data represent estimated cumulative impact of Priority 8 suspension—"pent-up demand."
Data Source: ADUSH End of Year/Fiscal Year to Date Enrollment Files—Sep03, Sep04, Sep05, Sep06.
March 2006 Model Enrollment Projections (BdgE1F0D0R0A0M5)

Reopening Priority 8 enrollment in FY 2008 is estimated to increase enrollment in Priority 8 by approximately 1.6 million and require an increase in funding of $1.7 billion. If the suspension on Priority 8 enrollees were lifted, the revenue associated with use by new Priority 8 enrollees for Medical Care Collections Fund (MCCF) first party co-payments and third party collections is estimated to be $591 million in FY 2008. VA has serious concerns that this additional demand will strain VA's capacity to provide timely, quality care for all enrolled veterans and lead to longer waits for care. VA must also consider the impact of this policy in future years. In 2017, this policy would increase Priority 8 enrollment by an estimated 2.4 million and would require an additional $4.8 billion. Over the next 10 years, resumption of Priority 8 enrollment would require $33.3 billion in funding requirements.

Question 5: OIF/OEF Veterans—Your estimate for the numbers of returning OIF/OEF veterans for FY 2006 was substantially off from the demand that you experienced. In addition, your estimates of the average medical care costs per returning servicemember were higher than what you experienced. Please provide us with the numbers of returning servicemembers you saw in FY 2006 as well as the total number of these veterans per priority group and the average cost per servicemember.

Response: The chart below provides FY 2006 data for OEF/OIF veterans.

FY 2006 OIF/OEF Unique Patients	
Priority Group	**Unique Patients**
1	16,360
2	17,891
3	29,500
4	677
5	49,461
6	20,040
7	2,799
8	18,544
Total Patients	155,272
Obligations ($000)	$404,840
Cost Per Patient	$2,607

Oversight

Question 1: Testimony at previous Budget Hearings indicates that VA projects its budget requirements based on planned utilization of services by veterans. Budgeting problems arose in previous years when the Administration used improper projections to plan for its budget requirements in the "out years." How do the ongoing military efforts in Iraq and Afghanistan affect VA's budget projections? What "in-country"—in harm's way—troop levels are used for this projection? What is the source or rationale for these troop level and veterans service needs estimates?

Response: VA does not use "in-country" troop levels in budget projections. VA has made every effort to account for the needs of OEF/OIF veterans within the actuarial model. The model has had several key methodological improvements, including development of separate enrollment, morbidity, and reliance assumptions for OEF/OIF veterans based on their actual enrollment and usage patterns. However, many unknowns can impact the number and type of services that VA will need to provide OEF/OIF veterans, including the duration of the conflict, when OEF/OIF veterans are demobilized, and the impact of our enhanced outreach efforts.

The number of veterans returning from Afghanistan being treated in the VA healthcare system is relatively small compared to the overall number of veterans already accessing VA healthcare and benefits (over 5.3 million).

Question 2: In post-hearing questions following the February 8, 2006 budget hearing in response to "Efficiency" question "1.f," concerning a lack of proper documentation for claimed savings, the Department advised the Committee that it had just begun to review the major process to establish policies and procedures to assure proper documentation is identified and control systems are developed to adequately track, monitor, validate, and record authentic instances of bona fide management savings throughout the 157 medical centers for which it is responsible. What is current ability for VA to adequately track, monitor, validate, and record authentic instances of bona fide management savings? What time and expense has been expended in designing and implementing this tracking, monitoring, validating, and recording system?

Response: Management efficiencies are no longer included in the budget estimates and other assumptions and calculations are verified to enhance the fundamental quality of the estimates. VA has taken steps to improve its overall quality control and made technical changes to strengthen the accuracy of its formulation methodologies and assessments of cost savings in the FY 2007 and future budgets.

During the execution year, VA is also monitoring budget performance with monthly reports to VA senior leaders and to the Office of Management and Budget (OMB), as well as with quarterly reports to Congress.

Question 3: In post-hearing questions following the February 8, 2006 budget hearing in response to questions regarding VA's Management Analysis/Business Process Reengineering (MA/BPR) program, VA advised the Committee that it was embarking on two pilot studies under MA/BPR. VA's response provided a listing of items for monitoring and measurement beginning with "(1) baseline costs and Key Performance Indicators (KPIs)" and ending with "(4) costs to conduct the study and implement the MEO." Please provide this information for each of the two pilot studies to the Committee for review.

Response: The information requested is not yet available. Under the MA/BPR design, baseline operational costs and key performance indicators are established no later than the ANALYZE phase. For the pilot studies, VA's objective is to complete the ANALYZE phase on or about July 31, 2007, at which time this information should be available for the majority of the sites being studied. Costs to conduct the study, which are considered part of the costs to implement the most efficient organization (MEO), are recorded cumulatively through the completion of each phase. Accordingly, information on pilot study costs accumulated through completion of the ENVISION phase should be available about April 30, 2007. Accumulated study costs through all phases should be available by VA's target date for completion of the pilot studies, which is December 31, 2007 for the majority of sites. Other costs to implement the MEO, such as the purchase of new capital equipment, are reported as part of actual operational costs incurred during the SUSTAIN phase, which is the ongoing operation of the approved MEO after the study has been completed. Information on such costs is recorded and available when incurred.

Question 4: Last year VA advised the Committee that the offices of the VA Inspector General were staffed at the lowest ratio—OIG FTE to Parent Agency FTE—among all statutory Inspectors General in the Federal Government. The Committee acknowledges VA's previous estimates that the VA OIG returns 15–20 dollars for each dollar invested in the OIG through fines, and other means. What was the rate of return for funds invested in the OIG in both FY 2005 and 2006 and what is the projected rate of return for FY 2007? What would be the impact of increasing the staffing of the VA OIG in terms of total dollars "returned"?

Response: In FY 2005 and 2006, the Office of the Inspector General (OIG) returned 30:1 and 13:1 for each dollar invested, respectively, through audit and inspection recommendations on the better use of funds; fines, penalties, restitution, savings and cost avoidance, and civil judgments as a result of criminal and administrative investigations; and $21.7 million in actual dollar contract review recoveries for the 2-year period—funds deposited back into VA's Supply Fund. OIG estimates its return in FY 2007 will approximate 10:1 for each dollar invested, and will include an estimated $11 million in actual dollar recoveries from contract reviews going back into the Supply Fund. The decline in cost-benefit ratio for FY 2007 is partially attributed to a 40 FTEE reduction from the previous year. We would expect additional staffing resources to continue providing similar incremental returns.

POST–HEARING QUESTIONS FOR THE RECORD

Questions from Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Committee on Veterans' Affairs
Washington, DC
March 5, 2007

Honorable R. James Nicholson
Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on the VA Fiscal Year 2008 budget on February 8, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on March 30, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

BOB FILNER
Chairman

Projected Costs for OEF/OIF Veterans (Bilmes Study)—Linda Bilmes of the John F. Kennedy School of Government at Harvard, in a paper released in January entitled "Soldiers Returning From Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits," has estimated that 255,000 returning servicemembers will seek VA healthcare in 2007 at a total cost of $1.4 billion. Bilmes further estimates that this number will increase to 308,000 in 2008 and cost $1.8 billion. The VA is estimating 209,000 returning servicemembers in 2007 and 263,000 in 2008. Bilmes estimates that the total costs of providing care to these veterans will be $315 billion by 2014.

Question 1(a): In light of this study do you stand by your estimates concerning the number of returning OEF/OIF veterans?

Response: In fiscal year (FY) 2008, the Department of Veterans Affairs (VA) estimates that it will treat over 263,000 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately $752 million. This estimate is based on the actual enrollment rates, age, gender, morbidity, and reliance on VA healthcare services of the enrolled OEF/OIF population. OEF/OIF veterans have significantly different VA healthcare utilization patterns than non-OEF/OIF enrollees, and this is reflected in the estimates above. For example, when modeling expected demand for post traumatic stress disorder (PTSD) residential rehab services for the OEF/OIF cohort, the model reflects the fact that they are expected to need three times the number of these services than non-OEF/OIF enrollees. The model also reflects their increased need for other healthcare services, including physical medicine, prosthetics, and outpatient psychiatric and substance abuse treatment. On the other hand, experience indicates that OEF/OIF enrollees seek about half as much inpatient acute medicine and surgery care from the VA as non-OEF/OIF enrollees.

Question 1(b): Do you believe these cost estimates are accurate, and what is the VA currently doing to meet the increased costs and demands on the healthcare system that these veterans represent?

Response: Many unknowns will influence the number and type of services that VA will need to provide OEF/OIF veterans, including the duration of the conflict, when OEF/OIF veterans are demobilized, and the impact of our enhanced outreach efforts. VA has estimated the healthcare needs of OEF/OIF veterans based on what we currently know about the impact of the conflict. To ensure that we are able to care for all returning OEF/OIF veterans, we have made additional investments in our medical care budget.

State Approving Agencies/Montgomery GI Bill—State Approving Agencies have partnered with the VA in the administration of veterans educational and training programs for nearly 60 years. Through the program approval and supervision process, they ensure that money spent on the Montgomery GI Bill is money well spent. Moreover, SAAs provide a critical assist in reducing the opportunities for fraud, waste and abuse throughout the system. For FY 2006 and 2007 the VA's Education Service was allocated $19 million from the Readjustment Benefits Account to enter into contracts with State Approving Agencies for purposes of approving courses of education under the Montgomery GI Bill and other related activities. Per section 301 of P.L. 103–330 at the end of fiscal year 2007, the SAA funding will decrease to $13 million.

Question 2(a): Does the VA plan to request resources to maintain funding at the fiscal year 2007 levels?

Response: VA does not plan to request resources to maintain funding at FY 2007 level.

Question 2(b): If not why not, and what is the Education Service's plan to maintain program and outreach services, as well as fraud prevention and general oversight over the Montgomery GI Bill programs without the full complement of 8M personnel?

Response: VA will assume the outreach duties performed by the State Approving Agencies (SAA). VA will evaluate the impact in the coming months. If it becomes apparent that some necessary outreach is not being accomplished, we will reallocate resources. Additionally, VA will continue to monitor the performance of SAAs in conducting program approvals, fraud prevention, and general oversight. If SAAs operating at the new funding levels are unable to perform these services, then the Department will reallocate existing VA staff and resources to cover the services previously provided by the SAAs. Our ultimate concern is always for the effective administration of educational benefits to our veterans.

Mental Health Spending—The VA's FY 2008 budget submission requests an additional $56 million, for a total of $360 million, for the VA's Mental Health Initiative. The GAO reported in November that you failed to fully allocate the resources you had pledged for the Mental Health Initiative in FY 2005 and FY 2006.

Question 3: Will the VA fully allocate the $306 million for this initiative in FY 2007, and the $360 million sought in FY 2008?

Response: Yes. More than 95 percent of the funds for FY 2007 have been committed. We are closely monitoring the use of the funds in the field. We are prepared to recover those funds that may go unspent as a result of delays in hiring and to reinvest them in meritorious projects proposed by the Veterans Integrated Service Networks (VISN).

Funds for FY 2008 will be committed for continuation of programs initiated in FY 2007.

VA Mental Health Effort—According to the VA's FY 2008 budget submission, the VA "plans to spend a total of $3 billion to continue our efforts to improve access to mental health services across the country." The GAO report on spending on the Mental Health Initiative from November stated that for FY 2006, the VA was "expected to spend more than $2 billion on mental health services." The FY 2008 budget submission includes $360 million for the Mental Health Initiative, and $311 million for outpatient mental health.

Question 4(a): Can you provide details concerning the remainder of your mental health spending for FY 2008?

Response: For efficiency, the allocation of FY 2007 and FY 2008 funds were combined. A number of programs will be implemented and expanded during FY 2007, and continued during FY 2008 to ensure spending of the total amount of funding for the 2 years. The allocation of FY 2008 funds to specific programs is outlined in the table as follows.

FY 2007 and FY 2008 Proposed Mental Health Initiative Spending Plan	FY 2007	FY 2008	Change
Continuation of FY 2005 and FY 2006 Recurring Initiated Activities	166,296,744	166,296,744	0
Primary Care/Mental Health Integration	38,380,506	55,691,153	17,310,647
Suicide prevention coordinators (156 sites)	8,624,890	16,249,780	7,624,890
Psychosocial Rehabilitation (PSR)	15,138,061	23,587,385	8,449,324
Mental Health Intensive Case Management (MHICM): Rural, multiple teams, etc.	10,185,091	12,345,644	2,160,553
Homeless Program Initiatives	17,556,002	17,342,238	−213,764
Substance Use Disorders	4,624,702	9,096,072	4,471,370
Mental Health staff in Community Based Outpatient Clinics (CBOCs)	15,290,157	21,883,139	6,592,982
Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) in reach	3,490,567	5,102,231	1,611,664
Post Traumatic Stress Disorder (PTSD), including Dual Diagnosis and Military Sexual Trauma (MST) Resource program	4,979,157	5,115,401	136,244
Telemental Health	7,018,000	3,100,000	−3,918,000
EES training	600,000	600,000	0
Centers of Excellence	3,000,000	4,950,000	1,950,000
Gulf Coast market survey	196,659	0	−196,659
Vet Center staff enhancement	3,379,923	10,531,046	7,151,123
TBI Transitional Housing	2,500,000	5,000,000	2,500,000
Other activities including training in evidence-based psychotherapy	4,849,541	3,109,167	−1,740,374
TOTAL	306,110,000	360,000,000	53,890,000

Question 4(b): Although your budget states that you are spending $3 billion on mental health, is this enough to meet the needs of veterans? In what areas, given additional resources, do you believe the VA should be doing more?

Response: The total budget of $3 billion is adequate both to meet the needs of returning veterans and those from prior eras. It will allow expansion of access for veterans entering the VA, and expansion of programs for veterans from prior eras. One area in which VA could be doing more is in working with families of veterans with mental health problems. It would be useful for VA mental health providers to work with families, even before the veteran came to VA for care. Providers could meet with families, help to evaluate symptoms they report, educate them about care needs and available resources, counsel them about how to manage symptoms, and collaborate with them to get the veteran into treatment. VA does provide bereavement counseling to families of servicemembers killed in action.

Questions from Hon. John Salazar to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Question 1: Mr. Secretary, I represent Colorado's 3rd Congressional District.

Colorado's 3rd makes up over 50 percent of the State of Colorado. Much of which is rural.

There are approximately 75,000 veterans that live in my district. Many of these veterans must travel as much as 5 hours through winding mountain roads to reach the VA Center in Denver. Can you tell me how you plan to address the issue of access to healthcare services for our veterans living in rural areas and can you please tell me the status of the CBOC proposed for Craig, Colorado?

Response: VA plans to establish an outreach clinic in the Craig, Colorado area this fiscal year. An Outreach Clinic is a part-time, VA-staffed clinic that will provide access to healthcare services for veterans living in rural Colorado.

Question 2: In the past, you have opposed allowing VA to contract for services in rural areas. Do you plan to oppose similar legislation if it's introduced again and why?

Response: VA contracts for services on a case by case basis in rural (and urban) settings when VA does not have the capability, capacity, or expertise to provide the necessary service within a defined service area. VA also has contracted for care for extraordinary hardship or humanitarian reasons. VA does not support a general policy of contracting out all care for patients in rural settings.

Questions from Hon. Steve Buyer, Ranking Republican Member, Committee on Veterans' Affairs, to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Committee on Veterans' Affairs
Washington, DC
February 20, 2007

Honorable R. James Nicholson
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Committee hearing of February 8, 2007, I would appreciate your response to the enclosed additional questions for the record by close of business Wednesday, March 14, 2007.

It would be appreciated if you could provide your answers consecutively on letter size paper, single spaced. Please restate the question in its entirety before providing the answer.

Thank you for your cooperation in this matter.

Sincerely,

Steve Buyer
Ranking Republican Member

Question 1: In January, the House passed H.R. 4, which would eliminate the prohibition on the Department of Health and Human Services (HHS) from interfering in setting prescription drug prices and require HHS to negotiate prices charged under Medicare prescription drug plans. What impact would this change in law have on VA's ability to negotiate favorable discounts from pharmaceutical companies and VA's prescription drug costs?

Response: H.R. 4 amends the Medicare Modernization Act by removing the non-interference language which prevents the Secretary of the Department of Health and Human Services (HHS) from negotiating drug prices directly with pharmaceutical manufacturers and by requiring semi-annual reports to Congress on the impact of the negotiations. H.R. 4 does not permit HHS to establish drug formularies as a negotiation tool.

H.R. 4 itself, as currently proposed, is likely to have no negative financial impact on the Department of Veterans Affairs (VA) drug procurement costs because it does not reference in any way section 603 of Public Law (P.L.) 102–585 which gives VA a 24 percent discount off commercial drug prices.

Question 2: In recent years, VA has experienced significant cost escalation in the construction of medical facilities. For example, the estimate for the construction of a new medical facility in Denver has almost doubled, now topping over $646 million.

Question 2(a): What are the causes for these increases?

Response: The Department, along with other government agencies and private sector businesses and individuals, is experiencing a significant growth in the cost of construction as a result of the booming construction economy worldwide. The sig-

nificant demand for contractors, labor and building materials has produced significant increases in pricing. This has been further exacerbated by higher petroleum prices on both petroleum based building products and fuel as well as construction related impacts of the hurricanes of 2004 and 2005 including Katrina.

Question 2(b): What steps has VA taken to prevent such escalation in the future?

Response: In order to position the Department to best deal with this situation, VA has taken several steps. These include developing a more detailed market analysis of individual geographic location to ensure the best available information is used when establishing the escalation rates to be used in the cost estimate. There is consideration to market timing to the extent practical in order to bid the project at a time when there is the best opportunity to have the greatest competition by the contracting community. VA has also begun to employ more extensive preplanning before a project is placed in the budget to be sure that all issues relating to scope, building systems, and constructability have been identified and their costs identified.

Question 2(c): What is the status of a possible collaborative arrangement in Denver between VA and 000 or the University of Colorado?

Response: The University of Colorado Hospital has completed its plan for build-out for the Fitzsimons Campus. Sharing of space with VA is not included in their build-out plans. The possible areas for short term clinical collaboration remain much the same as they currently exist: buying and selling of services between the facilities. Once VA has relocated to the Fitzsimons Campus, other opportunities might arise for the buying and selling of services related to high technology equipment, specialized laboratory tests, and specialized patient treatments.

The Department of Defense (DoD) has renewed its interest in sharing in the Denver VA facility replacement project and that option is being explored. The project initially included outpatient and administrative space for DoD that would be constructed by VA and then leased by DoD. The need for inpatient care was addressed by additional hospital beds that would be used to care for DoD patients. VA would charge DoD for inpatient care at a reduced cost. This option remains viable today but would increase the square footage and the cost of the current project.

Question 3: In 2004, the Secretary agreed with the CARES Commission's recommendation that a new medical facility was needed in Orlando. However, almost 3 years later, this project has not advanced.

Question 3(a): When will the site for the new Orlando facility be identified? (Originally, the site was scheduled to be identified last summer.)

Response: The Secretary announced on March 1, 2007, the selection of Lake Nona as the site for the new Orlando facility.

Question 3(b): What is the cause for delay?

Response: A number of actions have taken place since the decision was made to construct a new VA medical center in Orlando. These have included:

- a study to determine whether the site of the existing clinic would be adequate to support a new medical center (it was determined that a new site was required);
- appointment of a site selection board by the Secretary to recommend the best site for the new medical center;
- advertisement for new sites;
- a comprehensive technical evaluation of proposed sites;
- a public hearing with veterans and other stakeholders;
- an environmental assessment of the two preferred sites: Lake Nona and International Corporate Park; and
- publication of a finding of no significant impact (FONSI) and notice of availability.

These many actions were required to assure the best site was selected for the new Orlando medical center, and to satisfy Federal land acquisition requirements.

Question 3(c): How will this impact the cost of and time table for constructing a new facility?

Response: As site selection was underway, VA also contracted for preliminary studies and schematic design. As a result preliminary studies, work on schematic

design, and studies to define space requirements are underway. By performing site selection and schematic design concurrently, VA has minimized the impact on cost and time for the project.

Question 4: VA was required to submit to Congress a master plan for the West Los Angeles campus in 1998. To date, a master plan has not been submitted.

Response: To comply with section 707 of the Veterans Programs Enhancement Act of 1998 (P.L. 105–368), a 25 year master plan was developed for the West Los Angeles campus in April 2001. The master plan was completed and involved public meetings and the formation of a land use action committee. The master plan also included an environmental assessment. The master plan was shelved due to overwhelming public comments against the plan. Numerous letters were written opposing adoption of the proposed master plan.

Question 4(a): What is the cause for the delay in developing a master plan for West Los Angeles?

Response: After the 2001 master plan was shelved, the decision was made to develop a master plan as part of the Capital Asset Realignment for Enhanced Services (CARES) initiative. The CARES initiative would set some of the parameters about functions and probable locations of healthcare facilities on the campus that could be used to develop a new master plan. This approach seemed to fit best with the overall intent of CARES, which is to determine the best use of VA's assets and the best configuration of these assets. Once these decisions on assets are made, the local communities can interact with VA through publicly held CARES local advisory panel meetings.

Question 4(b): When do you expect to issue a final decision on the options for reusing excess land at West Los Angeles?

Response: The final Stage 2 CARES Report for West Los Angeles will be completed in July 2007. It will provide information to the Secretary on the advantages and disadvantages of each option selected for detailed study.

Question 5: As part of the President's Management Agenda, the Executive Brand Management Scorecard is used to track how well agencies are executing governmentwide initiatives. VA achieved "green" status on the scorecard for the Federal Government's real property initiative in 2006. What is VA doing to maintain this "green" status?

Response: VA continues to move forward aggressively on the Federal Government's real property initiative with a true capital investment life cycle approach. Real property is managed from planning/investment through performance monitoring and disposal.

Planning/Investment

The Department will continue to work toward achieving the goals, objectives, and milestones laid out in the VA Asset Management Plan, 5-Year Capital Plan, disposal plans, and sustainment model (used to maintain VA infrastructure at the current level). Development will continue through (1) implementation of VA's CARES program and (2) focus on deferred maintenance.

CARES Implementation Status

A total of 36 CARES projects are in process. One project, an enhanced-use lease in Chicago, is complete. Two projects are new; the status of the remaining 33 is as follows:

- Construction documents prepared—6
- Construction begun—14
- Schematics/design development in process—13

Eighteen sites were selected for further independent study. The one in Gulfport has been eliminated due to its loss during Hurricane Katrina.

CARES Business Plan Studies

Along with previous CARES projects selected in FY 2006 and FY 2007 for implementation, there are a number of sites where further study is required to determine suitability for future healthcare and re-use activities. These studies will include evaluating outstanding healthcare issues to recommend healthcare delivery options, developing capital plans, as well as determining the highest and best use for unneeded VA property. Completion of the studies going into more detailed analyses (Stage 2) is anticipated by the end of 2007.

Firms have been awarded the contract to assist the Secretary in reaching final healthcare decisions and re-use options. CARES planning data have been updated with FY 2003 actual use and refinement in planning assumptions for categories of care, including long-term and mental healthcare. This improved data will be utilized in the validation of construction plans and the annual strategic planning process.

The following table identifies the locations being studied and their current status:

Health Care, Capital Plan and Re-Use Studies	Comprehensive Capital Plan and Re-Use Studies
Study current in Stage 2: • Boston, MA Completed studies: • New York—Reject consolidation of 2 VA medical centers • Louisville, KY—Study validated need for replacement hospital • Big Spring, TX—Keep existing service in Big Spring; use Planning process to explore contracting and/or expansion in market including domiciliary • Walla Walla, WA—Construct new ambulatory care center contract inpatient care in capital planning process • Montgomery, AL—Maintain inpatient services; major modernization • Waco, TX—Retain all current services • Muskogee, OK—Keep facility and implement increase in psychiatric beds	Study pending Stage 1 decision: • West Los Angeles, CA Studies currently in Stage 2: • Canadaigua, NY • Lexington, KY • Livermore, CA • Montrose/Castle Point, NY Completed studies: • White City, OR—Construct new domiciliary • St. Albans—Replace existing facilities with nursing home outpatient clinics and domiciliary; VA to develop capital plan for new construction on site and a re-use plan for the campus • Perry Point, MD—Upgrade entire campus, continue and complete re-use plan. Removed from the study due to damage from Hurricane Katrina: • Gulfport, MS
Financial Analysis Study • Poplar Bluff—Keep facility; is cost effective to provide inpatient care	

At Walla Walla, St. Albans, Louisville, Perry Point and Montgomery VA medical centers (VAMC), capital investment proposals were developed for consideration in the next (FY 2009–2014) 5-year capital plan. For the new Louisville VAMC, a site selection committee has been established by the Under Secretary for Health.

The Secretary decided to retain all current services at Waco, Texas, and establish a center of excellence for post-traumatic stress disorder as part of VA's internal planning process. Waco will also pursue reuse of vacant buildings and land through VA's enhanced-use lease program.

The Secretary directed the VAMC in Walla Walla, Washington, to use existing contracting authority to provide inpatient and nursing home care and to explore partnerships and other opportunities to better use the historic campus.

In White City, Oregon, the Secretary directed that a capital plan be developed that (1) combines new construction and renovation; (2) replaces several domiciliary buildings through new construction; and (3) expands ambulatory specialties and outpatient mental health services. The master plan is also to consider enhanced-use leasing opportunities, which are currently being reviewed by the "reuse" contractor under Phase 3 reuse/redevelopment. For St. Albans, New York, the Secretary directed that a capital plan for new construction be developed for a new nursing home, domiciliary and outpatient clinic. The VAMC is leading the effort, designing the new medical components of the campus, and the reuse contractor has developed the Phase 3 Reuse/Redevelopment report.

Deferred Maintenance

VA will continue to fund construction to upgrade and replace existing facilities and fund repairs needed to improve VA-owned buildings.

Performance Monitoring

VA will continue to integrate its efforts on real property with VA's energy program. Real property management focuses on the inventory of assets, their mission alignment, use, condition and cost. The energy program is implementing metering,

energy sustainability and a renewable program. Goals include reducing energy use in both existing and planned buildings, and increasing the use of renewable energy as a percent of facility electricity use. These programs are mutually supportive and together provide a global strategy for improved real property performance management.

VA will continue to monitor real property performance in each of the areas noted above, reporting to the Office of Management and Budget (OMB) and VA Management Performance Review Board. Analysis will be conducted and actions identified for improved performance.

Disposal and Enhanced Use Leases

Lastly, VA will continue to use disposal and enhanced use lease (EUL) authority to relieve the Department of its responsibility for non mission-dependent, underused and vacant space. In FY 2006, VA was no longer responsible for 77 buildings. VA used the following methods to transfer responsibility: 6 buildings via sales, 19 buildings via demolition, and 52 buildings via enhanced-use lease. In FY 2007, 4 buildings (18,000 square feet) have been disposed of; an additional 99 buildings (including Gulfport and Marlin) and over 2.2 million gross square feet are planned for disposal or EUL by the end of the year.

Question 6: To your knowledge, are you or the Under Secretary for Health or any of your staff pursuing a proposal to standardize self monitoring blood glucose supplies and equipment at this time? Is the Department continuing to pursue a proposal to standardize self monitoring blood glucose equipment through a single national contract, even though the FY 2006 VA Appropriations Act specifically prohibits VA from replacing the current system by which VISNs select and contract for blood glucose testing supplies and monitoring equipment?

Response: VA, to include the Secretary, Under Secretary for Health or any of the staff, is not pursuing a national proposal to standardize self monitoring blood glucose (SMBG) supplies and equipment at this time. The Military Quality of Life and Veterans Affairs and Related Agencies Appropriations Act of 2006 prohibits VA from pursuing new contracts. Specifically, section 220 "*prohibits the expenditure of any funds available to the Department on implementation of a national standardization contract for diabetes monitoring systems*."

Decisions on which SMBG products are offered to veterans cannot be made at the national level and now must be made at the Veterans Integrated Service Network (VISN) level.

Question 7: I understand that in March of 2006, the Deputy Under Secretary of Health for Operations and Management sent a memo to the VISN directors notifying them of enacted legislation prohibiting VA from replacing the current system by which VISNs select and contract for blood glucose testing supplies and monitoring equipment. However, it has been reported that some VISN directors are continuing to prepare for a national standardization of diabetes monitoring supplies and equipment. Are you aware of any correspondence to the VISN directors on this topic since last year?

Response: The memo entitled "Termination of Proposal to Standardize Blood Glucose Devices" dated March 17, 2006 is still in effect. No other direction has been given to the field to reverse or change this memorandum. VISN field sites continue to use VISN procedures to select and contract for these supplies and equipment.

Question 8: I understand that notwithstanding Congressional actions that prohibit VA from moving forward with the standardization of blood glucose testing supplies, vendor competition has produced VA savings on the purchase of such supplies. Please provide me with VA's purchasing costs for blood glucose testing supplies and the annual savings the Department has achieved since September 2005?

Response: Vendor competition has not produced meaningful savings on blood glucose testing supplies. With the exception of a $0.01 price reduction for one low volume blood glucose testing strip, VA's unit prices have remained unchanged for the period September 2005 through December 2006. VA's expenditures during this time period were $77,346,967. Without the $0.01 reduction, VA's costs would have been $77,440,347. Therefore, VA saved a modest $93,380 (0.1 percent) from the price reduction from September 2005 through December 2006.

Questions from Hon. Henry E. Brown, Jr. to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Question 1: Mr. Secretary, you budget request $40 million for advance planning under the Veterans Health Administration. Can you provide a breakdown of where the Department plans to dedicate those funds?

Response: The FY 2008 advance planning funds will be used for several purposes including the early planning and design of projects expected to be included in the FY 2009 budget, support for the VISNs in developing the project capital asset applications for the FY 2010 projects, development of space and design standards, environmental and other studies, as well as supporting our ongoing CARES projects design.

Question 2: Mr. Secretary, I have reviewed the Department's 5-year capital plan and find only one mention, in passing, of the joint-use advanced planning at Johnson VAMC in Charleston. Is this because the VA was only authorized to conduct planning activities at the end of the 109th Congress, or are there additional reasons why this important project was not included in the Department's 5-year plan or budget request?

Response: The $36.8 million intended for advanced planning funds were authorized at the end of the 109th Congress, but not appropriated. The Veterans Health Administration (VHA) has many major construction projects that are identified in our 5-year capital plan that have a higher priority, based on significant safety and environmental quality concerns, for funding at this time.

Question 3: Outside of the absence of advance planning for Charleston in this year's budget, are you continuing to support development of that project, and who are the new national VA leaders from VHA who are leading the effort for VA?

Response: Replacement of the Ralph H. Johnson VA Medical Center in Charleston, SC is an undertaking that has a competitive disadvantage when viewed with the other major construction priorities of VA at this time. The Medical Center Director at Charleston, and the President of Medical University of South Carolina (MUSC), will continue to lead a local group who will explore collaboration options in Charleston between VA and MUSC.

Question 4: Mr. Secretary, I understand that you have recently made favorable comments about the innovative plan for increased VA and university collaboration/integration being developed at Charleston between the Johnson VAMC and the Medical University of South Carolina. If Congress appropriates the funds to proceed with planning as authorized under last year's VA Authorization bill, will you proceed aggressively with that planning, given that Charleston is at high risk for hurricane damage? Can we make progress fast enough to avoid a New Orleans/Katrina-like catastrophe in Charleston?

Response: VA and MUSC have long enjoyed a productive and mutually beneficial affiliation. The local group headed by the Medical Center Director and the President of MUSC, will continue to explore collaboration opportunities between VA and MUSC. An example of this collaboration is the procurement of high cost medical equipment. Contracts for these arrangements are very close to being signed, and VA is poised to procure the equipment. VA will purchase the equipment and it will be placed in MUSC facilities. In return, veterans will receive free or significantly discounted clinical services up to the purchase price of the equipment. Veterans and the citizens of South Carolina will both benefit from this arrangement.

Normally to deal with hurricanes, VA's policy is to harden, or hurricane strengthen. A VA study showed we would not need a new facility to do this, and the Johnson VAMC meets current hurricane structural standards. We still believe the priorities outlined in the President's Budget should be enacted into law. If, however, Congress funds a project not in the President's Budget and the President signs the bill into law, this would be considered direction and we would proceed. In such a scenario, where it would rise to a top priority, it is projected that it would take 5 to 6 years to build a hurricane-strengthened facility.

Questions from Congressman Gus M. Bilirakis to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Tampa Parking Situation:

The James Haley VA Medical Center (VAMC) in Tampa, Florida is one of the busiest, if not the busiest, medical centers in the country. Parking is a critical issue at the facility. Veterans complain about having to drive around for long periods of time looking for an available parking space. This issue has been highlighted in numerous paper stories in my local papers.

Question 1: As part of the Fiscal Year 2007 budget submission, the Department included a project to "improve patient parking" at the Tampa VAMC as a potential future construction project. What is the status of this proposed project?

Response: The 2007 Construction Budget Submission (5-Year Capital Plan) identified an effort to improve patient parking at the Tampa VAMC. Toward that end, VISN 8 submitted a major construction proposal for FY 2008 to expand the Tampa polytrauma unit that included a parking garage to increase access for these patients and relieve parking congestion at Tampa. While the project scored high, it was not funded due to other priorities ahead of it.

VA is presently going through the major project application review and scoring cycle for the FY 2009 budget. The Tampa proposal, for polytrauma unit expansion to include a parking garage, has been revised and resubmitted as part of the FY 2009 budget planning cycle. It is currently going through the validity review process where it will again be scored to determine its standing in VHA's national prioritization list for FY 2009 major construction funding cycle.

Question 2: What is the Department doing to address the parking in the interim?

Response: The medical center currently leases parking spaces at a nearby mall and operates continuous shuttles for patients, visitors, and employees from approximately 6 a.m. to 9 p.m. Additionally, they participate in the North Tampa Transportation Initiative, which supports van pooling and public transportation. Through this initiative, they have established 10 van pools, thereby reducing the number of parking spaces needed for employees by 51. An additional acquisition proposed for FY 2007, is the Alpha property (3.6 acres) across the street from the Tampa VAMC, which will produce approximately 650 parking spaces. A station level project will be required to address necessary grading and drainage of the property before parking can commence. The project to purchase this property is on the FY 2007 list for funding.

PVA Land Purchase:

Question 3: The Tampa VA is also in the process of purchasing some land near the facility from a local Paralyzed Veterans of America (PVA) chapter. I've been told that the sale is just awaiting your signature to be finalized. When do you anticipate signing the approval papers?

Response: The Secretary has approved the purchase and the offer to sell has been accepted, VA closed on March 12.

Coming Home to Work Program:

Question 4: One issue that I am particularly interested in is helping our servicemembers returning from Operation Iraqi Freedom and Operation Enduring Freedom transition back into civilian life. Your testimony highlights the VA's "Coming Home to Work" initiative. How many veterans have taken advantage of this program?

Response: Information for FY 2007 through the end of January shows that:

- 16 service members are participating in active work experience programs with Federal agencies while awaiting discharge or return to duty orders;
- 121 service members are receiving early intervention services in preparation for work experience programs, including vocational counseling, testing, and administrative support necessary for successful placement in a work experience program;
- 108 veterans participating in the "Coming Home to Work" (CHTW) program at a military treatment facility were referred to their local regional office for continuation of Vocational Rehabilitation and Employment (VR&E) services;
- 24 service members have returned to active duty following early intervention services; and
- 7 veterans have been hired directly by their work experience employers upon discharge from active duty.

Questions from Hon. John Boozman, Ranking Republican Member, Subcommittee on Economic Opportunity, to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Question 1: The Budget shows education performance goals as 25 and 12 days for original and supplemental claims respectively and translates to reductions of 37.5% and 31%, based on the latest FY 2007 performance reports. How do you propose to accomplish these very significant reductions with only 12 additional direct FTE and anticipated increase of claims by about 33,000?

Response: We expect to make substantial progress toward these FY 2008 goals by the end of FY 2007. In the first 5 months of FY 2007, we have reduced the average age of pending original claims by 30 percent, and the average age of supplemental claims by 39 percent. Our current targets for the end of FY 2007 are 35 days to process original claims and 15 days to process supplemental claims, leaving reductions of 10 days for original claims and 3 days for supplemental claims to be achieved in FY 2008. In FY 2003, with similar resources, we achieved similar reductions: from 34 days to 23 days for original claims, and from 16 days to 12 days for supplemental claims.

Question 2: In addition to having sufficient staff to meet performance goals, it is necessary to distribute those resources properly throughout the system. For example, there is significant difference in the time to determine eligibility for the voc rehab program ranging from about a month in San Diego to about 4 months here in DC, with other stations being only slightly more timely than the DC office. Several weeks ago, the staff asked for a report comparing the percentage of national workload and direct staff for each business line in each regional office. When do you anticipate we will receive that report?

Response: One of the largest influences on timeliness of vocational rehabilitation and employment (VR&E) is the variance of services provided to service members and veterans at each regional office (RO). The San Diego RO and the Washington RO are good examples of how timeliness is affected due to the nature and scope of individualized services provided at each station. For example, San Diego supports an extensive Disabled Transition Assistance Program (DTAP), which is a key element in receiving completed claims with assigned disability ratings. Rapid claims processing through DTAP enables the San Diego VR&E office to provide immediate case management services to applicants of the program. Both organizations support their diversified case management needs by using a balance of vocational rehabilitation counselors and contractors.

The attached spreadsheet compares the percentage of the national workload and direct staff for each business line in each regional office. The following information will further clarify the employee distribution for the compensation and pension programs.

The compensation and pension resource allocation model is based on four factors: (1) receipts of incoming work, (2) appellate work, (3) accuracy, and (4) timeliness. Receipt of incoming work is given the greatest weight as the single most important factor driving staffing requirements. Receipts include the rating workload shown on the attached spreadsheet as well as the non-rating workload (income and dependency adjustments, burial claims, etc.), public contact and outreach activities, and work performed by the fiduciary staff. Factoring in accuracy and timeliness ensures that staffing decisions are based on both output and quality. To minimize large variations in staffing allocations from year to year, the model uses a 2-year average for each of these factors.

Adjustments are made to the allocations developed by the model for special missions assigned to many of our ROs. The attached spreadsheet shows that compensation and pension staffing for FY 2006 was 7,377 full time employees (FTE). Of these, 431 FTE (6 percent) were allocated to stations with special claims processing missions. The largest segment of special mission staffing supports workload "brokering." Cases are sent from offices with high inventories to one of 12 ROs staffed with a resource center to assist other ROs in developing and/or rating "brokered" claims. These resource centers and the "brokering" strategy help to balance workload and staffing across all ROs.

Beginning in 2006, rating work for Benefits Delivery at Discharge (BOD) claims was consolidated at the Salt Lake City and Winston-Salem ROs. There are currently 136 employees at Winston-Salem and Salt Lake City processing only BOD claims. Other consolidations of claims processing and related functions include, radiation exposure claims to Jackson; claims from residents of Mexico to Houston; foreign claims to Pittsburgh; and the Special Issues Helpline at St. Louis.

Pension Maintenance Centers in Philadelphia, St. Paul, and Milwaukee are allocated a combined total of 448 employees to process pension maintenance actions,

such as income and dependency adjustments. On the spreadsheet, these resources are shown under the heading of "Pension" and are not included in the totals under the heading "Compensation."

The "FY2007 Dee" columns for FTE on the spreadsheet show the actual number of personnel on hand at each station. Most regional offices have hired subsequent to that date and are continuing to recruit additional claims processors and support personnel.

Question 3: What is the level of funding proposed for The Expert Education System (TEES), and what major milestones will that funding accomplish, and when do you anticipate that application coming online, and what will be the total cost to develop and field that system?

Response: The Expert Education System (TEES) comprises a suite of business applications engineered with a common architecture that work synergistically to achieve the goal of automated processing of education benefit claims with minimal human intervention. TEES incrementally delivers business improvements that will enable VA to provide educational benefits to veterans in a more timely and efficient manner. TEES will be accomplished in two distinct phases.

The first phase comprises near-term delivery of business applications to replace aging stand-alone applications. This strategy enables VA to quickly target critical business functionality.

The focus of phase two will be the development and deployment of the new education rules-based automated eligibility and award processing system. Incorporating rules-based technology will ensure consistency and accuracy of decisions rendered. The following are major milestones and associated levels of funding for TEES:

Milestones	Description	Projected Duration	FY 2008 Funding (Millions)
Phase I			
Business Assessment	Assess the continued development of TEES, including reviewing the potential for integration with the Financial Award Processing System (FAS).	07/07–10/07	
Requirements Definition	Gather and define business requirements associated with ECAP, Chapter 30 PC and Workstudy.	08/07–01/08	
Design and Build	Design and build ECAP, Chapter 30 PC and Workstudy.	10/07–09/08	$2.5
Test and Certify	Test and certify the ECAP, Chapter 30 PC and Workstudy applications.	01/08–10/08	$0.5
Implementation	Deploy ECAP, Chapter 30 PC and Workstudy to Regional Processing Offices.	04/08–12/08	$0.5
Phase 2			
Requirements Definition	Gather and define business requirements for building a new rules-based automated eligibility and award processing system.	07/07–09/08	
Data Conversion	Convert legacy Educational data and incorporating it into the new Education System.	10/08–09/11	
Design and Build	Design and build the new rules-based automated eligibility and award processing system.	10/08–09/11	
Test and Certify	Test and certify the new rules-based automated eligibility and award processing system.	10/08–09/11	
Implementation	Deployment of the new rules-based automated eligibility and award processing system.	10/08–09/11	
FY 2008 Total			$3.5

Question 4: VA projects a 2.5% increase in Voc Rehab workload and is requesting about 40 additional staff to bring the total VR&E staff to 1,260 to meet that increase. The Independent Budget suggests you will need 1,375 FTE. First how do you estimate the workload increase? Second, what positions will the new FTE fill? And third, what will be the average caseload for your direct service staff at that manning level?

Response: The workload for the Vocational Rehabilitation & Employment (VR&E) program, which dictates staffing levels, is projected to increase based on factors such as the Global War on Terrorism, the economy, and the processing rate of claims. The national workload at the beginning of FY 2007 was 89,126, with 621 counselors. This yields an average caseload per counselor of 144. VR&E service estimates the workload for FY 2008 will increase to 93,865 cases. To manage the increase in workload, the FY 2008 budget submission includes an additional 59 FTE, including 5 contract specialists, 5 employment coordinators, 4 FTE to support the new FY 2008 process consolidation initiative, and 45 vocational rehabilitation counselors (VRCs). VR&E service recommends that the ROs with the highest workload to counselor ratios be allocated the majority of the additional VRCs. This would balance the caseload ratio at each RO and bring the average caseload per counselor to 141. VR&E service uses contract professionals to meet the needs of variances in caseloads. Contract professionals augment VR&E staff by conducting initial evaluations, program case management, and job readiness and employment services.

Question 5: VA has had significant problems fielding new computer systems to support the Department's missions. To this point, the Veterans Affairs Committee has given VA a relatively free hand in developing and fielding new systems. I believe it is time that we do an annual authorization of VA IT programs just as we do for construction. What is The Department's position on an annual authorization for IT systems?

Response: Committee on Veterans' Affairs has encouraged the Department over the past year to centralize the management of information technology (IT). The VA Chief Information Officer (CIO) now has control over the development of IT systems and solutions, and has begun to implement rigorous standards and processes for articulating IT needs and managing IT development projects. These process improvements will result in outcome improvements in the delivery and fielding of IT solutions. IT is a demanding and challenging environment. As such, the VA CIO needs flexibility to meet rapidly changing requirements as well as respond to unforeseen circumstances. VA does not believe use of an annual authorization process will lead to better planning and execution of IT efforts. VA would look forward to in-depth discussions during the year with Members and staff on the direction and challenges VA is facing with critical projects. VA believes this would better serve the development and implementation of the necessary IT systems to support delivery of services to the Nation's veterans. This would ensure an ever changing environment that the VA CIO would have the flexibility to address issues within programs.

Question 6: How many veterans are currently waiting to enter the Independent Living program? If Congress removed the 2,500 limitation on new entrants into the independent living, how many additional FTE and other costs would be needed?

Response: No veterans are currently waiting to enter the Independent Living (IL) program. The count of veterans who have entered the program begins on the first day of each fiscal year. Action must usually be taken in early August to prevent exceeding the statutory limit of 2,500 new cases. From then until the end of the fiscal year on September 30, veterans may experience a delay in entering the program.

VR&E anticipates that there will be a steady increase of new IL cases over the next 10 years based on historical data and the need for increased IL by Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. It is anticipated that the steady increase will occur given that disabilities worsen over time and the need for IL may arise several years after discharge.

The following table provides a 10-year projection of the number of cases over the 2,500 cap for each year, the costs associated with the extra cases, and the FTE needed over the current staffing level.

The first year cost is $2,095,500. The cost over 5 years is $26,598,145. The 10-year cost is $76,765,365. We estimate that there will be a growth rate of 10 percent in 2008 and 2009, and that this rate will diminish to 5 percent in 2010 and reach a normal growth rate of around 2 percent beginning in 2011, assuming that the OEF/OIF conflicts have ended.

Fiscal Year	# Above Limit	$ Increase over Current Limit*	FTE Increase over Current Staffing**
2008	250	2,095,500	5
2009	525	4,505,025	11
2010	676	5,940,012	14
2011	739	6,649,552	15
2012	804	7,408,056	16
2013	870	8,216,280	17
2014	937	9,070,160	19
2015	1,006	9,981,532	20
2016	1,076	10,942,920	22
2017	1,147	11,956,328	23

*An economic assumption for the President's budget cost-of-living increase was used in the calculations for FY 2008 through 2017.
**Assuming caseloads of 50 IL-only cases per counselor, rounded to whole FTE.

Question 7: Much is made about the backlog in disability claims. Would you describe for the Members what happens to a cohort of 1,000 claims as they work through the system from the regional office to the Court of Appeals for Veterans claims?

Response:

Rating Process

When a veteran submits a claim, a claim file is established or requested from storage and the file is placed under control. The Veterans Claims Assistance Act (VCAA) requires VA to provide written notice to claimants of the evidence required to substantiate a claim and of which party (VA or the claimant) is responsible for acquiring that evidence. Under VCAA, VA's duty to assist the claimant in perfecting and successfully prosecuting his or her claim extends to obtaining government and private records, and obtaining all necessary medical examinations and medical opinions. The claimant has 60 days to respond to VA's request for information or submit substantiating evidence. As a claim progresses, additional notifications to the veteran may be required. After the evidence is received or after all notice periods have ended, the claim and evidence are reviewed. A rating decision is then prepared and the award or denial is processed.

Appeal Process

Veterans can appeal decisions denying service connection for any conditions claimed. They may also appeal the effective date of an award and the evaluation assigned to a disability. An appeal is initiated when the veteran files a Notice of Disagreement (NOD). Approximately 13 percent of all rating decisions result in an NOD. For every 1,000 rating decisions, 130 veterans on average would file a notice of disagreement.

If the appeal cannot be resolved at the regional office, VA issues a Statement of the Case (*SaC*). The veteran may then perfect the appeal and have it sent to the Board of Veterans' Appeals (Board) by filing a VA Form 9. About 50 percent of veterans who initially file an NOD formalize an appeal. This means around 65 of the 130 veterans appeal to the Board.

If the veteran submits new evidence that does not resolve the appeal, VA will issue a Supplemental Statement of the Case (SSOC). After the regional office issues an SSOC, the claims file is reviewed for completeness and is certified as ready for the Board. The regional office then transfers the record to the Board. The Board reviews the appeal and decides to grant the appeal, deny the appeal, or remand the appeal to the regional office or the Appeals Management Center for additional development and processing.

If the veteran disagrees with the Board's decision, he or she has 120 days from the date of the final Board decision to file an appeal to the Court of Appeals for Veterans Claims (CAVC). The CAVC may grant, deny, dismiss, or remand the appeal. Less than 1 percent of all regional office decisions are appealed to the CAVC.

Growth of Disability Claims Workload

The number of veterans filing *initial* disability compensation claims and claims for increased benefits has increased every year since FY 2000. Disability claims from veterans of all periods increased from 578,773 in FY 2000 to 806,382 in FY 2006. For FY 2006 alone, this represents an increase of nearly 228,000 claims or 38 percent over the 2000 base year.

The primary factors leading to the sustained high levels of claims activity are: Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF); more beneficiaries on the rolls, with resulting additional claims for increased benefits; improved and expanded outreach to active-duty service members, guard and reserve personnel, survivors, and veterans of earlier conflicts; and implementation of combat related special compensation (CRSC) and concurrent disability and retired pay (CDRP) programs by the Department of Defense (DoD).

The number of veterans receiving compensation has increased by almost 400,000 since 2000—from just over 2.3 million veterans to nearly 2.7 million in 2006. This increased number of compensation recipients, many of whom suffer from chronic progressive disabilities such as diabetes, mental illness, and cardiovascular disabilities, will continue to stimulate more claims for increased benefits in the coming years as these veterans age and their conditions worsen.

VA is committed to increased outreach efforts to active-duty personnel. These outreach efforts result in significantly higher claims rates. Original claim receipts increased from 111,672 in FY 2000 to 217,343 in FY 2006—a 95 percent increase.

The Veterans' Claims Assistance Act (VCAA) has significantly increased both the length of time and the specific requirements of claims development. VA's notification and development duties increased as a result of VCAA, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Since enactment, we are required to review the claims at additional points in the decision process.

The greater number of disabilities veterans now claim, the increasing complexity of the disabilities being claimed, and changes in law and Court decisions affecting the decision process pose additional challenges to timely processing the claims workload. As the number of claimed conditions increases, the potential for additional unclaimed but secondary, aggravated, and inferred conditions increases as well. The increasing number of claimed conditions also significantly increases the potential for appeal.

Question 8: Housing construction costs are escalating rapidly and the average adapted housing grant is bumping up against the maximum $50,000 limit. The budget request does not include additional funding for an increase in the limit. Does the Department intend to submit a legislative request to improve this important program to improve the lives of our most seriously disabled veterans?

Response: VA intends to consider such a legislative proposal during the upcoming FY 2009 legislative cycle.

Question 9: How many FTE are needed to administer the chapter 1606/1607 education programs, what are the other costs such as equipment, and does 000 reimburse VA for those costs?

Response: We estimate that both of these programs combined will represent approximately 20 percent of the students receiving benefits in FY 2008. The same percentage of claims processing FTE will be needed to administer these programs, equating to 80 FTE, plus equipment needs (PCs, printers, etc.).

Chapters 1606 and 1607 are processed using VBA's existing Benefits Delivery Network (BON). We have not distributed the costs of operating and maintaining the BON by benefit program. There are other administrative costs involved with these programs such as direct mailing, outreach, etc.

DoD reimburses VA for the actual benefit moneys that are disbursed but not for the administrative costs.

Question 10: Your goal for veteran home ownership is 104% of the non-veteran ownership rate. The U.S. Census lists the national home ownership for the general population at 68.9%. What is the current veteran home ownership rate?

Response: Our goal is for veteran home ownership to be 104 percent of the home ownership rate of the general population. The U.S. Census Bureau reports the home ownership rate for the general population was 68.9%, at the close of FY 2006. The corresponding figure for veteran home ownership was 82 percent.

Questions from Hon. Ginny Brown-Waite to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Question 1: What has the VHA done to correct the serious malpractice of data storage that endangers all veterans' data in VA research facilities?

Response: Recent events both inside and outside VA have highlighted the potential vulnerability of sensitive information, including patient data in research studies. VA is committed to protecting this sensitive information, and on February 6, 2007, implemented a comprehensive Security and Privacy Review of all VA research activities. The review consists of new training requirements and a project-by-project certification process focused on research data storage and security for all VA research. In response to the data incident at the Birmingham VAMC, on January 25, 2007, all research at the Birmingham VAMC Health Services Research and Development (HSR&D) Research Enhancement Award Program (REAP) was suspended. A formal review by the Office of Inspector General and the Office of Research Oversight is ongoing. As a precaution, on February 16, 2007, all research at the other six HSR&D REAP sites was suspended, pending a site visit assessment by the Office of Information and Technology accompanied by the Office of Research and Development and VHA Privacy Office.

Question 2: The FY2008 IT cyber-security budget requests $70.1 million. What are the specific initiatives by line item that this money purchases?

Response: The IT cyber security program includes 18 initiatives, as follows:

Initiative	**FY 2008**
Cyber Security Management	$28.7M
Certification & Accreditation	7.5
Identity Safety and Risk Management	6.0
Policy Development and Maintenance	5.7
Training, Awareness and Education	5.4
FISMA Reporting	2.3
Security Inspection	1.8
Field Security Operations	**$41.4M**
Enterprise Encryption and Data Protection	7.0
Maintenance/Support Services	6.5
Enterprise Framework	5.5
Antivirus	5.4
Vulnerability Assessment and Penetration	4.0
Patch Management	3.4
Encryption	2.7
Testing	2.2
Intrusion Prevention	1.9
E-Authentication	1.9
Media Disposal	0.5
COOP	0.4
Total	**$70.10M**

Question 3: When will the Department fully deploy the Education Expert System?

Response: The projected date to fully deploy TEES is September 2011. The phased approach of delivering discrete modules of business functionality enables VA to target priority business functionality and benefit from their incorporation into the business process as more strategic modules are developed.

Question 4: The budget requests $35 million in FY2008 for the FLITE program, which is the rebranding of the failed debacle of the CoreFLS program. How much was spent on the CoreFLS program before it bellied up?

Response: The core financial and logistics system (coreFLS) project was designed to provide VA with a state-of-the-art integrated financial and logistical capability that would eliminate existing material weaknesses, and replace legacy financial and logistic applications. However, unexpected technical and programmatic challenges forced VA to shut down coreFLS and reexamine our approach. As a result, VA is now pursuing the development and implementation of the FLITE program which will also provide an integrated financial/logistics management solution that will satisfy the Federal Financial Management Improvement Act and related regulatory requirements. More importantly, FLITE will expand upon the work completed under coreFLS by refining the list of business requirements and interface specifications, standardizing business processes, and incorporating lessons learned into program and risk management plans associated with the creation of a simple, high performance, cost effective financial management component. FLITE is different from coreFLS because VA is engaged in more upfront planning, communication and coordination across the administrations. Out year budget request will enable VA to complete development and integration of these components and deploy the system accordingly. The total expended on the coreFLS project was $233.5 million.

Question 5: Please provide a line-by-line authorization of each modernization project and a hard date of implementation.

Response: VA modernization projects are defined as those initiatives currently planned or underway to: (1) move applications off the benefits delivery network (BON) platform and/or (2) move legacy client-server applications to the *One* VA "to be" enterprise architecture. These projects are:

Project	Authorization	Planned Implementation Date
VETSNET Development	Compensation and Pension Maintenance and Operations OMB Exhibit 300	• August 2007—complete compensation • February 2008—Survivor Benefits • August 2008—Income Based • Pension • May 2009—conversion of all SON records complete
TEES Development	TEES OMS Exhibit 300	• Effort undergoing scope and re-baseline review
BON Migration Project	VA Computing Infrastructure OMB Exhibit 300	• Effort in planning stage (rough estimate) • September 2011
YBA Application Migration Program (VAMP)	YBA Application Migration Project OMS Exhibit 300	• FY 2008 initiative—planning estimate • July 2012

Question 6: Development of the VHA scheduling application is over 10 years old and still not implemented. Why? How much money has been spent on the scheduling project to date?

Response: The purpose of the VA scheduling project, which began in May 2001, is to develop a future business model intended to support (1) improved access to care for veterans, (2) decreased wait times for appointments, and (3) increased provider availability all intended to improve patient care. Application development

began in 2002 and has been underway for 5 years. VA is taking a phased approach to implement the application, as the move from a 25-year-old legacy system to a new infrastructure is understandably complex. This phased approach is part of the Health*e*Vet overarching strategic plan to modernize veterans health information systems and technology architecture (VistA) software. The scheduling project is now nearing development completion with costs to date (FY 2001 through FY 2006) totaling $66.5 million. Initial testing for both the application and new Health*e*Vet platform will be fielded at the first VA medical center in summer 2007.

Questions from Hon. Michael R. Turner to Hon. R. James Nicholson, Secretary, U.S. Department of Veterans Affairs

Question 1: In the budget proposals reviewed by the House Veteran's Affairs Committee, two main categories of VA long-term care include Non-institutional Extended Care (which includes home care), and Nursing Home Care (which includes VA nursing facilities and contract facilities). VA nursing facilities allow our nation's veterans long-term care often connected with a range of other medical services. It has been the policy of the VA that home care and contract facilities are used to supplement VA nursing home care. However, neither home care nor contract facilities are to be used as a substitute for traditional VA nursing facility when a VA nursing home facility is available and better suited to meet the veteran's needs. Does this continue to be the policy of the VA, and in light of the Administration's current budget request, how can the VA ensure that the use of home care and contract facilities won't undermine veteran's access to VA nursing facilities?

Response: VA continues to hold to the philosophy, in keeping with practice patterns in the private sector, to provide patient-centered long-term care services in the least restrictive setting that is suitable for a veteran's medical condition and personal circumstances, and whenever possible in home and community-based settings. This approach honors veterans' preferences at the end of life and helps to maintain relationships with the veteran's spouse, family, friends, and faith community. Nursing home care should be reserved for situations in which the veteran can no longer be safely maintained in the home and community.

The current budget request will support continued expansion of access to VA's spectrum of non-institutional home and community-based long-term care services while sustaining capacity in VA's own nursing home care units and the community nursing home program, and continuing to support modest growth in capacity in the State veterans home program. VA long-term care is comprised of a dynamic array of services provided in residential, outpatient, and inpatient settings that can be deployed as needed to meet a veteran's changing healthcare needs over time.

THE

A Comprehensive Budget & Policy Document Created by Veterans for Veterans

INDEPENDENT BUDGET

for the Department of Veterans Affairs

Fiscal Year

2008

Prologue

This is the 21st year *The Independent Budget (IB)* has been developed by four veterans service organizations: AMVETS, Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States. This document is the collaborative effort of a united veteran and health advocacy community that presents policy and budget recommendations on programs administered by the Department of Veterans Affairs (VA) and the Department of Labor.

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

The President has stated that the war on terrorism is likely to be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends.

With this new reality ever present in our minds, we must do everything we can to ensure that VA has all the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a country that not only cherishes their service but also honors them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome the employment challenges created by injury, and the best claims processing system to deliver education, compensation, and survivors' benefits in a minimum amount of time to those most harmed by their service to our nation.

It is fitting that our 21st *Independent Budget* comes early in the 21st century. *The Independent Budget* veterans service organizations, or IBVSOs, work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

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

Tom McGriff
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AMVETS

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National Commander
Disabled American Veterans

Randy L. Pleva, Sr.
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Paralyzed Veterans of America

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FY 2008 *INDEPENDENT BUDGET* SUPPORTERS

AAALAC International
Administrators of Internal Medicine
African American Post Traumatic Stress Disorder
Air Force Association
Air Force Women Officers Association
Alliance for Academic Internal Medicine
American Coalition for Filipino Veterans
American Ex-Prisoners of War
American Federation of Government Employees
American Veterans Alliance, USA
Association of American Medical Colleges
Association of Professors of Medicine
Association of Program Directors in Internal Medicine
Association of Subspecialty Professors
Blinded Veterans Association
Catholic War Veterans, USA, Inc.
Christopher Reeve Foundation
Clerkship Directors in Internal Medicine
Enlisted Association of the National Guard of the United States
Fleet Reserve Association
FOVA
Georgia Department of Veterans Affairs
Gold Star Wives of America, Inc.
Iraq & Afghanistan Veterans of America
Japanese American Veterans Association
Jewish War Veterans of the USA

continued on next page

Lung Cancer Alliance
Mental Health America
Military Officers Association of America
Military Order of the Purple Heart of the USA, Inc.
National Alliance on Mental Health
National Association for Uniformed Services
National Association of American Veterans, Inc.
National Association of County Veterans Service Officers
National Association of State Veterans Homes
National Association of Veterans' Research and Education Foundations
National Coalition for Homeless Veterans
National Gulf War Resource Center, Inc.
National Organization on Disabilities
National Spinal Cord Injury Association
Naval Reserve Association
Navy Club of the United States of America
Navy Seabee Veterans of America
Non Commissioned Officer Association
P-47 Thunderbolt Pilots Association
Nurses Organization of Veterans Affairs
State of Washington
The Forty & Eight
United States Coast Guard CPOA/CGEA
United States Federation of Korea Veterans Organization
Veterans Affairs Physician Assistant Association
Vietnam Veterans of America

Guiding Principles

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

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Introduction

As *The Independent Budget* begins its third decade, we are faced with predicting the needs of an ever-growing veterans population in the midst of a war. Even as the Department of Veterans Affairs (VA) continues to deny many veterans access to health care, many more men and women who have sacrificed themselves in the global war on terrorism are taking advantage of the VA health-care and benefits system. Unfortunately, the task of estimating the true resource needs for the VA to carry out a responsible budget has been significantly complicated by a lack of action on the part of Congress in 2006.

Yet last year proved to be a unique year for reasons very different from 2005. After the budget shortfall debacle that occurred in 2005, the Administration submitted a budget request last year for FY 2007 that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again. These recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our nation's veterans. We are proud that more than 50 veterans, military, and medical service organizations have endorsed the 21st edition of *The Independent Budget* this year.

As our nation's service members continue to be placed in harm's way in conflicts around the world, it is important that their needs upon returning home from the battlefield are met. The VA health-care and benefits system is a critical national resource for our nation's increasing veteran population. Veterans depend on VA for the health-care, housing, education, vocational rehabilitation, and insurance benefits they earned serving our country. As the Administration and Congress consider the monetary needs of VA this fiscal year, they should pause to consider how much is at stake.

Year after year, we call on Congress to provide funding necessary to meet the health-care needs of veterans and to do so in a timely manner. Unfortunately, VA remains underfunded and unable to provide timely access to quality health care to many of our nation's veterans. A system praised for the work it does is held hostage by the very people charged with the responsibility of meeting veterans' needs. If Congress cannot fulfill its solemn obligation to these men and women through the current process, it is only appropriate that the VA health-care system be made mandatory funding. Mandatory funding would ensure that the government meets its obligation to ensure all veterans eligible for VA health care have access to timely, quality care.

With regard to veterans' benefits, *The Independent Budget* recognizes a vastly growing crisis that has not been properly addressed in years past. It is time to take real steps to fix the backlog in claims processing before the system collapses under its own weight. Continuing to study these problems without developing real solutions serves no other purpose than to delay

the benefits that veterans have earned and deserve. Moreover, a large number of adjudication decisions are incorrect or have technical or procedural errors, further exacerbating the problem. Veterans' benefits are part of a covenant between our nation and its defenders and should never be denied, reduced, or delayed.

The Independent Budget covers the broadest spectrum of veterans' benefits and services with recommendations on each to make certain we keep the nation's obligation to those who have served and sacrificed so much in its defense. We understand that veterans' health care and benefits cost a lot of money, but these are men and women who have paid the price. They have taken the oath and served this country with honor and distinction. It is time that the promises made to them are promises kept.

VA Accounts FY 2008
(Dollars in Thousands)

	FY 2007 Appropriation**	FY 2008 Admin	FY 2008 IB
Veterans Health Administration			
Medical Services	25,512,000	27,167,671	28,979,220
Medical Administration	3,177,000	3,442,000	3,378,067
Medical Facilities	3,569,000	3,592,000	3,991,152
Total, Medical Care	**32,258,000**	**34,201,671**	**36,348,439**
Medical and Prosthetic Research	413,700	411,000	480,000
Subtotal, Veterans Health Administration	**32,671,700**	**34,612,671**	**36,828,439**
Veterans Benefits Administration	1,168,445	1,198,294	1,905,300
General Administration	312,319	273,543	328,541
Total, General Operating Expenses (GOE)	**1,480,764**	**1,471,837**	**2,233,841**
Information Technology	1,213,820	1,859,217	1,340,098
National Cemetery Administration	160,733	166,809	218,335
Office of Inspector General	70,674	72,599	73,233
Subtotal, Dept. Admin. and Misc. Programs	**1,445,227**	**2,098,625**	**1,631,666**
Construction, Major	399,000	727,400	1,602,000
Construction, Minor	198,937	233,396	541,000
Grants for State Extended Care Facilities	85,000	85,000	150,000
Grants for Construction of State Vets Cemeteries	32,000	32,000	37,000
Subtotal, Construction Programs	**714,937**	**1,077,796**	**2,330,000**
Other Discretionary	154,158	155,501	158,629
Subtotal, Discretionary	**36,466,786**	**39,416,430**	**43,182,575**
Cost for Category 8 Veterans Denied Enrollment			365,977
Total, Discretionary			**43,548,552**

***FY 2007 Appropriations Amounts Based on H.J.Res. 20, Continuing Resolution for FY 2007*

Benefit Programs

Through the Department of Veterans Affairs (VA), our citizens provide a wide array of vital benefits to veterans. Included are disability compensation, dependency and indemnity compensation (DIC), pensions, vocational rehabilitation and employment, education benefits, housing loans, ancillary benefits for service-connected disabled veterans, life insurance, and burial benefits.

Disability compensation payments fulfill our primary obligation to make up for the economic and other losses veterans suffer as a result of the effects of service-connected diseases and injuries. When veterans' lives are cut short by service-connected injuries or following a substantial period of total service-connected disability, eligible family members receive DIC. Veterans' pensions provide a measure of financial relief for needy veterans of wartime service who are totally disabled by nonservice-connected causes or who have attained the age of 65. Death pensions are paid to needy eligible survivors of wartime veterans. Burial benefits assist families in meeting the costs of veterans' funerals and burials and provide for burial flags and grave markers. Miscellaneous assistance includes other special allowances for smaller select groups of veterans and dependents and attorney fee awards under the Equal Access to Justice Act. Because of an apparent correlation between veterans' service in Vietnam and spina bifida and other birth defects in the children of these veterans, Congress authorized special programs to provide a monthly financial allowance, health care and vocational rehabilitation to these children.

In recognition of the disadvantages that result from interruption of civilian life to perform military service, Congress has authorized various benefits to aid veterans in their readjustment to civilian life. These readjustment benefits provide financial assistance to veterans in education or vocational rehabilitation programs and to seriously disabled veterans in acquiring specially adapted housing and automobiles. Educational benefits are also available for children and spouses of veterans who are permanently and totally disabled or for those who die as a result of service-connected disability. Qualifying students pursuing VA education or rehabilitation programs may receive work-study allowances. For temporary financial assistance to veterans undergoing vocational rehabilitation, loans are available from the vocational rehabilitation revolving fund.

Under its home loan program, VA guarantees commercial home loans for veterans, certain surviving spouses of veterans, certain service members, and eligible Reservists and National Guard members. VA also makes direct loans to supplement specially adapted housing grants. VA makes direct housing loans to Native Americans living on trust lands.

Under several different plans, VA offers life insurance to eligible veterans, disabled veterans, and members of the Retired Reserve. A group plan also covers service members and members

of the Ready Reserve and their family members. Mortgage life insurance protects veterans who have received VA specially adapted housing grants.

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

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

▼ ▼ ▼

Benefits Issues

COMPENSATION AND PENSIONS

Compensation

Annual Cost-of-Living Adjustment:

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

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

RECOMMENDATION:

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

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Full Cost-of-Living Adjustment for Compensation:

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

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

RECOMMENDATION:

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

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Standard for Service Connection:

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

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

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

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

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

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

Surprisingly, during deliberations on the annual defense authorization bill for fiscal year 2004, key members of the leadership of the United States House of Representatives developed a scheme to accomplish that very purpose by replacing the "line of duty" standard with a strict "performance of duty" standard, under which service connection would not generally be granted unless a veteran could offer proof that a disability was caused by the actual performance of military duty. Although this scheme was not enacted into law, the final legislation did require the establishment of a federal advisory commission to study the foundations of disability benefit programs for veterans—presumably with the same ultimate goal in mind. This action seems to be consistent with current systematic efforts to reduce spending on military personnel and veterans' programs in order to devote more resources to mission programs, personnel, weapons and other military hardware, and the operational costs of war.

The Independent Budget veterans service organizations believe that current standards governing service connection for veterans' disabilities and deaths are equitable, practical, sound, and time-tested. *The Independent Budget* veterans service organizations urge Congress to reject any revision of this longstanding policy standard for the purpose of permitting the federal government to coldly and expediently avoid its responsibilities for the human costs of war and our national defense.

RECOMMENDATION:

Congress should reject any suggestion from any source to change the terms for service connection of veterans' disabilities and deaths.

Concurrent Receipt of Compensation and Military Retired Pay:

All military retirees should be permitted to receive military retired pay and Department of Veterans Affairs (VA) disability compensation concurrently.

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

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

To the extent that military retired pay and VA disability compensation now offset each other, the disabled retiree is treated less fairly than a nondisabled military retiree. Moreover, a disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing the enlistment obligation can receive full VA compensation and full civilian retired pay—including retirement from federal civil service employment and employment in the U.S. Postal Service. A veteran who has served this country in the armed forces for 20 years or more, however, or one who was disabled and discharged before attaining the full military retirement service threshold, should have that same right. A disabled veteran should not suffer a financial penalty for choosing military service as a career rather than a civilian career, especially where in all likelihood a civilian career would have involved fewer sacrifices and greater rewards. Disability compensation to a disabled veteran should not be offset against military longevity retired pay. If a veteran must forfeit a dollar of retired pay for every dollar of VA disability compensation otherwise payable, our government is in effect compensating the veteran with *nothing* for the service-connected disability he or she suffered. *The Independent Budget* veterans service organizations urge Congress to correct this continuing inequity.

RECOMMENDATION:

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

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

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

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

RECOMMENDATION:

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

Increase in Rates of Special Monthly Compensation:

Congress should increase rates of payment to veterans suffering from service-connected disabilities who are determined housebound or in need of regular aid and attendance because of these service-incurred disabilities.

The Department of Veterans Affairs, under the provisions of title 38, United States Code, section 1114(k) through (s), provides additional special compensation to select categories of veterans with very severe, debilitating disabilities, such as the loss of a limb, loss of certain senses, and to those who require the assistance of an aide for the activities of daily living, such as dressing, toileting, bathing, and eating.

A veteran who, as the result of a service-connected disability, has suffered the anatomical loss of use of a creative organ, or one foot, or one hand, or both buttocks, or blindness of one eye having only light perception, or who has suffered complete organic aphonia with constant inability to communicate through speech, or deafness of both ears having absence of air and bone conduction, and, in the case of a woman, the anatomical loss of one or both breasts (including loss by mastectomy), the rate of special compensation is at present $84 per month for each such devastating loss, or loss of use, beyond the service-connected compensation level of disability granted.

The payment of special monthly compensation, while minimally adjusted for inflation each year, is now no longer sufficient to compensate for the special needs of these veterans.

RECOMMENDATION:

Congress should enact legislation to increase the special monthly compensation under title 38, United States code, section 1114(l) through (s) by an immediate 20 *percent* above the current base amount and additionally, increase by 50 *percent* the current base amount of special monthly compensation under title 38, United States Code, Section 1114(k).

More Equitable Rules for Service Connection of Hearing Loss and Tinnitus:

For combat veterans and those who had military occupations that typically involved noise exposure sufficient to cause hearing loss or tinnitus, service connection should be presumed.

Many combat veterans and veterans that had military duties involving high levels of noise exposure who now suffer from hearing loss or tinnitus likely related to noise exposure or acoustic trauma during service are unable to prove service connection because of inadequate testing procedures, lax examination practices, or poor record-keeping.

In a September 2005 report, "Noise and Military Service: Implications for Hearing Loss and Tinnitus," the Institute of Medicine found: "Patterns of hearing loss consistent with noise exposure can be seen in cross-sectional studies of military personnel…Because large numbers of people have served in the military since World War II, the total number who experienced noise-induced hearing loss by the time their military service ended may be substantial, but the available data provide no basis for a valid estimate of the number."

Hearing loss and tinnitus are common among combat veterans. The reason is simple: Combat veterans are typically exposed to prolonged and frequent loud noises from unusual sources, such as the sound of gunfire and jet and other loud aircraft engines, just to name a few. Combat veterans are likely to have suffered acoustic trauma from black powder and other explosive sources. Exposure to loud noise and acoustic trauma are both known causes of high-frequency hearing loss and tinnitus. Yet, many combat veterans are unable to document that their hearing loss or tinnitus is due to military service. World War II veterans are particularly at a disadvantage because testing by spoken voice and whispered voice was insufficient to detect hearing loss in many instances.

Other veterans serve in military occupations that typically involve noise exposure sufficient to cause hearing loss. Today, ear protection is mandatory in these military occupations, but many performed the same jobs without protection during earlier periods.

With some regularity, audiometric testing or records of testing are insufficient or lacking for a variety of reasons. Congress has made special provisions for other deserving groups of veterans whose claims are unusually difficult to establish because of circumstances beyond their control and should do the same for combat veterans and veterans whose military duties are generally recognized (e.g., artillery gun crews) to have involved noise exposure sufficient to cause hearing loss and tinnitus. When these veterans suffer from tinnitus or the type of hearing loss that can result from noise exposure and when their medical records are insufficient to prove absence of service-related hearing loss or tinnitus during service, service connection should be presumed after reasonably ruling out any post-service causation.

RECOMMENDATION:

Congress should enact a presumption of service-connected disability for combat veterans and veterans who performed military duties typically involving high levels of noise exposure and who subsequently suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma. This presumption of disability should be applied when the veteran's record does not affirmatively prove such condition or conditions are unrelated to service.

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Compensable Disability Rating for Hearing Loss Necessitating Hearing Aid:

The Department of Veterans Affairs (VA) disability rating schedule should provide a minimum 10 percent disability rating for hearing loss that requires use of a hearing aid.

The VA *Schedule for Rating Disabilities* does not provide a compensable rating for hearing loss at certain levels severe enough to require hearing aids. The minimum disability rating for any hearing loss warranting use of hearing aids should be 10 percent, and the schedule should be changed accordingly.

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

RECOMMENDATION:

VA should amend its *Schedule for Rating Disabilities* to provide a minimum 10 percent disability rating for any hearing loss for which the wearing of a hearing aid is medically indicated.

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Temporary Total Compensation Awards:

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

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

Hospitalization in excess of 21 days for a service-connected disability entitles the veteran to a temporary total disability rating of 100 percent. This rating is effective the first day of hospitalization and continues to the last day of the month of discharge from hospital. Similarly, where surgery for a service-connected disability necessitates at least one month's convalescence or causes complications, or where immobilization of a major joint by cast is necessary, a temporary 100 percent disability rating is awarded effective the date of hospital admission or outpatient visit.

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

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

Therefore, *The Independent Budget* veterans service organizations urge Congress to enact legislation exempting these temporary total disability ratings, administered under title 38 C.F.R. §§ 4.29 4.30, from the provisions of title 38 U.S.C. § 5111.

RECOMMENDATION:

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

Pension for Nonservice-Connected Disability:

Congress must amend basic eligibility for pensions for nonservice-connected veterans who serve in combat circumstances, irrespective of whether these are declared wars.

Many veterans who have participated in hostile military operations do not fall within any defined or declared period of war as currently listed in title 38, Code of Federal Regulations, paragraph 3.2. Accordingly, these veterans are ineligible for nonservice-connected war pension benefits under title 38, United States Code, Chapter 15, "Pension for Nonservice-Connected Disability/Death."

Some expeditionary medals and combat badges are awarded to members of the armed forces who have served deployments in hostile regions, situations and circumstances other than those officially designated combat operations, or during a wartime era as declared by Congress. These veterans may have served our nation under more dangerous and threatening circumstances than veterans who served during official periods of war and those who, while serving in a period of war, were not directly involved in combat or infantry operations.

RECOMMENDATION:

Congress should amend eligibility requirements in title 38, United States Code, Chapter 15, to authorize eligibility for nonservice-connected disability pension to veterans who have been awarded the Armed Forces Expeditionary Medal, the Navy/Marine Corps Expeditionary Medal, the Purple Heart, the Combat Infantryman's Badge, the Combat Medical Badge, or the Combat Action Ribbon for participation in military operations not falling within an officially designated or declared period of war.

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Dependency and Indemnity Compensation

Review of Adequacy of Overall Dependency and Indemnity Compensation Program:

Congress should review adequacy of dependency and indemnity compensation (DIC) to ensure the level of VA financial support is adequate to maintain these beneficiaries above the poverty level.

The VA Dependency and Indemnity Compensation program provides monthly financial support to the widow or widower of a veteran who dies from a service-connected disability (including the survivor of an active duty service member who dies while still in military service). Historically, DIC was intended to enable a survivor of a veteran to maintain a standard of living above the poverty level that might have ensued because of the loss of a spouse's life income and earning power. Current payment rates for DIC are set in law, and generally the maximum monthly payment is limited to $1,033, about 41 percent of the level of maximum service-connected disability payment to a totally disabled veteran—and considerably less than pensions paid to a survivor of a federal retiree, which is set in law at 55 percent of that federal annuity. Because of inflation and other economic factors, many widows (and some widowers) are in fact now living in poverty due to lack of income other than DIC. Their situations are often compounded by their own disabilities, child-care responsibilities, and consequent inability to work. *The Independent Budget* veterans service organizations feel strongly that no survivor of a veteran who died as a result of service-connected disability, and most certainly no survivor of a service member who died while serving our nation, ever should be reduced to poverty as a result of government compensation policy.

RECOMMENDATION:

Congress should use the General Accountability Office or another independent reviewer to examine the VA's DIC program to ensure that current policy adequately maintains the survivors of veterans who died as a result of service-connected disabilities and make legislative recommendations to Congress to correct any inequities observed from such examination.

Repeal of Offset Against Survivor Benefit Plan:

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of, and by an amount, equal to dependency and indemnity compensation (DIC) is inequitable.

A veteran disabled in military service in our armed forces is compensated for the effects of the service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the Department of Veterans Affairs. This benefit indemnifies survivors for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the SBP, deductions are made from the member's retired pay to purchase a survivors' annuity. This is not a gratuitous benefit. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected causes for the required time preceding his or her death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service-connected causes or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. Where the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

RECOMMENDATION:

Congress should repeal the offset between dependency and indemnity compensation and the Survivor Benefit Plan.

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Increase of DIC for Surviving Spouses of Service Members:

Congress should elevate rates of DIC to survivors of active duty military personnel who die while on active duty.

Current law authorizes the Department of Veterans Affairs to pay additional, enhanced amounts of dependency and indemnity compensation, in addition to the basic rate, to the surviving spouses of veterans who die from service-connected disabilities, after at least an eight-year period of the veteran's total disability rating prior to death. However, surviving spouses of military service members who die on active duty receive only the basic rate of DIC.

Needless to say, this is inequitable because surviving spouses of deceased active duty service members face the same financial hardship as survivors of deceased service-connected veterans who were totally disabled for eight years prior to their deaths.

RECOMMENDATION:

We urge Congress to authorize DIC eligibility at increased rates to survivors of deceased military personnel on the same basis as that for the survivors of totally disabled service-connected veterans.

Retention of Remarried Survivors' Benefits at Age 55:

Congress should lower the age threshold for eligibility for restoration of dependency and indemnity compensation (DIC) to remarriage of survivors of veterans who die from service-connected disabilities.

Current law permits remarried survivors of veterans who die from service-connected disabilities to requalify for DIC benefits if the remarriage occurs at age 57 or older, or if already remarried, they apply for reinstatement of DIC at age 57. While *The Independent Budget* veterans service organizations appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is based on no objective data related to this population or its needs. Remarried survivors of retirees in other federal programs obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other federal programs should govern Congressional action for this deserving group.

RECOMMENDATION:

Congress should lower the existing eligibility age for reinstatement of DIC to remarried survivors of service-connected veterans, from 57 years of age to 55 years of age.

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READJUSTMENT BENEFITS

Montgomery GI Bill

Expansion of Montgomery GI Bill Eligibility:

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

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

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

RECOMMENDATION:

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

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Refund of Montgomery GI Bill Contributions for Ineligible Veterans:

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

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

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

RECOMMENDATION:

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

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Matching Education Benefits to Service Performed—A 21st Century Montgomery GI Bill:

The nation's active duty, National Guard, and Reserve forces are operationally integrated under the Total Force policy. But educational benefits do not reflect the policy nor match benefits to service commitment.

Congress reestablished the GI Bill in 1984. The Montgomery GI Bill (MGIB) was designed to stimulate all-volunteer force recruitment and retention and to help veterans readjust to civilian life. Active duty veterans have up to 10 years post-service to use the MGIB. But Reservists who earn certain MGIB benefits during mobilization get no post-service use of those benefits. In the 1980s, policymakers and Congress never envisioned the routine use of Guard and Reserve forces for every operational mission, nor did many people perceive a need for a post-service readjustment benefit for Reserve participants. The Reserve MGIB worked well for the first 15 years of the MGIBs existence. Slippage of Reserve benefits in relationship to the active duty MGIB started at about the time that large and sustained call-ups of the Guard and Reserve began after the September 11, 2001, attacks. Congress attempted to respond to this benefit gap by authorizing a second Reserve Title 10 MGIB program—"Chapter 1607"—for reservists who were mobilized for more than 90 days for a contingency operation. However, the complexity of "Chapter 1607" program funding challenges, and the difficulty of correlating it with both the original Reserve MGIB—"Chapter 1606"—and the active duty program, have delayed its implementation, perhaps indefinitely.

The nation's total armed forces need a MGIB that supports recruitment and retention, readjustment to civilian life, proportionality of benefits for service rendered, and ease of administration.

The Total Force MGIB has two broad concepts. First, all active duty and reserve MGIB programs would be organized under title 38. (The responsibility for enlistment incentives, MGIB "kickers," and other incentives would remain with the Department of Defense under title 10.) Second, MGIB benefit levels should be simplified according to the military service performed.

To align benefits with service performed, National Guard and Reserve MGIB programs would be inte-

grated with the active duty program. Second, benefit rates would be structured as follows:

1. Tier one—similar to the current Montgomery GI Bill–Active Duty three-year rate—would be provided to all who enlist in the active armed forces. Service entrants would receive 36 months of benefits at the Active Duty Rate.

2. Tier two would be for nonprior service direct entry in the Selected Reserve (SELRES) for six years. Benefits would be proportional to the active duty rate. Historically, Selected Reserve Benefits have been 47 to 48 percent of active duty benefits.

3. Tier three would be for members of the Ready Reserve who are activated for at least 90 days. They would receive one month of benefits for each month of activation, up to a total of 36 months, at the active duty rate.

A service member would have up to 10 years to use remaining active duty or activated-service benefits—tier one and tier three—from the date of separation. A selected reservist could use remaining second tier MGIB benefits as long as he or she were satisfactorily participating in the SELRES and for up to 10 years following separation from the reserves if a separation were for disability or qualification for a reserve retirement at age 60.

RECOMMENDATION:

Congress should combine all active duty and reserve MGIB programs and tier benefits according to the service performed.

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Housing Grants

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

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

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

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

RECOMMENDATION:

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

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Grant for Adaptation of Second Home:

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

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

RECOMMENDATION:

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

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Automobile Grants and Adaptive Equipment

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

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

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

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

Because of a lack of adjustments to keep pace with increased costs, the value of the automobile allowance has substantially eroded through the years. In 1946 the $1,600 allowance represented 85 percent of average retail cost and a sufficient amount to pay the full cost of automobiles in the "low-price field." By contrast, in 1997 the allowance was $5,500, and the average retail cost of new automobiles, according the National Automobile Dealers Association, was $21,750. The 1997 average cost of an automobile was 1,155 percent of the 1946 cost, but the automobile allowance of $5,500 was only 343 percent of the 1946 award. Currently, the $11,000 automobile allowance represents only about 39 percent of the average cost of a new automobile, which is $28,105. To restore the comparability between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be $22,484.

Veterans eligible for the automobile allowance under 38 U.S.C. § 3902 are among the most seriously disabled service-connected veterans. Often public transportation is quite difficult for them, and the nature of their disabilities requires the larger and more expensive handicap-equipped vans or larger sedans, which have base prices far above today's smaller automobiles. The current $11,000 allowance is only a fraction of the cost of even the modest and smaller models, which are often not suited to these veterans' needs.

Accordingly, if this benefit is to accomplish its purpose, it must be adjusted to reflect the current cost of automobiles. The amount of the allowance should be increased to 80 percent of the average cost of a new automobile in 2006. And to avoid further erosion of this benefit, Congress should provide for automatic annual adjustments based on the rise in the cost of living.

RECOMMENDATION:

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

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Home Loans

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

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

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

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

RECOMMENDATION:

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

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INSURANCE

Government Life Insurance

Value of Policies Excluded from Consideration as Income or Assets:

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

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

RECOMMENDATION:

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

Lower Premium Schedule for Service-Disabled Veterans' Insurance:

The Department of Veterans Affairs (VA) should be authorized to charge lower premiums for Service-Disabled Veterans' Insurance (SDVI) policies based on improved life expectancy under current mortality tables.

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

RECOMMENDATION:

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

Increase in Maximum Service-Disabled Veterans' Insurance Coverage:

The current $10,000 maximum for life insurance under Service-Disabled Veterans' Insurance (SDVI) does not provide adequately for the needs of survivors.

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

Today, more than 88 years later, maximum coverage under the base SDVI policy is still $10,000. Given that the annual cost of living is many times what it was in 1917, the same maximum coverage well more than three-quarters of a century later clearly does not provide meaningful income replacement for the survivors of service-disabled veterans.

A May 2001 report from an SDVI program evaluation conducted for the Department of Veterans Affairs recommended that basic SDVI coverage be increased to $50,000 maximum. *The Independent Budget* veterans service organizations therefore recommend that the maximum protection available under SDVI be increased to at least $50,000.

RECOMMENDATION:

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

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Veterans' Mortgage Life Insurance

Increase in VMLI Maximum Coverage:

The maximum amount of mortgage protection under Veterans' Mortgage Life Insurance (VMLI) needs to be increased.

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

RECOMMENDATION:

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

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OTHER SUGGESTED BENEFIT IMPROVEMENTS

National Guard and Reserve Benefits:

Congress must improve and modernize federal benefits for members of the National Guard and Reserve forces.

The decade-long trend of our increasing reliance on National Guard, Air National Guard, and the Reserve forces of the Army, Navy, Marine Corps, Air Force, and Coast Guard for national security missions at home and peacekeeping and combat missions overseas, bears no sign of abatement. Reliance on Guard and Reserve forces has grown since the pre-Persian Gulf War era, and this trend continues even though both Reserve and active duty force levels remain far below their Cold War peak.

Since September 11, 2001, more than 410,000 individuals who serve in National Guard and Reserve forces have been mobilized for a variety of military, police, and security actions. Increasing demands on these serving members impose significant and repeated family separations (the single greatest disincentive for a military career) and create additional uncertainty and interruptions in their civilian career opportunities.

Furthermore, Guard and Reserve recruiting, retention, morale, and readiness are already at considerable risk. The nation cannot afford to promote the perception that we undervalue the great sacrifices and level of commitment being demanded from the Guard and Reserve community.

Various incentive, service, and benefit programs designed a half century ago for a far different Guard and Reserve philosophy are no longer adequate to address demands on today's Guard and Reserve forces. Accordingly, steps must be taken by Congress to upgrade National Guard and Reserve benefits and support programs to a level commensurate with the sacrifices being made by these patriotic volunteers. Such enhancements should provide Guard and Reserve personnel a level of benefits comparable to their active duty counterparts and provide one means to ease the tremendous stresses now being imposed on Guard and Reserve members and their families, and to bring the relevance of these benefits into 21st century application.

RECOMMENDATION:

With concern about the current missions of the Guard and Reserve forces, Congress must take necessary action to upgrade and modernize Guard and Reserve benefits, to include more comprehensive health care, equivalent Montgomery GI bill educational benefits, and full eligibility for the VA Home Loan guaranty program.

Protection of Veterans' Benefits Against Claims of Third Parties

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

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

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

table process whatever, either before or after receipt by the beneficiary."

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

However, unappreciative of the special character and superior status of veterans' rights and benefits, the courts have supplanted the will and plain language of Congress with their own expedient views of what the public policy should be and their own convenient interpretations of the law. The courts have chiseled away at the protections in § 5301 until this plain and forceful language has, in essence, become meaningless. Various courts have shown no hesitation to force disabled veterans to surrender their disability compensation and sole source of sustenance to able-bodied former spouses as alimony awards, although divorced spouses are entitled to no veterans' benefits under veterans laws. The welfare of ex-spouses has never been a purpose for dispensing veterans' benefits.

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

RECOMMENDATION:

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

General Operating Expenses

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

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

The best-designed benefit programs achieve their intended purposes only if the benefits are delivered to entitled beneficiaries in a timely manner and in the correct amounts. *The Independent Budget* veterans service organizations make the following recommendations to maintain VA's benefits delivery infrastructure and to improve VA performance and service to veterans.

General Operating Expense Issues

VETERANS BENEFITS ADMINISTRATION

VBA Management

More Authority Over Field Offices:

Department of Veterans Affairs (VA) program directors should have more accountability for benefits administration in the field offices.

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

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

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

In its March 2004 "Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran," the VA Vocational Rehabilitation and Employment (VR&E) Task Force recommended that the director of the VR&E Service be given "some line-of-sight authority for the field administration of the program." We agree with this assessment as well.

RECOMMENDATION:

To improve the management structure of the VBA for purposes of enforcing program standards and raising quality, VA's Under Secretary for Benefits should give VBA program directors more accountability for the performance of VA regional office directors.

VBA Initiatives

Investment in VBA Initiatives:

To maintain and improve efficiency and services, the Veterans Benefits Administration (VBA) must continue to upgrade its technology and training.

To meet ever-increasing demands and maintain efficiency, any benefits system must continually modernize its tools. With the continually changing environment in claims processing and benefits administration, the VBA must continue to upgrade its information technology infrastructure and revise its training to stay abreast of program changes and modern business practices.

Despite these undeniable needs, Congress has steadily and drastically reduced funding for VBA initiatives over the past five fiscal years. In FY 2001, Congress provided $82 million for VBA initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and, in 2006, $23 million. Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard to the added loss of buying power due to inflation.

With restored investments in initiatives, the VBA could complement staffing adjustments for increased workloads with a support infrastructure designed to increase operations effectiveness. The VBA could resume an adequate pace in its development and deployment of information technology solutions, as well as upgrading and enhancement of training systems, to improve operations and service delivery.

Some initiative priorities for funding follow:

- Replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET) for the Compensation and Pensions Service, the Education Expert System (TEES) for the Education Service, and Corporate WINRS (CWINRS) for the Vocational Rehabilitation and Employment Service.

  VETSNET serves to integrate several subsystems into one nationwide information system for claims development and adjudication and payment administration. TEES serves to provide for electronic transmission of applications and enrollment documentation along with automated expert processing. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

- Continued development and enhancement of data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS), which serve to replace paper-based records with electronic files for acquiring, storing, and processing of claims data.

  Virtual VA supports pension maintenance activities at three pension maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service's system for electronic education claims files, storage of imaged documents, and workflow management. This initiative is to modify and enhance TIMS to make it fully interactive to allow for fully automated claims and award processing by Education Service and VR&E nationwide.

- Upgrading and enhancement of training systems.

  VA's Training and Performance Support Systems (TPSS) is a multimedia, multi-method training tool that applies Instructional Systems Development methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

  VBA initiated its "Skills Certification" instrument in 2004. This tool helps the VBA assess the knowledge base of veterans service representatives. The VBA intends to develop additional skills certification modules to test rating veterans service representatives, decision review officers, field examiners, pension maintenance center employees, and education veterans claims examiners.

- Accelerated implementation of Virtual Information Centers (VICs).

  By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA achieves greater efficiency and improved customer service. Accelerated deployment of VICs will more timely accomplish this beneficial effect.

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced information technology, *The Independent Budget* veterans service organizations believe a conservative increase of at least 5 percent annually in VBA initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by 5 percent each year since then, the amount for FY 2008 would be $115.4 million.

RECOMMENDATION:

Congress should provide $115.4 million for VBA initiatives to improve its information systems.

Compensation and Pension Service

Improvements in Claims Processing Accuracy:

To overcome the persistent and longstanding problem of large claims backlogs and consequent protracted delays in the delivery of crucial disability benefits to veterans and their families, the administration must invest adequate resources in a long-term strategy to improve quality, proficiency, and efficiency within the Veterans Benefits Administration.

A core mission of the Department of Veterans Affairs is to provide financial disability compensation, dependency and indemnity compensation, and disability pension benefits to veterans and their dependent family members and survivors. These payments are intended by law to relieve economic effects of disability (and death) upon veterans and to compensate their families for loss. For those payments to effectively fulfill their intended purposes, VA must deliver them promptly, based on accurate adjudications. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits. Also, the need for financial support among disabled veterans is generally urgent. While awaiting action by VA on their pending claims, they and their families must suffer hardships; protracted delays can lead to deprivation and even bankruptcy. Some veterans have died while their claims for disability were unresolved for years at VA. In sum, VA disability benefits are critical, and meeting the needs of disabled veterans should always be a top priority of the federal government.

Recently VA has adopted a tactic of diverting public attention away from the structural claims backlog it holds by demonstrating great speed and efficiency in adjudicating the claims of wounded soldiers and Marines from the current conflicts in Iraq and Afghanistan. While boasting it is breaking all records in awarding these new veterans their rightful benefits, hundreds of thousands of claims of older veterans from prior conflicts and military services during earlier periods lie dormant, awaiting some future resolution. While we applaud VA's efforts to help new veterans, VA continues to fail older veterans every day that the backlog grows.

VA can promptly deliver benefits to veterans only if it can adjudicate and process their claims in a timely and accurate fashion. Given the critical financial importance of disability payments, VA has an undeniable responsibility to maintain an effective delivery system, and to take decisive and appropriate action to correct deficiencies as soon as they become evident. However, VA has neither maintained the necessary capacity to match and meet its growing claims workload nor corrected systemic deficiencies that compound the problem of inadequate capacity.

Rather than making headway and overcoming the chronic claims backlog and consequent protracted delays in disposition of claims, VA has lost ground on that problem, with

the backlog of pending claims growing substantially larger in recent years. In fact, looking retrospectively over the past six years, the backlog of compensation claims has moved from the December 2000 total of 363,412, to the September 2006 level of 589,583, a more than 50 percent increase during a period when three VA Secretaries of both political parties have stated publicly on multiple occasions that reducing this chronic backlog was their highest management priority. We also note that during this same period as these promises were being made, VBA staffing has essentially remained flat at about 9,000 FTEEs.

Historically, many underlying causes have acted in concert to bring on this seemingly intractable problem. These include poor management, misdirected goals, lack of focus or the wrong focus on cosmetic fixes, poor planning and execution, and outright denial of the existence of the problem—rather than the development and execution of real strategic remedial measures. These dynamics have been thoroughly detailed in several studies and reviews of the continuing problem, but they persist without remedy. While the problem has been exacerbated by lack of action, the IBVSOs believe most of the causes can be directly or indirectly traced to availability of resources. The problem was primarily triggered and is now perpetuated by insufficient resources.

Instead of requesting the additional funds and personnel needed to accomplish better results, the Administration has sought and Congress has provided fewer VBA resources. Recent budgets have requested actual reductions in full-time employees for the Veterans Benefits Administration—those who process the claims. Such reductions in staffing are clearly at odds with the realities of VA's growing workload and VA's own well-established adjudication policies and procedures. Adjudication of veterans' claims is a labor-intensive and "hands on" system of decision-making with lifelong consequences. These management and political decisions have conspired to diminish VA's quality of claims processing and to lose ground against the claims backlog. During Congressional hearings, VA is routinely forced to defend VBA budgets that it knows to be inadequate to the task at hand. The priorities and goals of the immediate political stagnation are at odds with the need for a long-term strategy by VA to fulfill its mission and confirm the nation's moral obligation to disabled veterans.

VA must establish a long-term strategy focused principally on attaining quality and not merely achieving production quotas in claims processing, or emphasizing how well and efficient it deals with the needs of new veterans of current wars. It must obtain supplementary resources for VBA, and it must invest these in that long-term strategy rather than reactively targeting them to short-term, temporary, and superficial gains. Only then can VBA proceed in a way that veterans' needs are addressed timely with the effects of disability alleviated by prompt delivery of appropriate benefits. Already-disabled veterans should not have to needlessly suffer additional economic deprivation because of the inefficiency and ultimately, the benign neglect, of their government. We believe this situation defines the very concept of "unconscionable."

As directed by law, VA has a duty to assist veterans in developing and presenting their claims. Congress established a special Federal Court to hear any disputes that arise as VA adjudicates those claims, and veterans possess the right by law to appeal their disagreements with adjudication decisions to a special appeals board as well. That self-checking system exists because national veterans organizations including the *IBVSOs* have insisted historically that veterans' war injuries and other service-related health problems be dealt with in a humane manner, and without rancor to the greatest extent practicable. The *IBVSOs* believe that each veteran who is awarded compensation is entitled to *full payment* and that no disabled veteran should be forced to obtain a private attorney to secure a proper and accurate disability rating from VA.

RECOMMENDATIONS:

To seek the beginning of the end of this long series of repeated failures from inadequate resources and misplaced priorities, *The Independent Budget* recommends funding levels for fiscal year 2008 adequate to meet the real staffing and other needs of the Veterans Benefits Administration. We urge the Administration and Congress to enact a higher level of resources in VA's fiscal year 2008 appropriation.

VA should establish a new strategy, premised on obtaining sufficient staff and other resources, to reduce the claims backlog with accurate adjudications to an irreducible minimum backlog. As a part of this strategy, VA should implement a new communications plan that will better inform veterans and the organizations that represent them of the status and progress of their claims.

Sufficient Staffing Levels:

To overcome its claims backlog and meet an increasing workload, the Department of Veterans Affairs (VA) must be authorized to increase its staffing for the Compensation and Pension (C&P) Service.

Despite ongoing efforts to reduce the unacceptably large claims backlog, the C&P has been unable to gain ground on its pending claims. Experience has shown that this problem has persisted primarily because inadequate resources compounded by higher claims volumes.

During FY 2004 and FY 2005, the total number of compensation, pension, and burial claims received in C&P increased by 9 percent, from 735,275 at the beginning of FY 2003 to 801,960 at the end of FY 2005. This represents an average annual growth rate in claims of 4.5 percent. During this same period, the number of pending claims requiring rating decisions increased by more than 33 percent. (As the Under Secretary for Benefits has stated, "[c]laims that require a disability rating determination are the primary workload component because they are the most difficult, time consuming, and resource intensive.") With an aging veterans' population and ongoing hostilities in Iraq and Afghanistan, no reason exists to believe that growth rate will decline during FY 2006 and FY 2007. With a 9 percent increase over the FY 2005 number of claims, VA can expect 874,136 claims for C&P in FY 2007, although it should be acknowledged that actual receipts totaled 810,000 in FY 2006, while VBA had expected to see more than 900,000 during the period. Whatever levels of C&P claims are received in FY 2007 and 2008, it is true that the overall backlog is growing, not shrinking. Without adequate resources and better performance by claims processing staffs, no reason exists to believe VA will be able to hold its pending claims backlog to existing levels, much less ever reduce it.

Moreover, legislation requiring VA to invite veterans in six states to request review of past claims decisions and ratings in their cases and to conduct outreach to invite new claims from other veterans in these states will add substantially to the expected increased workload. It is projected that, of the approximately 325,000 veterans receiving disability compensation and the additional estimated 50,000 who will be invited to file new claims, 15 percent will seek new or increased benefits, resulting in an estimated 56,000 additional claims. Given past claims-processing times, much of this workload will carry over into FY 2008, making the new total more than 930,000 claims in FY 2008.

In its budget submission for FY 2007, VA projected production based an output of 109 claims per direct program full-time employee (FTE). *The Independent Budget* veterans service organizations (IBVSOs) have long argued that VA's production requirements do not allow for thorough development and careful consideration of disability claims, thus resulting in compromised quality, higher error and appeal rates, even greater system overload, and further adding to the claims backlog. We believe a more reasonable estimate of accurate productivity is 100 claims per FTE. In addition to recommending staffing levels more commensurate with its expected workload, we have maintained that VA should invest more in training adjudicators and that it should identify ways to hold them more directly accountable for higher standards of accuracy in the claims they process or oversee.

In response to survey questions from VA's Office of Inspector General, nearly half of the adjudicators responding admitted that many claims are decided without adequate record development. They saw an incongruity between their objectives of making legally correct and factually substantiated decisions and management objectives of maximizing decision output to meet production standards and reduce backlogs. Nearly half reported that it is generally or very difficult to meet production standards without sacrificing quality. Fifty-seven percent reported difficulty meeting production standards when ensuring there is sufficient evidence for rating each case and thoroughly reviewing the evidence. Most attributed VA's inability to make timely and high-quality decisions to insufficient staff. They indicated that adjudicator training had not been a high priority in VA.

To allow for more time to be invested in training, the IBVSOs believe it prudent to recommend staffing levels based on an output of 100 cases per year for each direct program FTE. With an estimated 930,000 claims in FY 2008, that would require 9,300 direct program FTEs. With the FY 2007 level of 1,375 support FTEs added (primarily for management support and information

technology), this would require C&P to be authorized 10,675 total FTEs for FY 2008. These totals do not accommodate the kinds of demands that may arise as a consequence of Congressional injection of attorneys into the claims process, which may eventuate even more increases in C&P staffing in future years, but it is reasonable to expect that involving attorneys will negatively impact per capita productivity in the claims adjudication process.

RECOMMENDATIONS:

Congress should authorize 10,675 total FTEs for the C&P Service for FY 2008.

Congress should authorize the VBA to contract for disability medical examinations using its mandatory funding account without limitation. Currently, the VBA operates under "pilot" legislative language that confines the use of the mandatory account to an original 10 VA regional office sites. Should the Under Secretary determine that the need exists to go beyond those sites in getting these examinations scheduled more timely using contract physicians, the VBA must use its discretionary dollars to do so. This new flexibility of funds use would enable the VBA to improve processing timeliness of claims—a goal of *The Independent Budget*.

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Vocational Rehabilitation and Employment

Adequate Staffing Levels:

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

Given its increased reliance on contract services, VR&E needs approximately 100 additional full-time employees (FTE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended in its March 2004 report creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

To implement reforms to improve the effectiveness and efficiency of its programs, the task force recommended that VA should add approximately 200 new FTE positions to the VR&E workforce. The FY 2007 total of 1,125 FTEs for VR&E should be increased by 250, to 1,375 total FTEs.

RECOMMENDATION:

Congress should authorize 1,375 total FTEs for the VR&E Service for FY 2008.

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Education Service

Adequate Staffing:

To meet its increasing workload demands, the Education Service needs to increase direct program full-time employees (FTEs).

As it has with its other benefit programs, the Department of Veterans Affairs (VA) has been striving to provide more timely and efficient service to its claimants for education benefits. Though the workload (number of applications and recurring certifications, etc.) increased by 11 percent during FY 2004 and FY 2005, direct program FTEs were reduced from 708 at the end of FY 2003 to 675 at the end of FY 2005. Based on experience during FY 2004 and FY 2005, it is very conservatively estimated that the workload will increase by 5.5 percent in FY 2008. VA must increase staffing to meet the existing and added workload, or service to veterans seeking educational benefits will decline. Based on the number of direct program FTEs at the end of FY 2003 in relation to the workload at that time, the Veterans Benefits Administration must increase direct program staffing in its Education Service in FY 2008 to 873 FTEs, 149 more direct program FTEs than authorized for FY 2007. With the addition of the 160 support FTEs as currently authorized, the Education Service should be provided 1,033 total FTEs for FY 2008.

RECOMMENDATION:

Congress should authorize 1,033 total FTEs for the VA Education Service.

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Judicial Review in Veterans' Benefits

In 1988, Congress recognized the need to change the situation that had existed throughout the modern history of veterans' programs in which claims decisions of the Department of Veterans Affairs (VA) were immune to judicial review. Congress enacted legislation to authorize judicial review and created what is now the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from VA's Board of Veterans' Appeals (BVA).

Now, VA's administrative decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This provides a course for an individual to seek a remedy for an erroneous decision and a means by which to settle questions of law for application in other similar cases. When Congress established the CAVC, it added another beneficial element to appellate review. It created oversight of VA decision making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

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

In addition, most of VA's rulemaking is subject to judicial review, either in connection with a case before the CAVC or upon direct challenge to the United States Court of Appeals for the Federal Circuit. Here again, changes are needed to bring the positive effects of judicial review to all of VA's rulemaking.

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

Judicial Review Issues

THE COURT OF APPEALS FOR VETERANS CLAIMS

Scope of Review

Standard for Reversal of Erroneous Findings of Fact:

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

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

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

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

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

RECOMMENDATION:

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

Court Facilities

Courthouse and Adjunct Offices:

The Court of Appeals for Veterans Claims (CAVC) should be housed in its own dedicated building, designed and constructed to its specific needs and befitting its authority, status, and function as an appellate court of the United States.

During the nearly 16 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse. This court for veterans should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Rather than being a tenant in a commercial office building, the court should have its own dedicated building that meets its specific functional and security needs, projects the proper image, and concurrently allows the consolidation of VA General Counsel staff, court practicing attorneys, and veterans service organization representatives to the court in one place. The CAVC should have its own home, located in a dignified setting with distinctive architecture that communicates its judicial authority and stature as a judicial institution of the United States.

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

RECOMMENDATION:

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

COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Review of Challenges to VA Rulemaking

Authority to Review Changes to VA *Schedule for Rating Disabilities:*

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

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

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

RECOMMENDATION:

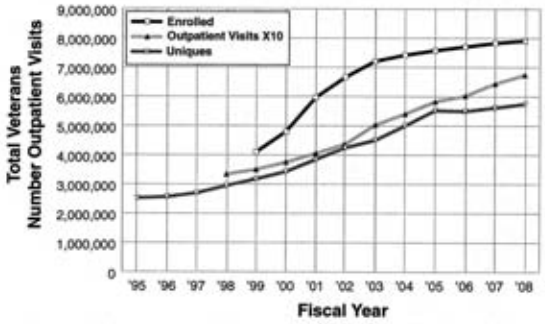
Congress should amend 38 U.S.C. § 502 to authorize the CAFC to review and set aside changes to the *Schedule for Rating Disabilities* found to be arbitrary and capricious or clearly in violation of statutory provisions.

Medical Care Introduction

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

Of the 7.7 million veterans enrolled in fiscal year 2006, the VHA provided health care to more than 5.5 million of them. The quality of VHA care is equivalent to, or better than, care in any private or public health-care system. The VHA provides specialized health-care services—blind rehabilitation, spinal cord injury care, and prosthetics services—that are unmatched in any other system in the United States or worldwide. The Institute of Medicine has cited the VHA as the nation's leader in tracking and minimizing medical errors.

CHART 1. UNIQUE VHA PATIENTS ENROLLED VETERANS AND TOTAL OUTPATIENT VISITS



This chart shows the trend toward the increasing number of patients treated in VHA facilities and the increase of veterans enrolled for care. The total number of estimated outpatient visits in fiscal year 2007 is expected to approach 65 million.

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

Year after year, the Department of Veterans Affairs (VA) faces inadequate appropriations and is forced to ration care by lengthening waiting times. Although the backlog of veterans waiting more than 60 days for their first appointment has been significantly reduced during the past couple of years, *The Independent Budget* veterans service organizations are concerned that the methodology used in producing the statistics that indicate this reduction in the backlog may be skewed.

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

Full implementation of VA electronic records into DOD health-care facilities

There has been a great deal of effort to develop proposals to promote VA/DOD initiatives within the medical care arena. Unfortunately, the results of those efforts have had minimal impact on agency operations. One very important link for the two agencies is the medical record. VA has developed an electronic record that has received major recognition throughout the medical community. It has allowed VA continue to meet the needs of its patients in an expeditious, efficient manner while reducing medical mistakes and duplication of testing while providing immediate availability of records at any of it locations nationwide. The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information.

Better coordination of the two electronic medical record systems will afford the opportunity to see tangible initiatives of VA/DOD programs. It will also expedite the handling of patient information especially in the transition of the patient from the DOD system to the VA system. It will provide a "complete" medical record that could be viewed by any appropriate provider within either system. It will also serve as a basic database for patients seeking compensation for service-related injuries. This database would be easily accessible and have a common language and arrangement of file information, making it easy for examiners to evaluate a patient's condition and needs.

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MEDICAL CARE ISSUES

Financing Issues

Adequate Funding for VA Health Care Needed:

The Department of Veterans Affairs (VA) must receive adequate funds to meet the ever-increasing demands of veterans seeking health care.

Last year (2006) proved to be a unique year for reasons very different from 2005. VA faced a tremendous budgetary shortfall during fiscal year (FY) 2005 that was subsequently addressed through supplemental appropriations and additional funds added to the FY 2006 appropriation. For FY 2007, the Administration submitted a budget request that nearly matched the recommendations of *The Independent Budget*. These actions simply validated the recommendations of *The Independent Budget* once again.

For FY 2007, the Administration requested $31.5 billion for veterans' health care, a $2.8 billion increase over the FY 2006 appropriation. Although this was a significant step forward, Congress took a giant step backward by not following through on its responsibility to provide these funds. As of the start of the calendar year—and more than one-third of the way through the new fiscal year—VA still had not received its appropriation. It is unconscionable that Congress has allowed partisan politics and political wrangling to trump the needs of the men and women who have served and continue to serve in harm's way. When VA does not receive its funding in a timely manner, it is forced to ration health care. VA is unable to hire much-need medical staff to prepare for the needs of veterans who will be seeking health care. Waiting times will continue to increase and the quality of care will decrease as VA will actually be forced to cut staff. These factors continue to place enormous stress on the system and will leave VA struggling to provide the care that veterans have earned and deserve.

Last year the Administration finally recognized the work of *The Independent Budget* when it indicated that it would actually take $25.5 billion to fund Medical Services, an amount very close to what *The Independent Budget* veterans service organizations (IBVSOs) recommended. However, the IBVSOs certainly disagreed with the Administration's desire to use a new enrollment fee and an increase in prescription drug copayments to achieve that funding level. Once again the President's recommendation included the $250 enrollment fee for veterans in categories 7 and 8 and an increase in prescription drug copayments from $8 to $15 for a 30-day supply. VA estimated that these proposals would force nearly 200,000 veterans to leave the system and more than 1 million veterans to choose not to enroll. As in previous years, the Congress soundly rejected these proposals, and we urge Congress to continue to do again so if these fees are proposed this year.

Unfortunately, this delayed budget will also have a significant impact on the nursing shortage that VA is experiencing. When managers do not have a budget for the coming year, they are unable to plan for new hires of critical staff. VA is forced to place hiring freezes on its medical centers nationwide. The hiring freezes have forced individual medical facilities to assign non-nursing duties to current nurses. This detracts from immediate bedside care and ultimately jeopardizes the health of the veteran.

For FY 2008, *The Independent Budget* recommends $36.3 billion for VA health care. Unfortunately, Congress chose not to enact the VA appropriations bills during the 109th Congress, and it remains to be seen when the legislation will be completed. In order to form a baseline for funding for VA for FY 2008, we used the appropriations figures contained in H.R. 5385, the "Military Quality of Life and Veterans Affairs Appropriations Act for FY 2007." These amounts most closely represent the recommendations that we made in *The Independent Budget for FY 2007*.

The medical care appropriation includes three separate accounts—Medical Services, Medical Administration, and Medical Facilities—that comprise the total VA health-care funding level. For FY 2008, *The Independent Budget* recommends approximately $29.0 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

MEDICAL SERVICES RECOMMENDATIONS

(Dollars in Thousands)

Current Services Estimate	$26,302,464
Increase in Patient Workload	$ 1,446,636
Increase in Full-time Employees	$ 105,120
Policy Initiatives	$ 1,125,000
Total FY 2008 Medical Services	**$28,979,220**

Our increase in patient workload is based on a 5.5 percent increase in workload. The policy initiatives include $500 million for improvement of mental health services, $325 million for funding the fourth mission, and $300 million to support centralized prosthetics funding.

For Medical Administration, *The Independent Budget* recommends approximately $3.4 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $4.0 billion.

Although *The Independent Budget* 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, we believe that adequate resources should be provided to overturn this policy decision. VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA health-care system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million. The IBVSOs believe the system should be reopened to these veterans and that this money should be appropriated in addition to our Medical Care recommendation.

Furthermore, previous inadequate budgets have exacerbated the problem. In the past several years, the VA health-care budget has not even kept pace with the rising cost of inflation. VA has testified in the past that the Veterans Health Administration requires a minimum 13 percent to 14 percent increase just to meet this cost. VA cannot be competitive in the market for health-care professionals if it does not have the funding necessary to do so. For example, the IBVSOs believe that the basic salary for nurses who provide direct bedside care is too low to be competitive with community hospitals. This leads to high attrition rates as these nurses seek better pay in the community.

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. This would not create a new entitlement; rather, it would change the manner of health-care funding, removing 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.

The Independent Budget's recommendations enable VA to meet the demands of current veterans and those who are now being denied care by VA. It ensures that VA is not faced with the possibility of a shortfall due to faulty modeling or any other reason. As the number of new veterans seeking health care continues to grow, and VA continues to care for veterans of prior conflicts, we must ensure that VA provides the quality health care that they have earned with their service and their sacrifices.

RECOMMENDATION:

Congress and the Administration must provide adequate funding for veterans' health care in a timely manner to ensure that VA can continue to provide the necessary services to all veterans seeking care.

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Accountability:

Department of Veterans Affairs (VA) Veterans Health Administration (VHA) managers must be held individually responsible for their areas of operation to achieve needed enhancements to operations efficiency and effectiveness.

The Independent Budget veterans service organizations (IBVSOs) firmly believe that sufficient funding in and of itself is not enough to achieve greater efficiency of processes and people within VA and increased effectiveness of results in order to further its mission. Enforcing accountability within VA will directly contribute toward providing greatly enhanced benefits and services to veterans within the context of finite budgetary resources.

To make management structure and function more effective, VHA employees—at all levels—must be held individually responsible for their areas of operation. *The Independent Budget* insists upon much greater focus and, ultimately, meaningful improvement through enforceable accountability in such areas as waiting times for medical appointments; supervision of part-time physicians; contract care coordination, particularly specialty care from academic affiliates; fee-basis care; formulation of valid and reliable workload data and program reporting; timeliness of claims processing; and quality in claims adjudication.

■ Waiting times for medical appointments

VA embarked on a nationwide initiative (the Advanced Clinic Access initiative) to provide frontline personnel the ability to maximize resources to treat more patients in a timely manner. As part of this initiative, the electronic wait list is utilized as a measuring tool for success. VA reports substantial reductions in the number of veterans on wait lists, and the VHA has also reduced the number of new enrollees waiting for their first clinic appointment. However, the accuracy of reported veterans' waiting times and facility wait lists is undermined by variability in VA's compliance with outpatient scheduling procedures and the cumbersome scheduling software being utilized from which waitlist data are being obtained.

While the current electronic waiting list has undergone a number of revisions since inception, reporting accuracy continues to be suspect and undermines the ability to produce effective and meaningful policy and procedures to best capture what is considered a symptom of an inadequately funded health-care system.

■ Contract care, particularly specialty care provided by academic affiliates

Many VA facilities award contracts with academic affiliates to provide needed medical care to sick and disabled veterans. However, some contracts contain no procedures for VA to monitor contract physician presence and level of performance to ensure that the level of services VA pays for under the contract is actually provided.

Flaws in the procurement process must be addressed and appropriately corrected; otherwise, these factors affect the contract's "price reasonableness determination" (whether the contract itself is in the best interest of the government). For example, solicitation during the procurement process does not adequately compensate VA for any losses incurred as a result of noncompliance nor require penalties for noncompliance with the terms and conditions of the contract. Furthermore, there are instances where VA physicians receiving compensation from the affiliate or its practice group are involved in the contracting process in violation of federal ethics laws and regulations.

■ Fee-basis care

To ensure access to and a full continuum of health-care services, VA should better coordinate clinical and claims information for veterans authorized to receive medical care from private community-based providers at VA expense. While required to receive minimal treatment records from a veteran's private physician as part of authorization to receive non-VA care, there is no requirement to ensure that VA receives the complete medical record of the veteran to be made part of his or her electronic VA health record. In addition to maintaining the quality or care veterans receive through this program, requiring the receipt of all medical records for the episode of care also would decrease the likelihood that the claim for services rendered will not be paid or delayed as a result of VA determination that the claim is incomplete to adjudicate for payment.

Timeliness of claims processing and quality in claims adjudication

There has been an ongoing challenge to reduce the backlog of claims being processed by VA. In many cases it can take years to get proper adjudication of a claim. Of greater concern is the number of errors in processing claims and the number of times claims must be remanded. The Veterans Benefits Administration's current focus on reducing the quantity of claims without an equal or greater focus on increasing the quality of decisions potentially increases the backlog. The focus on quantity of claims completed rather than a properly adjudicated claim is an easy way out of the backlog dilemma. It is easy to track and allows VA to claim success. But the focus should be on proper completion of an initial claim.

Issues that contribute to the focus on claims processing are awards and evaluations that are based on claims completed or on the reduction of backlog. This invariably forces the focus to production and not quality. A focus on quantity may also reduce quality because of the lack of accountability for incorrect claims. Without a doubt, most claims adjudicators are conscientious VA employees that desire to do the best job they can. But because claims are no longer remanded to the regional office that is processing the claim, there is no overt indication of a reduction in quality by the claims office. Only in the most remote of circumstances will responsibility for an improperly completed claim come back to reflect on the rating veterans service representative or Dispute Resolution Office adjudicator.

It is critical that a more objective method be developed for claims oversight and adjudicator evaluation. By setting specific performance standards that emphasize accuracy and quality, in addition to quantity, a more successful process may be created. Speed in claims processing cannot be ignored, and a requirement for the number of claims processed is helpful in evaluating employee work. But this is only beneficial when considered in conjunction with accurate work.

In order to have meaningful accountability, so as to provide greatly enhanced benefits and services to veterans, it is essential that management be provided all the requisite guidance and tools to enforce performance standards among the personnel under their direction. Management must be able to create an environment that promotes superior service, discourages mediocrity, and precludes substandard performance. Correspondingly, performance appraisals and senior executive contracts must accurately reflect execution in achieving specific outcomes. Success should be fittingly rewarded and failure appropriately sanctioned to enforce accountability and to promote a more efficient and effective provision of benefits and services to veterans. Furthermore, there must be greater transparency and oversight of network and facility performance plans to adjust the aspect of responsibility and accountability toward those that this federal agency was created to serve: sick and disabled veterans.

VA faces many challenges in its effort to use its limited resources efficiently, ensure reasonable access to high-quality health care, and manage its disability programs effectively. VA executives must be effective leaders, not just competent managers, particularly when making difficult decisions and taking decisive actions in a resource constrained environment.

RECOMMENDATIONS:

VA management must be provided with the requisite tools to enforce performance standards among the personnel under their direction.

VA must enforce meaningful performance standards. VA should then reward those individuals who exceed the standards and properly sanction those whose performance is substandard or unacceptable.

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Assured Funding:

The Administration's discretionary budget formulation for Department of Veterans Affairs (VA) health care and the manner in which Congress addresses these needs in the budget and appropriations acts are deeply flawed and cry out for true reform.

Budget formulation for veterans' health care continues to confound Congress and the Administration. While leaders in both government branches continue to boast about the "record-setting" increases they have produced compared to their predecessors, VA sources and sick and disabled veterans seeking VA health care tell a different story of crisis in the daily operating environment of the VA health-care system.

In both fiscal years 2005 and 2006, Congress was forced to confront VA health-care funding shortages with emergency or supplemental appropriations totaling nearly $3 billion. In 2006, VA continued to face challenges to meet known and expected demands for health care. Now, several months into fiscal year 2007, VA remains under the burden of a Continuing Resolution (CR) that maintains funding at the FY 2006 level. Likewise, we continue to hear reports that VA facilities must restrict services provided to veterans, delay hiring of new clinical staff, institute local and regional freelance policies to restrict eligibility and care, and impose a variety of questionable—and potentially hazardous—cost-cutting measures just to make ends meet. With the acknowledged budget shortfalls for veterans' health care in FY 2005 and FY 2006, and another CR for the first several months of FY 2007, the record is clear that VA operates in a state of management paralysis, planning chaos, and structural financial crisis as a direct consequence of the discretionary budget process.

Although welcomed, temporary funding supplements provided by Congress in urgent circumstances do not solve the underlying problem. For this reason, *The Independent Budget* veterans service organizations (IBVSOs) propose a lasting solution in the form of mandatory, assured, or guaranteed funding, or a workable combination of mandatory and discretionary funding, for veterans' health care. An assured system, even one that provided only partial guarantees, would make the management of veterans' health care more dependable and stable and eliminate the uncertainties that have perennially disrupted management of VA health care. Funding uncertainty has prevented VA executives and managers from being able to adequately plan for and meet the needs of a growing enrolled-veteran population, of which a large majority either service-disabled or poor. A guaranteed system of funding also would resolve the serious challenges created by late-arriving supplemental funds and stop the meddling on policy and politically motivated budget gimmicks proposed by the Office of Management and Budget.

Reforming VA's health-care budget is more important today than ever. The current conflicts in which our nation is engaged are producing a significant number of veterans suffering from traumatic amputations, brain injuries, blindness, burns, spinal cord injuries, and post-traumatic stress disorder (PTSD). These severely disabled veterans will need a lifetime of specialized health care. Veterans injured in Iraq, Afghanistan, and other parts of the world, as well as veterans wounded in previous conflicts, need the government's assurance that VA will remain a stable and reliable provider that receives sufficient funding to provide the specialized services they will need and have earned through their military service.

The Administration must also consider other costs the Veterans Health Administration (VHA) has incurred as it struggles to fulfill its core mission and mandates. Even with the stress of a chronic budget shortfall, VA was an integral part of the national and regional response providing emergency relief to veterans and all residents affected by the 2005 storms in Louisiana, Mississippi, Alabama, Texas, and Florida. During these disasters, VA played an indispensable role, not only in continuing to serve sick and disabled veterans but also serving the Gulf Coast community in general with rescue, security and police, health-care, transport, and other lifesaving services. Although necessary and admirable, VA is not funded to carry out this type of mission without compromising or disrupting its ability to care for veterans in routine operations. The IBVSOs continue to strongly recommend that VA be provided funds to replenish its expenditures for such additional services in times of emergency.

The IBVSOs also remain concerned that under a discretionary budgeting method the VHA remains vulnerable to the political pressures of cost-cutting proposals, such as those suggested in 2006. If higher copayments or other cost-saving measures are imposed,

some veterans undoubtedly will be forced out of the VA system only to fall back on Medicaid, Medicare, and other government-sponsored programs. VA's existence reduces the financial burden on other federal and state health-care systems. If funded adequately, the VA health-care system, by many measures, offers the most cost-effective and highest quality health-care services available in the United States to care for America's sick and disabled veterans.

During the 109th Congress, assured funding bills were introduced in both chambers. Unfortunately, none of these measures were enacted. The Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations, has urged the Administration and Congress to reform the method for funding veterans' health care. Our repeated requests for hearings and public debate on this key issue were denied or ignored by the House and Senate authorizing and appropriations committees. Additionally, during the 109th Congress an alternative funding plan (combining mandatory with discretionary funding) was proposed to resolve VA's health-care funding crisis. Unfortunately, this proposal was also defeated—even with full support of the Partnership. In spite of an obvious need to reform the way VA health care is funded, the Administration and Congress embraced other prerogatives, such as tax cut extensions and massive pork barrel spending, that took precedence over ensuring health-care funding for millions of older veterans dependent on VA care and tens of thousands of men and women returning sick and disabled as a result of current military service for our country.

Providing health care to our nation's sick and disabled veterans is a continuing cost of defense and national security and should be a top priority of our government. We are hopeful that the 110th Congress will be open to addressing the issue of assured funding by holding hearings and making the necessary changes to reform the budget process for veterans' health care.

Without reform, all the current advantages of VA health care, originating from a decade of internal improvements, are at risk. The manner in which the Administration and Congress provide funding for VA health care poses well-documented annual uncertainty that prevents VA managers from planning effectively to continue these vital services. When funding is eventually secured, it has proven time and again to be insufficient, causing VA practitioners to ration and delay care needed by sick and disabled veterans who depend on VA, and even forcing a former VA Secretary to restrict access to new priority group 8 enrollments. Including VA's projection estimates for FY 2007, nearly one million veterans will have been denied access to VA health care as a result of that decision. Currently, combat veterans of the global war on terrorism have eligibility for two years of free VA health care for conditions potentially related to their military service after discharge or release—and according to VA will have continued access to such care after that time period regardless of the priority group to which they are assigned. However, we are concerned that if these veterans need to access the system after this two-year period, but have not used the system within the specially prescribed eligibility period and fall into priority group 8, they, too, would be ineligible for VA health-care services.

Our government needs to take the politics, guesswork, and political gamesmanship out of VA health care and fully fund this transparent need with an assured mechanism. The Administration has a fundamental obligation to provide Congress an honest, accurate statement of the VA's known financial needs. And Congress is obligated to fully fund VA health care in a timely manner. The best way to meet these obligations is to overhaul the budget and appropriations process to guarantee an adequate, predictable, reliable, and available funding stream to meet the health-care needs of America's sick and disabled veterans.

RECOMMENDATIONS:

The Administration and Congress must address the acknowledged shortfalls of the current approach and support legislation to reform funding for VA health care. This reform should move VA from its current status in domestic discretionary appropriations to full mandatory funding—or some combination of discretionary and assured funding—in order to ensure all eligible and enrolled veterans may gain and retain access to VA health care programs and services in a timely manner.

When funding has been ensured, VA should reopen enrollments to so-called "priority 8" veterans, or, at minimum, extend the two-year period of eligibility for free VA health care offered to combat veterans of the global war on terrorism for conditions potentially related to their military service after discharge or release.

Homeland Security/Funding for the Fourth Mission:

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

The Department of Veterans Affairs (VA) has four critical health-care missions. The primary mission is to provide health care to veterans. Its second mission is to educate and train health-care professionals. The third mission is to conduct medical research. The VA's fourth mission, as stated in a General Accounting Office Report of October 2001, is to "serve as a backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters[.]"

In 2005, the devastation created by Hurricanes Katrina and Rita in the Gulf Coast region more than met the criteria for the fourth mission. VA proved to be fully prepared to care for veterans affected by the hurricanes. Nearly 10,000 VA employees around the country received recognition for their actions during the hurricanes, including 73 Valor Awards for risking personal safety to prevent the loss of human life or government property, and 3,000 official commendations. After Katrina, VA facilities along the Texas Gulf Coast prepared for Rita by stocking up on food, water, medical supplies, emergency communications (satellite telephones), and extra fuel for emergency generators and vehicles. VA facilities outside the Gulf Coast region were on standby to evacuate patients, and health-care professionals were ready to travel to the storm area if called upon. Yet the skills and abilities of VA were not leveraged to support other federal, state, and local agencies that struggled to react to these events. Had this occurred, it might have reduced the suffering of the region.

VA has statutory authority, under 38 U.S.C. § 8111A, to serve as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" On September 18, 2001, in response to the terrorist attacks of September 11, 2001, the President signed into law an "Authorization for Use of Military Force," which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers VA's responsibilities to serve as a backup to the DOD.

As part of its fourth mission, VA has a critical role in homeland security and in responding to domestic emergencies. The National Disaster Medical System (NDMS), created by P.L. 107-188 (the "Public Health Security and Bioterrorism Preparedness Response Act of 2002") has the responsibility for managing and coordinating the federal medical response to major emergencies and federally declared disasters. These disasters include natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including weapons of mass destruction events, in accordance with the National Response Plan. The NDMS is a partnership between the Department of Homeland Security, VA, the DOD, and the Department of Health and Human Services. According to the VA website (www.va.gov), some VA medical centers have been designated as NDMS "federal coordinating centers." These centers are responsible for the development, implementation, maintenance, and evaluation of the local NDMS program. VA has also assigned "area emergency managers" to each VISN to support this effort and assist local VA management in fulfilling this responsibility.

In addition, P.L. 107-188 required VA to coordinate with HHS to maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other emergency supplies. The Secretary was also directed to enhance the readiness of medical centers and provide mental health counseling to those individuals affected by terrorist activities.

In 2002, Congress also enacted P.L. 107-287, the "Department of Veterans Affairs Emergency Preparedness Act of 2002." This law directed VA to establish four emergency preparedness centers. These centers would be responsible for research and would develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, incendiary, or other explosive weapons or devices posing threats to the public health and safety. In addition, the centers would provide education, training, and advice to health-care professionals. They would also provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health-care agencies and personnel involved in or

responding to a disaster or emergency. These centers, although authorized by law, have not received any funding.

The Independent Budget veterans service oeganizations (IBVSOs) are concerned that VA lacks the resources to meet its fourth mission responsibilities. The actions of VA in Louisiana, Mississippi, and Alabama in 2005 prove that VA has done everything it can to prepare itself under the requirements of the fourth mission. It has also invested considerable resources to ensure that it can support other government agencies when a disaster occurs. However, VA has not specifically received any funding to support the fourth mission. Although VA has testified in the past that it has requested funds for this mission, there is no specific line item in the budget to address medical emergency preparedness or other homeland security initiatives. This funding is simply drawn from the Medical Care Account, providing VA with fewer resources with which to meet the health-care needs of veterans. VA will make every effort to perform the duties assigned it as part of the fourth mission, but if sufficient funding is not provided, already-scarce resources will continue to be diverted from direct health-care services.

The VA's fourth mission is vital to our defense, homeland security, and emergency preparedness needs. In light of the natural disasters that have recently wreaked havoc on this country, this fact has never been more apparent. These important roles once again reiterate the importance of maintaining the integrity of the VA system and its ability to provide a full range of health-care services. The IBVSOs do not believe that VA currently has the resources it will need to adequately care for veterans. If VA is to fulfill its responsibilities, it must be provided these resources.

RECOMMENDATIONS:

Congress should provide funds necessary in the VHA's FY 2008 appropriation to fund VA's fourth mission.

Funding for the fourth mission should be included in a separate line item in the Medical Care Account.

Congress and the Administration should provide the funds necessary to establish and operate the four emergency preparedness centers created by P.L. 107-287.

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Seamless Transition from the Department of Defense to Veterans Affairs:

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As military service personnel return from the conflicts in Iraq and Afghanistan, the DOD and VA must provide them with a seamless transition of benefits and services when they leave military service and become veterans. Currently, the transition from the DOD to VA is anything but seamless, and undue hardship is placed on many new veterans trying to gain access to VA. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The Independent Budget supported the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report, released in May 2003, regarding transition of soldiers to veteran status. The PTF stated that "providing these individuals [veterans] timely access to the full range of benefits earned by their service to the country is an obligation that deserves the attention of both VA and the DOD. To this end, increased collaboration between the Departments for the transfer of personnel and health information is needed." This need has not been fully met.

The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. We applaud the DOD for beginning to collect medical and environmental exposure data electronically while personnel are still in theater, and are confident this practice will continue. But it is equally important that this information be provided to VA. These electronic medical records should also include an easily transferable electronic DD214 forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Joint Electronic Health Records Interoperability plan, as agreed to by both VA and the DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchange of related health data between the two departments culminating in the bidirectional exchange of interoperable health information. However, with continued successes from the first phase through milestones in the second phase, achieving real-time sharing of computable health information is heavily dependent upon agreement on common health data standards and the development of technology not wholly under the control of either department. Moreover, the IBVSOs are not encouraged by reports that in some instances medical data gathered in theater and stored on electronic smart cards provided to the soldier are not even readable by other military medical facilities upon the service member's return. This does not bode well for an electronic system meant to exchange information between federal agencies.

The Independent Budget is not the only party concerned about this exchange. In June 2004, the Chairman and Ranking Member of both the House Committee on Veterans' Affairs and Committee on Armed Services sent letters to then-VA Secretary Principi and then-DOD Secretary Rumsfeld expressing concern with the current transition of servicemen and -women and indicating that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurs with the PTF's recommendation that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." The problem with separation physicals identified for active duty members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing reservists have improved in recent years, there are still a number of soldiers who "opt out" of the physical exams, even when encouraged by medical personnel to have them. Though the expense, manpower, and delays needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing soldiers. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War syndrome, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

The IBVSOs also support the Army Wounded Warrior Program (AW2), formerly called the Disabled Soldier Support System, implemented in spring 2005, as well as the Marine for Life program. Their responsibility is to assist the most severely injured service members and their families in transition from military to civilian life. However, the AW2 program maintains only minimal staff with a limited budget. With a high number of severely injured service members returning from Iraq and Afghanistan, it is essential that Congress and the Administration support and enhance these successful programs.

While more progress needs to occur on health-care transition, in the past several years the DOD and VA have made some good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL's) Transition Assistance Program (TAP) handled by the Veterans Employment and Training Service (VETS) and VA Vocational Rehabilitation and Employment Disabled Transition Assistance Program (DTAP) are generally the first services that a separating service member will receive. In fact, local military commanders, through the insistence of the DOD, began to allow their soldiers,

sailors, airmen, and marines to attend well in advance so as to take greatest advantage of the program. Under this scenario, the programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their individual circumstances and then seek answers prior to discharge.

TAP and DTAP continue to improve. But challenges continue at some local military installations, at overseas locations, and with services and information for those with significant injuries. Disabled service members who wish to file a claim for VA compensation benefits and, thus, other ancillary benefits, are dissuaded by the possibility of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in conducting these programs, and the haphazard nature may allow some individuals to fall through the cracks. This is of particular risk in DTAP for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still remaining on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. Consequently, DTAP has not had the same level of success as TAP, and to improve this, it is critical that coordination be closer between the DOD, VA, and VETS.

The DOD, the DOL, and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. Despite the successes of TAP, the program lacks the flexibility required to meet the erratic surges in demand from soldiers who are rapidly discharged and demobilized en masse just a few months after returning from the front lines. Such short timelines force service members to enter veteran status without the benefits of TAP. Unless these soldiers are injured, they may clear the demobilization station in a few days or be discharged from active duty in a few weeks. DOD personnel at these sites are most focused on processing service members through the site, and little time is dedicated to informing them about veterans' programs. Lack of space and facilities often allows for limited contact with the demobilizing service members by VA representatives. Moreover, waiting lists for the TAP program have surfaced at some sites, primarily a result of the reduction in the number of TAP providers and the resulting limited class capacity in combination with large numbers of rapidly transitioning service members.

To address these issues, the number of TAP providers should be increased and the DOD should formally incorporate TAP at every demobilization station to ensure all new veterans are exposed to necessary information on VA benefits and services. In addition, those veterans who are unable to avail themselves of TAP while on active duty should be allowed to participate. For this purpose, the restriction that only active duty service members may participate in TAP should be eliminated. We recommend however that some prerequisites are met, including that veterans who are requesting to attend a TAP class not displace a service member. Furthermore, it is crucial that demand for such services be captured where each station providing TAP must report the number of recently discharged veterans requesting participation and, of those, the number of veterans who eventually completed TAP.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, a truly seamless transition must be created. In doing so, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and -women exiting military service should be afforded easy access to the health care and other benefits that they have earned. This can only be accomplished by ensuring that the DOD and VA improve coordination and information sharing to provide a seamless transition.

RECOMMENDATIONS:

The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

The DOD and VA must develop electronic medical records that are interoperable and bidirectional, allow-

ing for two-way electronic exchange of computable health information and occupational and environmental exposure data. The records should also include an electronic DD214.

The DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process.

Congress and the Administration must provide additional funding for the AW2 and Marine for Life programs to allow for appropriate expansion of these programs to address the needs of more seriously disabled soldiers.

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Mental Health Services:

Mental health services for older veterans must be maintained in addition to Department of Veterans Affairs (VA) efforts to address increased mental health challenges arising from the ongoing conflicts in Iraq and Afghanistan.

■ President's New Freedom Commission on Mental Health/VA Mental Health Strategic Plan

Following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health programs. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms, rather than aiding patients' recovery and restoration. The New Freedom Commission found that many people with mental illness can regain productive lives, and the effort provided the President and the government a bold new blueprint for system change based on the goal of recovery. VA leaders embraced the change the commission envisioned for the mental health system and developed an agenda for realizing that goal. VA established a National Mental Health Strategic Plan (MHSP) as an outgrowth of the President's New Freedom Commission report and promised to commit $100 million in fiscal year 2005 and $200 million in fiscal year 2006 to fund new mental health initiatives.

In November 2006, the United States Government Accountability Office (GAO) issued a report on resources allocated for VA's MHSP initiatives. The GAO found that VA did not allocate all of the funding it planned to commit in fiscal year 2005 for new mental health initiatives to address identified gaps in mental health services. Funding was intended to be used for such priorities as the expansion of post-traumatic stress disorder (PTSD) services, post-deployment mental health services for veterans returning from combat in Iraq and Afghanistan, and expansion of programs for the treatment of substance-use disorders. Additionally, the GAO reported that the VA Central Office did not inform network and medical center officials that certain funds were to be used for these specific mental health initiatives, and therefore it is likely some funds went for other health-care priorities. Likewise, according to the GAO, some medical center officials were not certain they would be able to spend all the funds planned for fiscal year 2006 for plan initiatives by the end of the year. These findings illustrate the need for continued Congressional oversight to ensure proper use of dedicated mental health funds for MHSP initiatives.

Additionally, *The Independent Budget* veterans service organizations (IBVSOs) understand that VA's internal policy on funding certain new initiatives to address gaps in services related to psychosocial rehabilitation and recovery-oriented services will be limited to only two years. The expectation is that this "seed money" provided to specific initiatives will generate sufficient creditable patient care workload counts through VA's internal resource allocation system to make further earmarks unnecessary after the first two years. This is an untested concept that may dampen local interest in proposing or embracing these new initiatives. If a VA medical center director believes that a centrally controlled earmark is temporary, there may be tempta-

tion to limit investment in the program. The aftereffects of this two-year funding policy warrant close scrutiny from mental health advocates and Congress.

■ Overseas Engagement

The U.S. military engagement in Southwest Asia extends into its fifth year. This is a difficult, dangerous campaign for American troops, whether they are regular active duty members, Reserves, or National Guard. Ground combat units have faced fierce fighting, whether in close combat in the streets and buildings of urban area or while traversing rugged mountain passes. Danger is imminent, even for military members working in support positions. The ever-present improvised explosive device (IED) threatens U.S. convoys as they travel treacherous roadways. Vehicular accidents are commonplace, and no one is immune. Despite the threats and risks, our regular active duty, National Guard, and Reserve forces are performing magnificently in current conflicts. Many Guard and Reserve members have served multiple tours of duty, leaving families and full-time civilian jobs when they were called to duty as citizen soldiers. Their families are also making extreme sacrifices.

■ Issues Affecting our Newest Generation of Combat Veterans

VA and the Department of Defense (DOD) are well aware that combat veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are at higher risk for PTSD and other mental health problems. In a 2006 study published in the *Journal of the American Medical Association*, Col. Charles Hoge, MD, of the Walter Reed Military Research Institute, evaluated relationships between combat deployment and mental health-care use in the first year following return from the war. The study also reviewed lessons learned from postdeployment mental health screening efforts, correlation between screening results and subsequent use of military mental health services, and attrition from military service.

The Hoge study found that 19 percent of soldiers and marines who had returned from Iraq screened positive for mental health problems, including PTSD, generalized anxiety, and depression. Hoge reported that mental health problems recorded on the postdeployment self-assessments by military service members were significantly associated with combat experiences and mental health-care referral and utilization. Thirty-five percent of Iraq war veterans had received mental health services in the year after returning home, and 12 percent each year were diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months postdeployment among soldiers preparing to return to Iraq for a second deployment. Hoge postulated that although OIF veterans are using mental health services at a high rate, many military personnel with mental health concerns do not seek help due to fear of stigma and other barriers. The study revealed that service members resisted care because of personal concerns over being perceived as weak—or that seeking treatment would have a negative impact on their military career. Finally, Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

The VA health-care system is also seeing increasing trends of health-care utilization among OEF/OIF veterans. VA reports that veterans of these current wars seek care for a wide range of possible medical and psychological conditions, including mental health conditions, such as adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. As of November 2006, VA reported that of the 205,000 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, a total of 73,157 unique patients had received a diagnosis of a possible mental health disorder. Nearly 34,000 of the enrolled OEF/OIF veterans had a probable diagnosis of PTSD.

VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health-care utilization among this group reflect the fact that these veterans have ready access to VA health care, which is free of charge for two years following separation from service for problems related to their wartime service. However, VA estimates that only 109,191 veterans of the Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than expected to see in 2006). With increased outreach, internal mental health screening efforts under way, and expanded access to health care for OEF/OIF veterans, we are concerned that these estimates are artificially low and could result in a shortfall in funding necessary to meet the demand. Experts agree that if newly returning

veterans do not have timely access to PTSD counseling and other readjustment services, an opportunity will be lost to reduce the severity of symptoms and more serious long-term chronic mental health problems in this population.

VA's Specialized PTSD Programs

According to VA, it operates a network of more than 190 specialized PTSD outpatient treatment programs throughout the country, including specialized PTSD clinical teams or a PTSD specialist at each VA medical center. Vet centers, which provide readjustment counseling in 207 community-based centers, have reported rapidly increasing enrollment in their programs, with nearly 77,000 readjustment counseling visits of OEF/OIF veterans in fiscal year 2005 and projected visits of 242,000 in fiscal year 2006.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder as a focal point to promote research into the causes and diagnosis of this disorder, to train health-care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The center offers a monthly five-day clinical training program to VA clinical staff and maintains a website (www.ncptsd.va.gov) with information about trauma and PTSD. The center also offers guidance on the effects of PTSD on family and work and notes treatment modalities and common therapies used to treat the disorder. Last year the center provided a guide for military personnel titled "Returning from the War Zone." This guide discusses common experiences in combat, postdeployment readjustment issues including the primary symptoms of PTSD, as well as other common stress reactions, such as depression, anger, aggressive behavior, alcohol and drug abuse, shame, guilt, and suicidal ideation. The center offers guidance on the effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat the condition. Included in the guide is a checklist of trauma symptoms for self-assessment, eligibility requirements for VA services, and guidance for seeking further help.

Because of increased roles of women in the military and their exposure to combat in OEF/OIF theaters, we encourage VA to continue to address, through its treatment programs and research initiatives, the unique needs of women veterans related to treatment of PTSD and military sexual trauma.

Although VA has improved access to mental health services at its 800-plus community-based outpatient clinics, such services are still not readily available at all sites. Likewise, VA has not yet achieved its goal of integration of mental health staff in all its primary care clinics. Also, we remain concerned about the capacity in specialized PTSD programs and the decline in availability of VA substance-use disorder programs of all kinds, over time, including virtual elimination of inpatient detoxification and residential treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and consequent rationed access to, these specialized services.

Traumatic Brain Injury and Mental Health

It has been said that traumatic brain injury (TBI)—caused by IEDs, vehicular accidents, gunshot or shell fragment wounds, falls, and other traumatic injuries to the brain and upper spinal cord—is the signature injury of Operations Enduring and Iraqi Freedom. Severe TBI resulting from blast injuries or powerful bomb detonations that severely shake or compress the brain within the skull often causes devastating and permanent damage to brain tissue. Likewise, veterans who are in the vicinity of an IED blast or involved in a motor vehicle accident can suffer from a milder form of TBI that is not always immediately detected and can produce symptoms that mimic PTSD or other mental health disorders. It is believed that many OEF/OIF veterans have suffered mild brain injuries/concussions that have gone undiagnosed and that symptoms will only be detected later, when these veterans return home. We are concerned about emerging literature (August 11, 2006, memorandum, issued by the Armed Forces Epidemiological Board regarding Traumatic Brain Injury in Military Service Members) that strongly suggests that even "mild" TBI patients may have long-term mental and medical health consequences. The DOD admits that it lacks a systemwide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI/concussion, in particular mild TBI/concussion. Therefore, VA should coordinate with the DOD to better address mild TBI/concussion injuries and develop a standardized follow-up protocol utilizing appropriate clinical assessment techniques to recognize neurological and behavioral consequences of TBI as recommended by

the Armed Forces Epidemiological Board. The influx of OEF/OIF service members returning with brain trauma has provided an increased opportunity for research into the evaluation and treatment of these injuries in newer veterans; however, we suggest that any studies include older veterans of past conflicts who may have also suffered similar injuries that went undetected, undiagnosed, and untreated.

The most severely injured service members will require extensive rehabilitation and lifelong personal and clinical support, including home caregiver, neurological and psychiatric services, physical, psychosocial, occupational, and vocational therapies. Currently VA has four designated TBI facilities: in Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; and Tampa, Florida. These TBI lead centers provide a full spectrum of TBI care for patients suffering moderate to severe brain injuries. VA is also establishing polytrauma centers in each of its Veterans Integrated Service Networks for follow-up care of polytrauma and TBI patients referred from the four lead centers or from military treatment facilities. In an attempt to raise awareness of TBI issues, VA requires training of primary care, mental health, spinal cord, and rehabilitation providers via a web-based independent study course. However, VA is still working to develop a systemwide screening tool for clinicians to use to assess TBI patients.

The VA's Office of the Inspector General (OIG) issued a revealing report in July 2006, "Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation." The report assessed health care and other services provided for VA patients with TBI and then examined their status approximately one year following discharge from inpatient rehabilitation. The OIG found that improvement and better coordination of care were needed so veterans could make a smoother transition between the DOD and VA health-care services. The report also called for additional assistance to immediate family members of brain-injured veterans, including additional caregivers and improved case management.

VA has designated TBI as one of its special emphasis programs and is committed to working with the DOD to provide comprehensive acute and long-term rehabilitative care for veterans with brain injuries. We are encouraged that VA has responded to the growing demand for specialized TBI care and, fulfilling the requirements of Public Law 108-422, established four polytrauma rehabilitation centers (PRCs) that are colocated with the existing TBI lead centers. However, we remain concerned about capacity and whether VA has fully addressed the resources and staff necessary to provide intensive rehabilitation services, treat the long-term emotional and behavioral problems that are often associated with TBI, and to support families and caregivers of these seriously brain injured veterans. During a September 2006 House Veterans' Affairs Subcommittee on Health hearing, a statement was provided for the record that indicated the 20-year health-care costs for TBI could exceed $14 billion. As noted in the OIG report, "these problems exact a huge toll on patients, family members, and health care providers." There are several challenges we face in ensuring these veterans and their families get the specialized care and support services they need. Clinicians indicate that in the case of mild TBI, the [veteran's] denial of problems that can accompany damage to certain areas of the brain often leads to difficulties receiving services. Likewise, with more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

To help facilitate access to services, VA assigns a case manager to each OEF/OIF veteran seeking treatment at one of its medical facilities. The case manager is responsible for coordination of all VA services and benefits. Additionally, VA has created liaison and social work positions at DOD facilities to assist injured service members. In interviewing these case managers, the OIG found several problems that warrant attention. These case managers reported continued problems related to transfer of medical records from referring military facilities; difficulty in securing long-term placements of TBI patients with extreme behavioral problems; difficulty in obtaining appropriate services for veterans living in geographically remote areas; limited ability to follow patients after discharge to remote areas; poor access to transportation and other resources; and inconsistency in long-term case management. The report found that while many of the patients they assessed had achieved a substantial degree of recovery, "*...approximately half remained considerably impaired.*" The report concluded that improved coordination of care is necessary between agencies, and that families need additional support in the care of TBI patients.

Finally, the IBVSOs are concerned about media accounts and reports from veteran patients with TBI and their family members who claim that VA care for TBI is not up to par—requiring them to seek rehabilitation services in the private sector. We encourage VA and Congress to address these types of complaints to ensure severely wounded TBI veterans are receiving the best rehabilitative care available.

■ Summary

Overall, we are pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that the DOD has acknowledged that it needs to conduct more rigorous pre- and postdeployment health assessments and reassessments with military service personnel who serve in combat theaters and that it is working to improve collaboration with VA to ensure this information is accessible to VA clinicians. Likewise, VA and the DOD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services. Although we recognize and acknowledge both agencies' efforts, the DOD and VA are still far from achieving the universal goal of "seamless transition."

Emerging evidence suggests that the burden of combat-related mental illness from OEF/OIF will be high. Utilization rates for health care and mental health services predict an increasing demand for such services in the future, and evidence suggests that the current wars are presenting new challenges to the DOD and VA health-care systems. Fortunately, Americans are united in agreeing that care for those who have been wounded as a result of military service is a continuing cost of national defense. PTSD, TBI, and other injuries with mental health consequences that are not so easily recognizable can lead to serious health catastrophes, including occupational and social disruption, personal distress, and even suicide, if not treated. We can meet that challenge by ensuring a stable, robust VA health-care system that is dedicated to the unique needs of the nation's veterans—one that is there now for aging veterans of World War II, Korea, and Vietnam and will remain viable for the newest generation of war fighters who will need specialized medical and mental health services for decades to come.

The DOD and VA share a unique obligation to meet the health-care (including mental health care) and rehabilitation needs of veterans who are suffering from readjustment difficulties as a result of combat service or have been wounded as a result of a TBI. Therefore, the DOD, VA, and Congress must remain vigilant to ensure that federal mental health programs are sufficiently funded and ***adapted*** to meet the unique needs of the newest generation of combat service personnel and veterans, while continuing to address the needs of older veterans with PTSD and other combat-related mental health challenges.

RECOMMENDATIONS:

The IBVSOs recommend that VA work more effectively with the DOD to ensure it establishes a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan obtain effective treatment and follow-up services for war-related mental health problems.

VA must do its part to sustain VA mental health care as a high priority grounded in the principles of the New Freedom Commission on Mental Health. The system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes the guiding beacon for VA mental health planning, programming, budgeting, and clinical care.

Congress should carefully monitor VA's two-year limit on providing start-up funding for new initiatives under VA's National Mental Health Strategic Plan and provide oversight to ensure resources allocated to expand and improve mental health services are used for this express purpose.

The IBVSOs believe more research into the consequences of brain injury and best practices in its treatment is needed and is warranted by VA to deal with both medical and mental health aspects of TBI, including research into the long-term consequences of mild TBI in OEF/OIF veterans, as well as similar injuries in previous generations of combat veterans.

To ensure a smoother transition for veterans with TBI and their caregivers, VA should evaluate ways to provide additional assistance to immediate family

members of brain-injured veterans, including additional resources, improved case management, and continuous follow-up. In this connection we urge VA to implement the family caregiver authorization recently enacted by Congress, Public Law 109-461, at the earliest possible time.

The goal of achieving optimal function of each individual TBI patient requires improved coordination and interagency cooperation between the DOD and VA. Veterans should be afforded the best rehabilitation services available and the opportunity to achieve maximum functioning so they can reenter society or, at minimum, achieve stability of function in an appropriate setting.

The President and Congress should sufficiently fund the DOD and VA to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of older veterans with PTSD and other combat-related mental health challenges.

Waiver of Health Care Copayments and Fees for Catastrophically Disabled Veterans:

Veterans in priority group 4 should not be subject to copayments.

Veterans meeting the definition of having catastrophic disabilities as a result of nonservice-connected causes and who have incomes above means-tested levels can still enroll in the Department of Veterans Affairs (VA) as priority 4 veterans instead of the less preferential categories 7 and 8. This heightened priority for VA health-care eligibility was granted in recognition of the unique nature of these disabilities and the need for these veterans to avail themselves of the complex specialized health-care services in many cases unique to the mission of the VA health-care system. The higher priority 4 enrollment category would also protect these veterans from not having access to the system were they, under usual circumstances, to be considered in the lower priority categories 7 or 8 if VA health-care resources were to be curtailed.

However, current VA regulation stipulates that even though these veterans are to be considered priority 4 for the purpose of enrollment because of their specialized needs, they still have to pay all health-care fees and copayments as though they were still in the lower eligibility category. This interpretation violates the intent of the statute in recognizing the unique needs of these veterans and the role of VA in providing their care. These veterans are not casual users of VA health-care services. Because of the nature of their disabilities, they require a lot of care and a lifetime of services. Private insurers do not offer the kind of sustaining care for spinal cord injury found at VA even if the veteran is employed and has access to those services. Other federal or state health programs fall far short of VA. In most instances, VA is the only as well as the best resource for a veteran with a catastrophic disability, yet these veterans, supposedly placed in a priority enrollment category, have to pay fees and copayments for every service they receive as though they had no priority at all. This puts great financial hardship on these catastrophically disabled veterans who need to use far more VA health-care services at a far greater extent than the average VA health-care user. In many instances fees for medical services equipment and supplies can climb to thousands of dollars per year.

It is certainly a tribute to these individuals to have sought gainful employment to support themselves and their families despite the nature of their catastrophic disabilities. Far too often veterans with such disabilities give up opportunities to lead productive lives, falling back on low-income veterans' pensions and other federal and state support systems. In so doing, they fall within the complete definition of priority 4 health-care enrollment and are exempt from all fees and copayments. Yet when of a veteran's industry and employ-

ment bring annual income above the means-test levels, he or she is then unduly penalized by exorbitant fees. This "catch-22" status does little to reward or provide an incentive for a highly disabled veteran to maintain employment and a productive life.

RECOMMENDATION:

Those veterans designated by VA as being catastrophically disabled veterans for the purpose of enrollment in health-care eligibility category 4 should be exempt from all health-care copayments and fees.

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Access Issues

While the Veterans Health Administration (VHA) has made commendable improvements in quality and efficiency, veterans' access to the VA health-care system is severely limited. Excessive waiting times and delays imposed to keep health-care demand within the limits of available resources amount to health-care rationing for enrolled veterans.

Advanced Clinic Access Initiative:

Veterans have to wait too long for appointments.

Limited access is the primary problem in veterans' health care. Demand for care at many Department of Veterans Affairs (VA) facilities is straining capacity, and with limited resources, VA has continued to restrict enrollment. Perennially inadequate health-care budgets have resulted in a VA health-care system struggling to meet the needs of our nation's sick and disabled veterans. Without funding to increase clinical staff, veterans' demand for health care will continue to outpace the VHA's ability to supply timely health-care services and erode the world-renowned quality of VA medical care.

At its peak in July 2002, the VHA had more than 310,000 veterans waiting for medical appointments, half of whom had to wait six months or more for care and the other half having no scheduled appointment. In response, regulations were instituted, and subsequent business practices now allow the most severely disabled service-connected veterans priority access in the VA health-care system. Though VA is committed to providing priority care for veterans of Operations Enduring and Iraqi Freedom and veterans with service-connected disabilities, these actions have not equitably provided timely access to quality heath care for veterans eligible for VA health care under the provisions of the Health Care Eligibility Reform Act of 1996.

To reduce waiting times for sick and disabled veterans seeking care, the Advanced Clinic Access (ACA) Initiative, a program designed to eliminate waiting times and reject the supply constraint theory of managing outpatient health-care demand, has been implemented and continues to show promise. The goal is to build a system in which veterans can see their health-care providers when needed. Through the work of a few leaders, this program reduced average waiting times and significantly improved veterans' access to their health-care system.

We commend Veterans Integrated Service Network (VISN) and facility leadership for their support, which is instrumental in the wide acceptance and success of the ACA initiative. However, their respective performance plans measure waiting times for only 9 clinics, while VHA currently monitors 50 clinics for which its waiting list report captures a large majority of medical appointments made. Such a disparity must be reconciled to ensure sweeping support for the ACA initiative.

Measuring improvement in access to care with wait-time reports is part of this initiative, and in 2004 a change in reporting measurements was established. Operating on the premise that not all veterans waiting six months or greater should automatically be considered delayed because of limited access to care—particularly for such appointments as routine or follow-up care—VA instituted a new standard of measuring waiting times. Waiting times were to be reported on two

veteran patient populations: new enrollees and established patients. Since this change in reporting, *The Independent Budget* veterans service organizations (IBVSOs) have been concerned that a true measurement remains elusive with regard to the demand for medical care and the existing capacity for VA to provide such care. Despite the validation of some aspects of the VA waitlist report for new enrollees, the data remain suspect in light of established business practices of measuring true waiting time, demand, and capacity. In addition, it is a concern that wait list reports have been relegated to providing only "the number of new enrollees waiting for their first appointment where an appointment has not been scheduled," while ignoring a significant portion of the veteran patient population: the established patient.

Despite any measurable improvements in waiting times for needed appointments, continued disparities exist in the implementation of the ACA initiative nationwide. With a growing number of volunteer coaches who serve as consultants and trainers and growing support from VISNs and facility leadership, success is largely dependent upon the availability of funding. In addition to a fully staffed ACA initiative, the IBVSOs encourage greater support from VA leaders for recommendations made by the ACA initiative toward a more robust tool to accurately measure patient experiences and waiting times, link performance measures to improvements in waiting times, improve decision support by improving clinic efficiency, and compare VHA patients' waiting times with those of private sector patients.

VA's struggle to best capture and measure the veterans' experience in seeking VA medical care with the software system currently in use is clear. While much of the criticism for limited access to VA medical care has been met by the ACA initiative, business processes remain inefficient, primarily due to the aging and cumbersome VistA scheduling software being used to manage appointment activities. The VHA should replace the current scheduling software system to be in line with VA's emerging web-based electronic health system enterprise to provide more comprehensive capacity and demand data to improve resource utilization, to increase provider and patient satisfaction as well as reduce waiting times.

While the IBVSOs believe it is imperative that our government provide a health-care budget that will enable VA to serve the needs of disabled veterans nationwide, both increased medical care appropriations and VA's Advanced Clinical Access Initiative are needed to improve veterans' access and ensure that all service-connected disabled veterans and all other enrolled veterans have access to the system in a timely manner.

RECOMMENDATIONS:

VISNs and facility directors should evaluate whether veterans, as well as the clinics in their area, would benefit from the Advanced Clinic Access Initiative.

The VHA should improve the way it measures administrators' performance on waiting times for appointments.

The VHA should provide the necessary support to implement the Advanced Clinic Access Initiative recommendations for a replacement scheduling software package.

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Community-Based Outpatient Clinics:

Many community-based outpatient clinics (CBOCs) lack staff and equipment to serve the specialized needs of veterans.

The Independent Budget veterans services organizations (IBVSOs) commend Veterans Health Administration (VHA) efforts to expand access to needed primary care services. For many veterans who live long distances from Department of Veterans Affairs medical centers (VAMCs) and for those whose medical conditions make travel to VAMCs difficult, CBOCs reduce the need/necessity for travel. CBOCs also improve veterans' access to timely attention for medical problems, reduce hospital stays, and improve access to and shorten waiting times for follow-up care. As VA proceeds in implementing the CBOCs and engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will need to enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural areas. VA also needs to enable overcrowded facilities to better serve veterans and must support sharing initiatives with the Department of Defense.

While the IBVSOs support establishment of CBOCs, we remain concerned that they often fail to meet the needs of veterans who require specialized services. For example, many CBOCs do not have appropriate mental health providers on staff, nor do they necessarily improve access to specialty health care for either the general veteran population or those with service-connected mental illness. To VA's credit, the revised criteria for establishment of CBOCs includes the availability of mental health with disease specific documentation. Moreover, too often CBOC staff lack the required knowledge to properly diagnose and treat conditions commonly secondary to spinal cord dysfunction, such as pressure ulcers and autonomic dysreflexia. Indeed, some veterans service organizations caution their members to avoid CBOCs, even if the alternative is travel to a more distant VA facility having the appropriate specialty care programs.

Inadequately trained providers are less likely to render appropriate primary or preventive care or to accurately diagnose or properly treat medical conditions. Additionally, some CBOCs do not comply with required accessibility standards in Section 504 of the Rehabilitation Act (29 U.S.C. § 791 et seq.). Regarding physical accessibility to medical facilities, veterans frequently complain of inaccessible exam rooms and medical equipment at these facilities.

CBOCs must contribute to the VHA mission to provide health services to veterans with specialized needs. Veterans with specialized needs require primary and preventive care, which in many cases can be appropriately provided in CBOCs that use clinically specified referral protocols to ensure veterans receive care at other facilities when CBOCs cannot meet their specialized needs.

Unless the VHA is adequately funded and properly managed, the proliferation of CBOCs could ultimately reduce the comprehensive scope of VA hospitals and impact in VHA care.

RECOMMENDATIONS:

The VHA must ensure that CBOCs are staffed by clinically appropriate providers capable of meeting needs of veterans.

The VHA must develop and use clinically specific referral protocols to guide patient management in cases where a patient's condition calls for expertise or equipment not available at the facility at which the need is recognized.

The VHA must ensure that all CBOCs fully meet the accessibility standards set forth in Section 504 of the Rehabilitation Act.

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Veterans' Rural Health Care Access and "Veterans Rural Access Hospitals":

The Department of Veterans Affairs (VA) should work to improve access to VA health-care services for veterans living in rural areas.

The Independent Budget veterans service organizations (IBVSOs) believe that after serving their country, veterans should not see their health-care needs neglected by VA because they choose to live in rural and remote areas far from major VA health-care facilities.

We have gathered some pertinent findings dealing with rural veterans in general as well as newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). For example, one in five veterans nationwide who is enrolled to receive VA health care lives in a rural area. *(Am. J. Pub. Health,* Oct. 2004). Likewise 44 percent of today's active duty military service members and tomorrow's veteran population list rural communities as their homes of record.

Also, from other studies we are able to provide insight on the special, and even unique, needs of rural veterans:

- Veterans who live in rural settings are older and have more physical and mental health diseases compared to veterans who live in suburban or urban settings. *(Am. J. Pub. Health,* Oct. 2004)
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive compensation. *(Am. J. Pub. Health,* Oct. 2004)
- According to "The Future of Rural Health," report, "the smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services." ("Quality Through Collaboration: The Future of Rural Health," Institute of Medicine, Committee on the Future of Rural Health Care, 2005)
- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for suicide, stress, depression, and anxiety disorders as major rural health concerns. ("Rural Healthy People 2010," Vol. 2, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas. (President's New Freedom Commission on Mental Health, Final Report, July 2003)
- Nearly 22 percent of our elderly live in rural areas. Rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care. ("Rural Healthy People 2010," Vol. 3, Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center)

Without question, section 212 of Public Law 109-461, signed into law by the President on December 22, 2006, is the most significant advance to date to address health-care needs of veterans living in rural areas. Under this legislation, VA must establish a new Office of Rural Health within the Veterans Health Administration. This office must carry out a series of requirements in an effort to improve VA health care for veterans in rural and remote areas. This legislation is also aimed—of particular importance—at better addressing the needs of returning veterans who have served in Iraq and Afghanistan. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in these communities. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and the National Guard to ensure that returning veterans and Guard members who, after completing their deployments, can have ready access to the VA health benefits they have earned by that service. The legislation also requires an extensive assessment of the existing VA fee-basis system of contract care and

the development of a plan to improve access and quality of care for enrolled veterans in rural areas.

Although the authors of *The Independent Budget* acknowledge this legislative measure will be beneficial to veterans living in rural and remote areas, the legislation also raises potential concerns about the unintended consequences it may have on the mainstream VA health-care system. As we indicate elsewhere in this *Independent Budget*, in general, current law places limits on VA's ability to contract for private health-care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support broad-based contracting for the care of populations of veterans, whether rural or urban. The IBVSOs believe VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems, such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health care programs only exacerbates the problems currently encountered.

VA has had continuing difficulty securing sufficient funding through the Congressional discretionary budget and appropriations process to ensure basic and adequate access for the care of sick and disabled veterans. Congress repeatedly has been forced to add additional funds to maintain VA health-care services. Also, VA receives no Congressional appropriation dedicated to support the establishment of rural community-based outpatient clinics or to aid Veterans Rural Access Hospital (VRAH)–designated facilities, and thus VA must manage any additional expenses from within generally available Medical Services appropriations. VA has established and is operating more than 711 community-based outpatient clinics, of which 100 are located in areas considered by VA to be rural or highly rural. Given current financial circumstances, we are skeptical that VA can cost-effectively justify establishing additional remote facilities in areas with sparse veteran populations.

Under the federal Medicare program, a critical access hospital (CAH) is a private hospital that is certified to receive cost-based reimbursements from Medicare. The higher reimbursements that CAHs receive under this program compared to urban facilities are intended to improve their financial security and thereby reduce rural hospital closures. In other words, the federal policy is to financially aid struggling rural hospitals in hopes that they will survive. Also CAH facilities are certified under Medicare "conditions of participation" that are more flexible than those used for other acute care hospitals. As of March 2006 [the latest data available], there were 1,279 certified CAH facilities in rural and remote areas.

As a part of the CARES initiative, VA employed Medicare's CAH model as a guide to establish a new VA policy to govern operations of, and planning for, many of VA's rural and remote facilities, now designated VRAH. In 2004, however, the CARES Advisory Commission questioned whether VA's policy was adequate and recommended VA "…establish a clear definition and clear policy on the CAH [now VRAH] designation prior to making decisions on the use of this designation."

Following this guidance from the CARES Commission, on October 29, 2004, VA issued a directive [still in force] that sets a significant number of parameters for VRAH designation, but seems pointed in a direction opposite from that of Medicare for the CAH facilities in the private sector. Illustrative is the basic definition of VRAH, as follows:

> "A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or

other specialized care not available at the rural facility. The facility should be part of a system of primary health care (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc." (VHA Directive 2004-061, October 29, 2004)

We believe VA must carefully monitor the scope of services performed at its smaller, rural facilities, specifically for those procedures that are complex in nature. Further, as medical care advances in the use of high technology and thereby elevates the standard of care, small VA inpatient facilities may find it increasingly difficult to effectively maintain, and actually use these new tools, to provide health care at its most sophisticated levels. However, we believe VA must maintain a safe and high-quality health-care service within each of its facilities, and to the greatest degree possible offer comprehensive care to veterans at each of its facilities, whether rural, suburban, or urban.

The IBVSOs remain concerned about whether VA's VRAH policy fully considers the implications of large-scale referrals from rural VA medical centers in continuing to provide high quality health care in those locations, particularly when veterans are referred to other far off medical centers within a Veterans Integrated Service Network or to private facilities. VA must also consider patient satisfaction, family separation, and travel burdens in the criteria they use for determining which rural facilities should retain acute care services. If acute care beds are to be retained in one facility because of distances that veterans must travel to access inpatient care or receive specialized services, we believe this logic should be standardized and used systemwide to the greatest extent possible.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IBVSOs believe that these veterans, too, should have access to specialized services offered at VA's vet centers.

Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling for military-related trauma. Building on the strength of the Vet Centers program, VA should be required to establish a pilot program to have mobile Vet Centers that could help reach veterans in rural and remote areas.

The new legislation holds VA accountable for improving access for rural veterans through CBOCs and other access points by requiring VA to develop and implement a plan for improving veterans' access to care in rural areas. The May 2004 Secretary's CARES decision identified 156 priority CBOCs and new sites of care nationwide. The VA Secretary is also required to develop a plan for meeting the long-term and mental health care needs of rural veterans. We urge Congress to include funding in fiscal year 2008 to specifically support at least some of these needs in rural areas.

Health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. "The Future of Rural Health" report cited previously recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deeper involvement in health professions education of future rural clinical providers seems essential in improving these situations in VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their health personnel needs.

Helping homeless veterans in rural and remote locations recover, rehabilitate, and reintegrate into society is complex and challenging. VA has no specific programs to help community providers who focus on rural homeless veterans. The rural homeless also deserve attention from VA to aid in their recoveries.

Likewise, Native American, Native Hawaiian, and Native Alaskan veterans have unique health-care needs that VA needs to address with outreach and other activities.

Rural veterans, veterans service organizations, and other experts need a seat at the table to help VA consider important program-and-policy decisions, such as those described here, that would have positive effects on veterans who live in rural areas. The final legislative language of Public Law 109-461 failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans, and other rural experts to recommend policies to meet the challenges of veterans' rural health care. We are disappointed that Congress did not include this requirement in law, but the Secretary of Veterans Affairs retains the authority to establish such a committee. The IBVSOs urge the Secretary to take this action.

RECOMMENDATIONS:

VA must ensure that the distance veterans travel, as well as other hardships they face be considered in VA's policies in determining the appropriate location and setting for providing VA health-care services.

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reductions in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

Mobile Vet Centers should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and remote areas.

Through its affiliations with schools for the health professions, VA should develop a policy to help supply health-professions clinical personnel to rural VA facilities and to rural areas in general.

VA must focus some of its homeless veteran program resources, including contracts with, and grants to, community-based organizations, to address the needs of homeless veterans in rural and remote areas.

VA rural outreach should include a special focus on Native American, Native Hawaiian, and Native Alaskan veterans' unmet health-care needs.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee, to include membership by the veterans service organizations among those that have offered this *Independent Budget*.

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VHA-DOD Sharing:

The Independent Budget *encourages collaboration between Department of Veterans Affairs (VA) and Department of Defense (DOD) health care and recommends careful oversight of sharing initiatives to ensure beneficiaries are assured timely access to partnering facilities.*

The Independent Budget veterans service organizations (IBVSOs) have been discussing this initiative for a number of years, as has Congress, with little success for our efforts. The United States Constitution, Article I, Section 8 requires Congress: "To raise and support Armies…To provide and maintain a Navy…[and] To make all laws which shall be necessary and proper for carrying into Execution the foregoing Powers…" Additionally, federal law (38 U.S.C. § 8111(a)) states: "The Secretary and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, material, and other resources as may be needed to operate such facilities properly[.]."

However, there appear to be a number of gaps in what is required by statute and what actually occurs. In a report released in January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance (The Principi Commission) addressed the need for greater sharing between VA and the DOD. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), created by Executive Order in May 2001, was asked to:

- "identify ways to improve benefits and services for VA beneficiaries and DOD military retirees who are also eligible for benefits from VA through better coordination of the two departments;
- review barriers and challenges that impede VA-DOD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement; and
- identify opportunities for partnership between VA and the DOD to maximize the use of resources and infrastructure."

The Capital Asset Realignment for Enhanced Services (CARES) Commission report of February 12, 2004, states: "Over the past decade, a number of commissions, advisory organizations, and the General Accounting Office [now the General Accountability Office] have studied various approaches to providing quality health care to veterans. One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DOD."

Presidential Review Directive 5 of August 1998 requires VA and the DOD to develop a computer-based patient record system that would accurately and efficiently exchange information between the departments. Eight years later the envisioned system still remains a challenge.

It is time to stop doing studies, writing reports, and taking minimal action. In this time of tight funding and a war against world terrorism, it is imperative that VA and the DOD begin implementing many of the recommendations made by these various reports, as well as take further actions to foster VHA-DOD sharing.

The IBVSOs continue to support the careful expansion of VA-DOD sharing agreements. However, we concur with the statement of Dr. C. Ross Anthony (one of the PTF commissioners) before the House Committee on Veterans' Affairs in June 2003, when he said that the PTF "concluded that it would be almost impossible for there to be effective collaboration between two systems if one was well funded and the other was not. While not always the case, the DOD appears at present to have adequate funding to fulfill its health-care responsibilities. As this committee is well aware and our report details, the same is not true in the case of the Department of Veterans Affairs. As an economist, I feel that it is important to fashion good policy and then finance it adequately—hopefully, in a manner that creates incentives for efficiency." VA and the DOD will not be able to accomplish either their mandated or recommended sharing goals until Congress addresses the mismatch between the veterans' demand for services and the appropriated resources made available to the Veterans Health Administration of VA.

■ Leadership and Reporting

The VA-DOD Joint Executive Council should report, at least annually, to the House Committees on Armed Services and Veterans Affairs on collaborative activities, including development of tools to measure outcomes

relating to access, quality, cost, and progress toward meeting goals set for collaboration, sharing, and outcomes. Not only do the IBVSOs believe that there has been insufficient transparency in the work of various DOD and VA executive planning forums, but we also believe that without direct guidance from the respective Secretaries, to include responsibility and accountability of local management personnel, these sharing agreements are doomed to failure. This has also been announced as the viewpoint of the previous Chairman of the House Committee on Veterans' Affairs.

It has been noted, specifically in GAO report GAO-06-794R, that rather than resolve the issues pertaining to various proposed joint-sharing programs, the DOD prefers to "throw stones" at the GAO and VA. The DOD refuses to acknowledge, citing the Health Insurance Portability and Accountability Act, that the health-care and medical records of our veterans and service members fall under the purview of both the DOD and VA. In this report, the DOD admonishes VA for a security breach resulting in the loss of a laptop with 28.6 million files on it. In actuality, from February 15, 2005, to November 3, 2006, VA had six security breaches that affected millions of veteran records. At the same time, the DOD had 10 breaches that affected millions of service member records (Privacy Rights Clearinghouse).

Neal P. Curtin, director, Operations and Readiness Issues, General Accountability Office, stated, in GAO Letter GAO-04-292R to the Chairman of House Committee on Veterans' Affairs, "VA and DOD have been pursuing ways to share in their health information systems and create electronic records since 1998…." They still haven't accomplished that goal. Without the successful electronic integration of health-care information, neither "seamless transition" nor joint ventures will be successful. The CARES Commission report states: "At those locations where collaboration was not successful or where it had been proposed for some time but had not gained momentum, the Commission found…no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense to the local leadership in support of the collaboration."

From its review, the commission concluded that to ensure a successful collaborative relationship between the DOD and VA, there must be a clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired.

To this end, the IBVSOS believe that sharing agreements should be negotiated and written by local leadership, as they are now, but when ready for signature, they should be signed by the VA Under Secretary for Health and the appropriate service Secretary. This would preclude future local management personnel from repudiating the agreements.

The Departments signed a memorandum of agreement (MOA) November 17, 2004, concerning Cooperative Separation/Process Examinations. However, this MOA simply allows only the local Veterans Affairs medical center and military treatment facility (MTF) at benefits delivery at discharge sites to sign individual memorandums of understanding (MOU). According to the appendices to the MOA, this will be require 138 separate MOUs be negotiated and signed.

■ Joint Venture Sites

The DOD and VA have identified 74 sharing initiatives at the facility level, 35 of which appear promising to VA. The DOD has identified 20 and VA has identified 21 of these as priority initiatives. In addition, the DOD and VA announced, in October 2003, a series of demonstrations, required by P.L. 107-314, to test improving business collaboration between the DOD and VA health-care facilities. The Departments will use the demonstration projects at eight locations to test initiatives in joint budget and financial management, staffing, and medical information and information technology systems. *The Independent Budget* does not object to these ventures, but we do have serious concerns about maintaining an independent presence in serving enrolled veterans as its top priority.

One issue regarding joint venture sites of real concern to the IBVSOs is physical access. Appendix A of the Secretary of Veterans Affairs CARES decision, released in May 2004, lists a number of existing or proposed joint venture sites located aboard military installations. In event of an increase in either terrorist threat level, or force protection level, the probability is that military

installations will go into "lock down" status. This would effectively deny Veterans Health Administration (VHA)–enrolled patients, who are not military retirees, access to their health-care facility. We suggest that the involved military installations accept the VA universal identification card for access to the installation and issue a vehicular decal to VHA patients. Currently, the DOD issues color-coded vehicular decals to personnel requiring access to the facility. These decals are blue for military officers, red for enlisted personnel, green for civilian employees, and black for vendors and contractors. A fifth color could be used for VHA patients.

Of the 21 sites identified by VA as primary joint venture locations, only two have been opened: Bassett ACH, Alaska, and Patterson ACH, New Jersey. However, Patterson ACH is a joint venture with Fort Monmouth, New Jersey. The 2005 Base Realignment and Closure recommended Fort Monmouth be closed. Of the two joint venture clinics in Puerto Rico, one was to have been in conjunction with Naval Hospital Roosevelt Roads, which was closed in 2004. Of the remaining 19 sites, 2 were heavily damaged by Hurricane Katrina, and, to the best of our knowledge, only the VAMC North Chicago-USNACC Great Lakes project is being implemented. Of the other 16 sites, 9 of them could result in veterans being denied health care during increased force readiness conditions.

■ VA and DOD Access Standards

VA has had access standards since 1995, but *these standards have not been enforced*. The DOD, however, has mandatory standards and is required, by statute, to meet them. The DOD standards drive funding levels to meet demand for care at MTF and within TRICARE. In examining the funding mismatch, the PTF, in its report, concluded that the VHA should receive "full funding to meet demand, within access standards[.]" PTF Report at 81.

■ Fully Funded Enrolled Veterans

The PTF recommended that the "Federal Government should provide full funding to ensure that enrolled veterans…are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism[.]" PTF Report at 77.

The PTF recommendation is clear: The gap between resources and demand must be closed by increasing, *and by sustaining*, VA health-care funding. As outlined elsewhere, *The Independent Budget* strongly recommends mandatory funding for all enrolled veterans for whom the Secretary has directed care be provided.

The IBVSOs appreciate that the PTF acknowledged the funding mismatch problem and expressed concern that VA-DOD collaboration cannot work without fundamentally addressing this issue.

RECOMMENDATIONS:

Congress should provide the necessary resources to accelerate the creation of a single separation physical and "one-stop shopping" to enable veterans' benefits decisions to be made more expeditiously.

Congress should provide sufficient resources to enable the DOD and VA to enhance information management interoperability and efficiency.

Congress should mandate establishment of VA's published access standards in Title 38 United States Code.

Congress should mandate that all interdepartmental agreements between departments of the executive branch be approved/signed off at the Under Secretary level or higher.

Congress should mandate that, in the case of joint health-care facilities operated by the DOD/VA, procedures be implemented to preclude the loss of health care to veterans in case of an increased force protection condition.

Congress should mandate that, in locations where VA-DOD joint-sharing agreements exist, in event of involuntarily dissolution due to a base realignment and closure, VA be completely funded to assume total control of the facility or facilities.

Congress should require mandatory funding of VA health care.

Priority 4 Veterans

Classification of Priority 4 Veterans Remains a Problem:

Catastrophically disabled veterans may be incorrectly classified and, as a result, denied care within the Department of Veterans Affairs (VA) health-care system. Current benefits for the catastrophically disabled veteran should be enhanced.

Reports of catastrophically disabled veterans being denied care still persist. VA has acknowledged Public Law 104-262, which specifies that veterans who are receiving an increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled will be classified as enrollment priority 4. However, after nine years, the Veteran's Health Administration (VHA) has not developed a consistent and effective mechanism for identifying eligible veterans and properly classifying them.

Individual requests are processed when brought to the attention of the VA; however, national service officers still experience some reluctance when requesting a reclassification. This has a direct effect on those with new injuries and those who have not enrolled in the VA health-care system. Many of these veterans may have been classified as a priority 8 prior to the injury, and now when they need the services of the VA, may be denied care as they are not accepting priority 8 veterans. This is further affected by concerns for future VA reductions in priority levels which could result in denied care for the catastrophically disabled veteran.

Currently, priority group 4 includes veterans granted VA Aid and Attendance (A&A) or Housebound benefits and veterans who are determined by VA as "catastrophically disabled." Those veterans determined as "catastrophically disabled" who are not otherwise exempt from copayments and/or eligible for beneficiary travel benefits are still required to make applicable copayments for medical care and medications and/or denied beneficiary travel assistance. The hardship endured by a catastrophic injury or disease is unique and devastating to the veteran and the families who may be responsible for his or her care. At a time when a veteran is in need of specialized assistance to regain some independence and quality of life, the financial burden of medical bills should be lifted. Any veteran determined by VA to be "catastrophically disabled" and placed in the priority group 4 should be afforded the same benefits as if rated as entitled to A&A to eliminate medical/prescription copays and provide assistance with travel for that care.

RECOMMENDATIONS:

The VHA should develop a program to identify veterans with disabilities as defined in PL 104-262 and properly classify them as priority 4.

The VHA should report to Congress the number of veterans reclassified as a result of PL 104-262.

VA should, based on a catastrophic disability determination, exempt all enrollment priority group 4 veterans from copayments and provide them with the medical and travel benefits that are due a veteran who is entitled to A&A.

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Non-VA Emergency Services:

Enrolled veterans are being excluded from non–Department of Veterans Affairs (VA) emergency medical services as a result of established eligibility restrictions.

The non-VA emergency medical care benefit was established as a safety net for veterans who have no other health-care insurance coverage and experience a medical emergency. Under this benefit, VA will pay for services rendered to a veteran who is found eligible and files a claim for payment for emergency treatment received from a private facility. However, some veterans' claims are denied payment due to the restrictive nature of the eligibility criteria.

To qualify under this provision, a veteran must be enrolled in the VA health-care system and must have been seen by a VA health-care professional within the 24 months prior to the emergency. In addition, the veteran must not be covered by any other form of health-care insurance, including Medicare or Medicaid.

The Independent Budget veterans service organizations object to eligibility limitations on enrolled veterans: All enrolled veterans should be eligible for VA payment of emergency medical services provided at non-VA medical facilities.

The frequency with which VA denies payment for the emergency care veterans receive, and who are then held liable by the private facilities, is alarming. In addition to denial by eligibility requirements, VA denies payment even after advising the veteran (or family member) to request transport by emergency medical services to receive emergency care at a non-VA medical facility. On occasion, the decision relative to approval or denial of a claim is based on the discharge diagnosis, e.g., "esophogitis," rather than the admitting diagnosis, e.g., "chest pain." Veterans should not be penalized for seeking emergency care when experiencing symptoms that they believe manifest a life-threatening condition.

RECOMMENDATIONS:

Congress must enact legislation eliminating the provision requiring veterans to be seen by a VA health-care professional at least once every 24 months to be eligible for non-VA emergency care service.

VA must establish and enforce a policy that it will pay for emergency care received by veterans at a non-VA medical facility when they exhibit symptoms that a reasonable person would consider a manifestation of a life- or health-threatening medical emergency.

Rather than an arbitrary medical contact requirement, veterans' enrollment should govern VA's policy of reimbursement for emergency medical services in private facilities.

VA should establish a policy consistent with these recommendations that would appropriately allow all enrolled veterans to be eligible for emergency medical services when needed.

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SPECIALIZED SERVICES

Prosthetics and Sensory Aids

Continuation of Centralized Prosthetics Funding:

Centralized prosthetic and sensory aids funding for the Department of Veterans Affairs (VA) has been an improvement; however, veterans continue to encounter problems in the timely distribution of service and equipment. Program enhancements have been developed to eliminate or minimize obstacles; however, they have not been fully implemented throughout the VA health-care system.

The protection of these funds by a centralized budget for prosthetics has had a major positive impact on disabled veterans. *The Independent Budget* veterans service organizations (IBVSOs) applaud Veterans Health Administration (VHA) senior leadership for remaining focused on the need to ensure that adequate funding is available, through centralization and protection of the prosthetics budget, to meet the prosthetics needs of veterans with disabilities.

The IBVSOs also are in full support of the decision to distribute FY 2007 prosthetics funds to the Veterans Integrated Service Networks (VISNs) based on prosthetics fund expenditures and utilization reporting. This decision continues to improve the budget-reporting process.

The IBVSOs believe the requirement for oversight of the expenditures of centralized prosthetics funds has had positive results and should be continued. This requirement is being monitored through the work of VHA's Prosthetics Resources Utilization Workgroup (PRUW). The PRUW is charged with conducting extensive reviews of prosthetics budget expenditures at all levels, primarily utilizing data generated from the National Prosthetics Patients Database (NPPD). As a result, many are now aware that proper accounting procedures will result in a better distribution of funds.

The IBVSOs continue to applaud senior VHA officials for implementing and following the proper accounting methods and holding all VISNs accountable. We believe continuing to follow the proper accounting methods will result in an accurate accounting and requesting of prosthetics funds.

The IBVSOs are pleased that centralized funding continued in FY 2007. The present 2007 allocated budget for prosthetics is $1,231,512,000. Funding allocations for FY 2007 were primarily based on FY 2006 NPPD expenditure data, coupled with Denver Distribution Center billings, and other pertinent items. The VHA also looked at VISN requests, past accuracy between request and expenditures, and new programs being established. The prosthetics budget also includes funds for surgical, dental, and radiology implants.

It is anticipated that, $1,339,131,000 will be required to cover the FY 2008 prosthetics budget. This is a result of advancements in prosthetics technology, telehealth, and the increase in unique health-care issues of veteran patients who require specialized prosthetics needs.

Considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader on developing new prosthetics devices. The VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. As new technologies and devices become available for use, the VHA must ensure that these products are appropriately issued to veterans and that funding is available for such issuance.

Listed on the next page are examples of NPPD expense costs in fiscal year 2006 with projected expense costs for fiscal year 2007.

NPPD EXPENSE COSTS

Prosthetic Item	Total Cost Spent in FY 06	Projected Expenditure in FY 07
Wheelchairs & Access	$ 129,506,709	$ 140,636,876
Artificial Legs	$ 69,144,331	$ 75,086,787
Artificial Arms	$ 3,438,282	$ 3,733,778
Orthosis/Orthotics	$ 32,929,691	$ 35,759,760
Shoes/Orthotics	$ 26,738,433	$ 29,036,408
Sensori-Neuro Aids	$ 56,311,246	$ 61,150,791
Restorations	$ 3,003,352	$ 3,261,468
Oxygen & Respiratory	$ 156,873,103	$ 170,355,215
Medical Equipment & Supplies	$ 133,657,071	$ 145,143,932
Home Dialysis	$ 1,298,507	$ 1,410,104
HISA	$ 6,235,912	$ 6,771,844
Surgical Implants	$ 340,735,579	$ 370,019,344
Other Items	$ 147,667,468	$ 189,145,693
Total Spent	**$ 1,107,539,684**	**$ 1,231,512,000**

RECOMMENDATIONS:

Congress must ensure that appropriations are sufficient to meet the prosthetics needs of all disabled veterans, including covering the latest advances in technology, so that funding shortfalls do not compromise other programs.

The Administration must allocate an adequate portion of its appropriations to prosthetics to ensure that the prosthetics and sensory aids needs of veterans with disabilities are appropriately met.

The VHA must continue to nationally centralize and fence all funding for prosthetics and sensory aids.

The VHA should continue to utilize the PRUW to monitor prosthetics expenditures and trends.

The VHA should continue to allocate prosthetics funds based on prosthetics expenditure data derived from the NPPD.

VHA senior leadership should continue to hold its field managers accountable for failing to ensure that data are properly entered into the NPPD.

Assessment of "Best Practices" to Improve Quality and Accuracy of Prosthetic Prescriptions:

National contracts for single-source prosthetic devices may potentially lead to inappropriate standardization of prosthetic devices.

The Independent Budget veterans service organizations (IBVSOs) continue to cautiously support Veterans Health Administration (VHA) efforts to assess and develop "best practices" to improve the quality and accuracy of prosthetics prescriptions and the quality of the devices issued through VHA's Prosthetics Clinical Management Program (PCMP). Our concern with the PCMP is that this program could be used as a veil to standardize or limit the types of prosthetic devices that the VHA would issue to veterans.

The IBVSOs are concerned with the procedures that are being used as part of the PCMP process to award single-source national contracts for specific prosthetic

devices. Mainly our concern lies with the high compliance rates that are contained in the national contracts. The typical compliance rate, or performance goal, in the national contracts awarded so far as a result of the PCMP has been 95 percent. This means that for every 100 devices purchased by the VHA, 95 are expected to be of the make and model covered by the national contract. The remaining 5 percent consist of similar devices that are purchased "off contract" (this could include devices on federal single-source contract, local contract, or no contract at all) in order to meet the unique needs of individual veterans. The problem with such high compliance rates is that inappropriate pressure may be placed on clinicians to meet these goals due to a counterproductive waiver process. As a result, the needs of some individual patients may not be properly met. The IBVSOs believe national contract awards should be multiple-sourced. Additionally, compliance rates, if any, should be reasonable. National contracts need to be designed to meet individual patient needs. Extreme target goals or compliance rates will most likely be detrimental to veterans with special needs. The high compliance rates set thus far appear arbitrary and lack sufficient clinical trial.

Under VHA Directive 1761.1, prosthetic items intended for direct patient issuance are exempted from the VHA's standardization efforts because a "one-size-fits-all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. Yet despite this directive, the PCMP process is being used to standardize the majority of prosthetic items through the issuance of high compliance rate national contracts. This remains a matter of grave concern for the IBVSOs, and we remain opposed to the standardization of prosthetic devices and sensory aids.

Significant advances in prosthetics technology will continue to dramatically enhance the lives of disabled veterans. In our view, standardization of the prosthetic devices that VA routinely purchases threatens future advances. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market.

Another problem with the issuance of prosthetic items relates to surgical implants. While funding through the centralized prosthetics account is available for actual surgical implants (e.g., left ventricular assist device, coronary stints, cochlear implants), the surgical costs associated with implanting the devices come from local VHA medical facilities. The IBVSOs continue to receive reports that some facilities are refusing to schedule the implant surgeries or are limiting the number of surgeries due to the costs involved. If true, the consequences to those veterans would be devastating and possibly life threatening.

RECOMMENDATIONS:

The VHA should continue the prosthetics clinical management program, provided the goals are to improve the quality and accuracy of VA prosthetics prescriptions and the quality of the devices issued.

The VHA must reassess the PCMP to ensure that the clinical guidelines produced are not used as means to inappropriately standardize or limit the types of prosthetic devices that VA will issue to veterans or otherwise place intrusive burdens on veterans.

The VHA must continue to exempt prosthetic devices and sensory aids from standardization efforts. National contracts must be designed to meet individual patient needs, and single-item contracts should be awarded to multiple vendors/providers with reasonable compliance levels.

VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids on the basis of patient needs and medical condition, not costs associated with equipment and services. VHA clinicians must be permitted to prescribe devices that are "off contract" without arduous waiver procedures or fear of repercussions.

The VHA should ensure that its prosthetics and sensory aids policies and procedures, for both clinicians and administrators, are consistent regarding the appropriate provision of care and services. Such policies and procedures should address issues of prescribing, ordering, and purchasing based on patient needs—not cost considerations.

The VHA must ensure that new prosthetic technologies and devices that are available on the market are appropriately and timely issued to veterans.

Congress should investigate any reports of VHA facilities withholding surgeries for needed surgical implants due to cost considerations.

Restructuring of Prosthetics Programs:

The prosthetics program continues to lack timely and consistent service to the patients.

The Independent Budget veterans service organizations (IBVSOs) believe Veterans Health Administration (VHA) headquarters must provide more specific information and direction to Veterans Integrated Service Networks (VISNs) on the restructuring of their prosthetics programs. The current organizational structure has communication inconsistencies that have resulted in the VHA central office trying to respond to various local interpretations of Department of Veterans Affairs (VA) policy.

■ **VHA HEADQUARTERS MUST DIRECT VISN DIRECTORS TO:**

- Designate a qualified VISN prosthetic representative who will be the technical expert responsible for ensuring implementation and compliance with national goals, objectives, policies, and guidelines on all issues of interpretation of the prosthetics policies.
- Ensure that the VISN prosthetic representative has direct input into the performance evaluation of all prosthetics full-time employees at local facilities that are organized under the consolidated prosthetics program or product line.
- Ensure that the VISN prosthetic representative not have collateral duties as a prosthetic representative for a local VA facility within his or her VISN.
- Establish a single VISN budget for prosthetics and steps taken to ensure that the VISN prosthetic representative has control of and responsibility for that budget.
- Establish time limits for prosthetic denials in order to expedite the appeal process.

RECOMMENDATIONS:

The VHA must require all VISNs to adopt consistent operational parameters and authorities in accordance with national prosthetics policies. VISN directors as well as VHA central office staff should be held responsible for implementing a consistent prosthetics program that reduces the need for central office intervention. Time limits for denial of prosthetics requests should be established and adhered to.

The VHA should establish a time limit for denials of prosthetic requests.

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Failure to Develop Future Prosthetics Staff:

There continues to be a shortage in the number of qualified prosthetics staff available to fill current or future vacant positions.

The Veterans Health Administration (VHA) has developed and requested 12 training billets for the National Prosthetic Representative Training Program projected in fiscal year 2007 and 2008. Interns in this program are invited to the annual National Prosthetic Representative Training Conference for a one-week intense prosthetics forum. In fiscal year 2005, trainee recruitment for the program was suspended by the Technical Career Field (TCF) per request of the National Leadership Board (NLB). It was reestablished in 2006 and 2007. *The Independent Budget* veterans service organizations (IBVSOs) would like ensure that this training program be established on a permanent basis.

This program will ensure that prosthetics personnel receive appropriate training and experience to carry out their duties. In the past, some Veterans Integrated Service Networks (VISNs) have selected individuals who do not have the requisite training and experience to fill the critical VISN prosthetic representative positions. There are some VISNs who have developed their own Prosthetic Representative Training Program.

These VISN interns are included in the annual National Prosthetic Representative Training Conference. The IBVSOs recommend that all VISNs have a Prosthetic Representative Training Program to enhance the quality of health-care service within the VHA system. The IBVSOs believe the future strength and viability of VA's prosthetics program depends on the selection of high-caliber prosthetics leaders. To do otherwise will continually lead to grave outcomes based on the inability to understand the complexity of the prosthetics needs of patients.

We are seeing an increasing number of injuries as a direct result of Operation Enduring Freedom and Operation Iraqi Freedom, and our returning military personnel are being issued complex technological prosthetic devices. Each major prosthetics department within the VA must have trained certified technologists that can maintain and repair these devices.

RECOMMENDATIONS:

The VHA must fully fund and implement its National Prosthetic Representative Training Program on an ongoing basis, with responsibility and accountability assigned to the chief consultant for Prosthetics and Sensory Aids. Sufficient training funds and employee staff must be dedicated to this program to ensure success.

VISN directors must ensure that sufficient training funds are reserved for sponsoring prosthetics training conferences and meetings for appropriate managerial, technical, and clinical personnel.

The VHA must be assured by the VISN directors that selected candidates for vacant VISN prosthetic representative positions possess the necessary competency to carry out the responsibilities of these positions.

The VHA and its VISN directors must ensure that prosthetics departments are staffed by certified professional staff that can maintain and repair the latest technological prosthetic devices.

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Hearing Loss and Tinnitus:

The Veterans Health Administration (VHA) needs to provide a full continuum of audiology services.

While loud noise has been part of military life since muskets and cannons were part of the arsenal, Iraq is proving one of the noisiest battlegrounds yet. Roadside bombs—the signature weapon of the country's insurgency—regularly hit patrols, popping eardrums in their wake.

According to Veterans Affairs' (VA) data, major hearing loss disability cases held steady through the late 1990s. The number rose markedly from nearly 40,000 cases in 2002 to about 50,000 in 2005, the latest year for which data were available. In 2005 the Department of Veterans Affairs spent nearly $800,000 treating major hearing loss—a nearly 20 percent jump from 2004.

■ Invisible Injury

Many service members returning from war are physically disabled. Those types of injuries are easily seen by a physician and are often easily diagnosed and treated. Many soldiers exposed to blasts from roadside bombs suffer internal injuries that are not as easy to detect and treat. One of the most prevalent disabilities from exposure to IEDs (improvised explosive devices) is an injury that is one of the hardest to detect—and even harder to treat. Soldiers may even be unaware of this injury upon separation from the military. It is called tinnitus.

Tinnitus is defined as the perception of sound in the ears where no external source is present. Some with tinnitus describe it as "ringing in the ears," but people

report hearing all kinds of sounds, such as crickets, whooshing, pulsing, ocean waves, or buzzing. For millions of Americans, tinnitus becomes more than an annoyance. Chronic tinnitus can leave an individual feeling isolated and impaired in their ability to communicate with others. This isolation can cause anxiety, depression, and feelings of despair. Tinnitus affects an estimated 30 million, or more, people in the United States to some degree. Ten to 12 million are chronically affected and 1 to 2 million are incapacitated by their tinnitus (Brown et al., 1990). It is estimated that 250 million people worldwide experience tinnitus (Holme et al., 2005).

■ Adding to the Rolls Every Year

The number of veterans who are receiving disability compensation for their tinnitus has risen steadily over the past 10 years and spiked sharply in the past 5 years. From 2004 to 2005, the number of veterans receiving compensation for their tinnitus increased by 20 percent. That's the single largest one-year increase since tinnitus became compensable in 1945. Veterans with tinnitus may be awarded up to a 10 percent disability, which currently equals about $115 a month. Though it is considered to be a "disease of the ear" according to Title 38 of United States Code (the veterans disability rating handbook), only one "ear" is considered in determining disability rating for tinnitus.

Translated into economic terms, the government paid out nearly $418 million in disability compensation for tinnitus in 2005. If you couple that dollar amount with what was paid out for hearing loss disability compensation, the total is more than $1 billion for fiscal year 2005 alone. If tinnitus continues on the upward trend seen over the past five years, which is an average annual rate of $53.6 million, the cost to taxpayers for tinnitus disability claims will reach $1.2 billion by 2025. This is one of the many reasons why the federal government needs to begin addressing this epidemic from an effective medical research and prevention standpoint.

■ Noise-Induced Hearing Loss and Tinnitus

Although tinnitus has a number of different causes, one of the primary causes among military personnel is noise exposure. Service members are exposed to extreme noise conditions on a daily basis during both war and peace time. During present day combat, a single exposure to the impulse noise of an IED can cause tinnitus and hearing damage. An impulse noise is a short burst of acoustic energy, which can either be a single burst or multiple bursts of energy. Most impulse noises, such as the acoustic energy emitted from an IED, occur within one second. However, successive rounds of automatic weapon fire are also considered impulse noise.

According to the National Institute on Deafness and other Communication Disorders (NIDCD), any sounds that emit noise of 80 decibels (dBA) or higher can cause tinnitus and hearing damage. Prolonged exposure from sounds at 85+ dBA can also be damaging, depending on the length of exposure time. As decibel levels intensify, the time an individual needs to be exposed decreases and the chance of noise-induced hearing loss and tinnitus increases. A single exposure at 140+ dBA may cause tinnitus and damage hearing immediately. The table below shows a few common military operations and their associated noise levels.

NOISE LEVELS–COMMON MILITARY OPERATIONS

Type of Artillery	Position	Decibel Level (dBA) (Impulse Noise)
105 mm Towed Howitzer	Gunner	183
Hand Grenade	At 50 feet from target	164
Rifle	Gunner	163
9 mm Pistol	N/A	157
F18C Handgun	N/A	150
Machine Gun	Gunner	145

Source: U.S. Army Center for Health and Preventative Medicine, http://chppm-www.apgea.army.mil/

It's no surprise that service members using weaponry that emits such high decibel levels, in training or combat, are at greater risk of this type of disability than the general U.S. population. So what's being done to help our military? Hearing conservation programs have been in place since the 1970s to protect and preserve the hearing of our soldiers. However, a study released by the Institute of Medicine in 2005 reviewed these hearing conservation programs and concluded they were not adequately protecting the auditory systems of service members.

Additional studies conducted to assess the job performance of those exposed to extremely noisy environments in the military concluded that the noise not only caused disabilities, but put the overall safety of the service member and their team at risk. Reaction time can be reduced as a result of tinnitus, thus degrading combat performance and the ability to understand and execute commands quickly and properly.

Many soldiers develop tinnitus and other hearing impairments prior to active combat as a result of training. If a soldier is disabled prior to combat, his or her effectiveness already may be compromised at the beginning of active duty. A study in "Tank Gunner Performance and Hearing Impairment" (Garinther & Peters, *Army RD&A Bulletin* 1990) concluded that hearing impairments may delay a soldier's ability to identify his or her target by as much as 50 seconds.

The same study concluded that those with hearing impairments who were operating tank artillery were 36 percent more likely to hear the wrong command, and 30 percent less likely to correctly identify their target. Further, the authors noted that soldiers with hearing impairments only hit the enemy target 41 percent of the time, while soldiers without hearing impairments hit the enemy target 94 percent of the time. Finally, the article stated that those with hearing impairments were 8 percent more likely to take the wrong target shot and 21 percent more likely to have their entire tank crew killed by the enemy. According to the study's authors, hearing impairments, such as tinnitus, can very much be a life-or-death situation in the military.

■ The Role of Medical Research

Research has increased our knowledge on hearing loss and how the ear loses the ability to hear, while less has been discovered about tinnitus. We do know that tinnitus is a condition of the auditory system. The sound a person hears is actually generated in the brain. This raises another question of possible correlation to another injury that has seen a recent increase. Traumatic brain injuries (TBIs) have been on the rise as more and more soldiers have been exposed to IEDs. Of 692 TBI patients at Walter Reed Army Medical Center between January 2003 and March 2006, nearly 90 percent had nonpenetrating head injuries *(National Geographic,* Dec. 2006).

Since tinnitus is something that happens in the brain, could there be a correlation between tinnitus and TBIs? It's a question that will remain unanswered unless the federal government funds more medical research as encouraged by *The Independent Budget* veterans services organizations (IBVSOs).

In FY 2005, VA funded about $4.4 million in auditory research. About one-tenth of that was spent on clinical research to learn best practices for treating veterans with tinnitus. Based on evidence from VA data, an audiological evaluation should be mandatory upon separation from the military.

Even though tinnitus research has come a long way, especially in recent years, we need to know much more. With so many veterans being added to the rolls every year for service-connected tinnitus, VA and the DOD should be emerging as leaders in tinnitus research.

The total number of veterans disabled for hearing loss and tinnitus: 414,025 veterans were disabled for hearing loss; 339,573 veterans were disabled for tinnitus. In total, 753,598 veterans were disabled for hearing loss or tinnitus.

RECOMMENDATIONS:

The VHA must rededicate itself to the excellent of program for hearing loss and deficiency.

The VHA must continue its work with networks to restore clinical staff resources in both inpatient and outpatient audiology programs.

Congress must continue to work for increased funding for VA and the DOD to prevent and treat tinnitus.

Blinded Veterans:

The Veterans Health Administration (VHA) needs to provide a full continuum of vision rehabilitation services.

The Department of Veterans Affairs (VA) Blind Rehabilitation Service (BRS) is known worldwide for its excellence in delivering comprehensive blind rehabilitation to our nation's blinded veterans. VA currently operates 10 comprehensive residential blind rehabilitation centers (BRCs) located across the country with plans for three new BRCs. Approximately 44,438 blind veterans were enrolled in FY 2005 with the visual impairment service team (VIST) coordinators offices, and projected demographic data suggest that by 2009 the VA system could realize an increase to approximately 53,000 enrolled blind and visually impaired veterans requiring services.

The Independent Budget veterans service organizations (IBVSOs) emphasize that data compiled between March 2003 and April 2005 by the Department of Defense (DOD) show that **16 percent** of those evacuated from Iraq have eye injuries. As of August 2006, Walter Reed Army Medical Center has surgically treated approximately 670 soldiers with either blindness or moderate to severe significant visual injuries. The National Naval Medical Center has a list of more than 350 veterans with eye injuries that will require surgery. Approximately 40 of these service members have received treatment at the 10 VA BRCs while others are in the process of being referred for admission. Nevertheless, we fear that many are unaccounted for and lost in the DOD system and that the BVA has found some in medical hold companies that had never been referred to the VA BRS. With some 22 percent of the wounded being Army National Guard or Reserves, *The Independent Budget* veterans service organizations are concerned that many others who could benefit from VA rehabilitative services are being lost in the seamless transition process, and we request that Congress exercise greater oversight on the lack of tracking of these eye-injured service members from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

As of January 14, 2006, the DOD had reported more than 11,852 returning wounded service members had suffered exposure to blast injuries, the most common being from improvised explosive devices (IEDs). Traumatic brain injury (TBI) has become the "signature injury" of OEF and OIF. Blast-related injury is now the most common cause of trauma in Iraq. A recent study found that 88 percent of military troops treated at an echelon II medical unit in Iraq had been injured by IEDs, and 47 percent of those suffered TBI. Data from screening of 7,909 marines with the 1st Marine Division revealed that 10 percent suffered from TBI 10 months after returning from Iraq. At Fort Irwin, 1,490 soldiers were screened in May of 2006, and almost 12 percent of them had suffered concussions resulting in mild to moderate TBI injuries.

More than 1,750 of the total of service members with TBI have sustained severe enough TBI to result in neurosensory complications, with epidemiological TBI studies finding that 24 percent have associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, and inability to interpret print, with some TBIs resulting in legal blindness and other manifestations known as post-trauma vision syndrome. *The Independent Budget* fully endorsed the increased funding of $19 million for the Defense and Veterans Brain Injury Center for FY 2007 and supports increases in FY 2008 to meet new injuries. According to a recent study by researchers at Harvard and Columbia, it is estimated that the cost of medical treatment for service members with TBI will be at least $14 billion over the next 20 years. The current discretionary budget process does not address this issue.

Historically, the residential BRC program has been the primary option for severely visually impaired and blinded veterans to receive services. As the VHA made the transition to more outpatient primary care systems of healthcare delivery in the 1990s, the BRS failed to make the same transition for blind rehabilitation services for veterans. During Congressional testimony on July 22, 2004, the Government Accountability Office recommended that the VA BRS expand its capacity to provide a full continuum of blind rehabilitation services. This has not occurred because of a lack of overall funding. By the VHA's own estimates, it needs $14.4 million to implement the full continuum of rehabilitative care. At present, approximately 1,200 blinded veterans are waiting an average of 24 weeks for entrance into 1 of the 10 VA BRCs. Under the present system, many older veterans will not attend a residential BRC—so they do not receive any type of rehabilitation.

The Independent Budget encourages directed funding of an additional $9.6 million in FY 2008 for new models of blind rehabilitation outpatient services. By encompassing the full spectrum of visual impairment services—blind rehabilitative outpatient specialists (BROS), Visual Impairment Center to Optimize Remaining Sight a specialized low vision optometry program, and the Visual Impairment Services Outpatient Rehabilitation Program—all the various outpatient programs could screen those service members with high risk or history of TBI for neurological visual complications that might otherwise be undiagnosed—plus be effective outpatient programs for the aging population requiring outpatient services.

Now is the time for implementation of the full continuum of outpatient services for all visually impaired veterans. Congressionally mandated BRS capacity must be maintained. BRS continues to suffer losses in critical full-time employee equivalents, compromising the BRS's capacity to provide comprehensive residential blind rehabilitation services with some of the blind rehabilitation centers operating at only 82 percent of all of their beds because of staff reductions caused by overall funding shortages. Other critical BRS positions, such as full-time VIST coordinators and the current 26 BROS, must be increased and are necessary for the four polytrauma centers and the 17 secondary polytrauma centers. Blind rehabilitative outpatient specialists (BROS), in addition to conducting comprehensive assessments to determine whether a blinded veteran needs to be referred to a blind rehabilitation center, also provide blind rehabilitation training in veterans' homes. They also assist in follow-up training when veterans return from a blind rehabilitation center.

RECOMMENDATIONS:

The VHA must restore the bed capacity in the blind rehabilitation centers to the level that existed at the time of the passage of Public Law 104-262.

The VHA must rededicate itself to the excellence of the full continuum of programs for blinded veterans.

The VHA must require the networks to restore clinical staff resources in both inpatient and outpatient blind rehabilitation programs.

VHA headquarters must undertake aggressive oversight and allocate an additional $9.6 million to ensure the full continuum of care for blind services.

The VHA should expand capacity to provide computer access evaluation and training for blinded veterans by contracting with qualified local providers when and where they can be identified.

The VHA should ensure that concurrence is obtained from the director of the Blind Rehabilitation Service in VA headquarters before a local VA facility selects and appoints key BRS management staff and disputes must be elevated to the Under Secretary for Health for resolution.

Spinal Cord Dysfunction:

Quality health care delivered to the patient with spinal cord dysfunction continues to be hindered by the lack of qualified staff to support the mission of the Spinal Cord Injury/Spinal Cord Dysfunction (SCI/D) program.

■ SCI/D leadership

Several major SCI/D programs are under "acting" management, with a serious shortage of qualified, board-certified SCI physicians. The shortage of qualified board-certified SCI physicians has resulted in delays in policy development and a loss of continuity of care.

It must be recognized that SCI medicine is a major subspecialty and clinical leadership of these departments is as vital to the Department of Veterans Affairs (VA) health-care program as the specialties of general medicine and surgery. Vacancies, specifically in chief positions, reflect adversely on the management of the local VA hospital and the Veterans Health Administration (VHA) system of care. It can be assumed that either the hiring process is flawed, applicants were not available, or that appropriate incentives have not been included to make these positions attractive.

■ Nursing staff

VA is beginning to experience delays in admission and bed reductions based upon availability of qualified nursing staff. *The Independent Budget* veterans service organizations (IBVSOs) continue to agree that basic salary for nurses who provide bedside care is not competitive with community hospital nurses. This results in high attrition rates as these individuals leave the VA for more attractive compensation in the community.

Recruitment and retention bonuses have been effective at several VA SCI/D centers, resulting in an improvement in both quality of care for veterans and the morale of the nursing staff. Unfortunately, facilities are faced with the local budget dilemma when considering the offering of any recruitment or retention bonus. The funding necessary to support this effort is taken from the local budget, thus shorting other needed medical programs. Because these efforts have only been used at local or regional facilities, there is only a partial improvement of a systemwide problem.

A consistent national policy of salary enhancement should be implemented across the country to ensure qualified staff is recruited. Funding to support this initiative should be made available to the medical facilities from the network or central office to supplement their operating budget.

■ Patient Classification

VA has a system of classifying patients according to the amount of bedside nursing care needed. Five categories of patient care take into account significant differences in the level of injury, amount of time spent with the patient, technical expertise, and clinical needs of each patient. A category III patient, in the middle of the scoring system, is the "average" SCI/D patient. These categories take into account the significant differences in hours of care in each category for each shift in a 24-hour period. The hours are converted into the number of full-time employee equivalents (FTEEs) needed for continuous coverage. This formula covers *bedside nursing care hours* over a week, month, quarter, or the year. It is adjusted for net hours of work with annual, sick, holiday, and administrative leave included in the formula.

The emphasis of this classification system is based on *bedside nursing care*. It does not include administrative nurses, non-bedside specialty nurses or light-duty nursing personnel because these individuals do not or are not able to provide full-time labor-intensive bedside care for the patient with SCI/D. According to the *California Safe Staffing* Law, dealing with registered nurses to patient staffing ratios, "Nurse administrators, nurse supervisors, nurse managers, and charge nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those administrators are providing direct patient care."

Nurse staffing in SCI/D units has been delineated in VHA Handbook 1176.1 and VHA Directive 2005-001. It was derived on 71 FTEEs per 50 staffed beds, based on an average category III SCI/D patient. Currently, nurse staffing numbers do not reflect an accurate picture of bedside nursing care provided because administrative nurses, non-bedside specialty nurses and light-duty staff are counted as part of the total number of nurses providing bedside care for SCI/D patients.

VHA Directive 2005-001 mandates 1,347.6 bedside nurses to provide nursing care for 85 percent of the available beds at the 23 SCI/D centers across the country. This nursing staff consists of registered nurses (RNs), licensed vocational/practical nurses, nursing assistants, and health technicians.

At the end of fiscal year 2006, nurse staffing was 1,297.7. This number is 49.9 FTEEs short of the mandated requirement of 1,347.6. The 1,297.7 FTEEs includes nursing administrators and non-bedside RNs (79.5) and light duty staff (35). Removing the administrators and light duty staff makes the total number of nursing personnel at 1,183.2 FTEEs to provide *bedside nursing care*.

The regulation calls for a staff mix of approximately 50 percent RNs. Not all SCI/D centers are in full compliance with this ratio of professional nurses to other nursing personnel. There are 515.6 RNs working in SCI/D. Out of that, 79.5 are in non-bedside or administrative positions, leaving 436.1 RNs providing bedside nursing care. With 1,297.7 nursing personnel and 515.6 of those RNs, this leaves an RN ratio of 40 percent to provide *bedside nursing care*. If the non-bedside RNs were excluded, the percentage of RNs drops to 36 percent. These numbers are well below the mandated 50 percent RN ratio.

SCI/D facilities recruit only to the minimum nurse staffing required by VHA Directive 2005-001. As shown above, when the minimal staffing levels include non-bedside nurses and light duty nurses, the number of nurses available to provide bedside care is severely compromised. It is well documented in professional medical publications that adverse patient outcomes occur with lower levels of nurses.

The low percentage of professional registered nurses providing bedside care and the high acuity of SCI/D patients puts SCI/D veterans at increased risk for complications secondary to their injuries. Studies have shown that low RN staffing causes an increase in adverse patient outcomes, specifically with urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and longer hospital stays. SCI/D patients are prone to all of these adverse outcomes because of the catastrophic nature of their condition. A 50 percent RN staff in the SCI/D service is crucial in promoting optimal outcomes.

This nurse shortage has manifested itself by VA facilities beginning to restrict admissions to SCI/D wards. Reports of bed consolidations or closures have been received due to nursing shortages. Such situations create a severe compromise of patient safety and continue to stress the need to enhance the nurse recruitment and retention programs.

RECOMMENDATIONS:

The VHA should authorize substantial recruitment incentives and bonuses to attract board-certified physicians for staff as well as the SCI chief position.

The VHA needs to centralize policies and funding for systemwide recruitment and retention bonuses for nursing staff.

Congress should appropriate funding necessary to provide competitive salaries and bonuses for SCI/D nurses.

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Gulf War Veterans:

Gulf War veterans still suffer from illnesses related to their military service.

In the 15 years since the Gulf War, both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) have seen many service members and veterans who participated in the Gulf War and have concerns regarding chronic illnesses and disabilities possibly related to their military service. The controversy over "Gulf War syndrome" still exists, but it is clear that many Gulf War veterans suffer from a wide range of chronic symptoms, including fatigue, headaches, muscle and joint pain, skin rashes, memory loss and difficulty concentrating, sleep disturbance, gastrointestinal problems, and chest pain.

Scientists and medical researchers who continue to search for answers and contemplate the various health risks associated with service in the Persian Gulf theater report illnesses affecting many veterans who served there. To date, experts have concluded that while Gulf War veterans suffer from real illnesses, there is no syndrome, single disease, or medical condition affecting them. Some progress has been made in focusing and managing research by both departments, but there is room for improvement, particularly when laboratory and research findings offer improved clinical care and new therapies for Gulf War veterans.

We are concerned that the current conflict in Iraq has, once again, placed our ground troops fighting and living in the same areas as Gulf War veterans did. VA's response to this unique situation was to broaden the scope of Gulf War illness research to include "deployment related health research." In reviewing VA-funded research on Gulf War illnesses, the Research Advisory Committee on Gulf War Veterans' Illnesses has raised questions on the nature of some VA-funded research as to whether these research projects will directly affect veterans suffering from Gulf War illnesses. *The Independent Budget* veterans service organizations (IBVSOs) are concerned that the decision to extend the umbrella of Gulf War illness research will dilute the focus and erode the management of VA research.

While it is unclear whether veterans of the current Persian Gulf conflict should be categorically grouped with veterans of the first Gulf War for purposes of VA research on Gulf War illnesses, it is clear that any research program based on the attributes of a specific population of veterans should not be funded at the expense of the others. We believe that funding for research proposals categorized under Gulf War illnesses should be subject to a review by experts in this area to ensure precious research funding that is committed is properly managed, particularly with Congress's sustained interest in this issue depicted in the conference report of the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (Public Law 109-114), which directs VA to provide no less than $15 million to be used for Gulf War illness research and to evaluate establishing a research center of excellence devoted specifically to Gulf War illness.

As testing and research continue, veterans affected by these multisymptom-based illnesses hope answers will be found and that they will be properly recognized as disabled as a result of their military service in the Gulf War. The IBVSOs expect to see additional health-care issues and disability claims related to some of the same undiagnosed illnesses that veterans of the Gulf War have experienced.

Unfortunately, veterans returning from all of our nation's wars and military conflicts have faced similar problems attempting to gain recognition of certain conditions as service connected. With respect to Gulf War veterans, even after countless studies and extensive research, there remain many unanswered questions. Accordingly, the IBVSOs urge that Congress extend the provision of P.L. 107-135, thus prolonging eligibility for VA health care of veterans who served in Southwest Asia during the Gulf Wars. In this connection, we strongly recommend establishment of an open-ended presumptive period until it is possible to determine "incubation periods" in which conditions associated with Gulf War service may manifest.

Many sick and disabled Gulf War veterans are frustrated over ineffective VA medical treatment and frequent denial of compensation for their poorly defined illnesses. Likewise, VA health-care professionals face a variety of unique challenges when treating these veterans, many of whom are chronically ill and complain of numerous, seemingly unrelated symptoms. Physicians must devote ample time to properly assess and treat these chronic, complex, and debilitating illnesses. For example, VA uses clinical practice guidelines for chronic pain and fatigue; however, VA has not

yet developed clinical practice or treatment guidelines for management of patients with multisymptom-based illnesses. Nor has VA tailored its health-care or benefits systems to meet the unique needs of Gulf War veterans; instead, VA continues to medically treat and handle these cases in a more traditional manner.

The IBVSOs believe Gulf War veterans would greatly benefit from such guidelines, as well as from a medical case manager. Oversight, coupled with a thorough and comprehensive medical assessment, is not only crucial to treatment and management of the illnesses of Gulf War veterans, but also to VA's ability to provide appropriate and adequate compensation.

Equally essential is continuing education for VA health-care personnel who treat this veteran population. VA physicians need current information about the Gulf War experience and related research to appropriately manage their patients. VA should request expedited peer reviews of its Gulf War–related research projects, such as the antibiotic medication trial and the exercise and cognitive behavioral therapy study. Moreover, the Secretary should support significant increases in the effort and funds devoted to such research by both federal government and private entities.

RECOMMENDATIONS:

Congress should ensure continued funding is provided for Gulf War veterans' illness research.

VA should continue to foster and maintain a close working relationship with the National Academy of Sciences in an effort to determine the toxins to which Gulf War veterans were exposed and what illnesses may be associated with such exposure.

Congress should continue prudent and vigilant oversight to ensure both VA and the NAS adhere to time limits imposed upon them so they effectively and efficiently address the continuing health-care needs of Gulf War veterans.

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Lung Cancer Screening and Early Disease Management Pilot Program:

More than 50 percent of new lung cancer cases are diagnosed in former smokers, including many who had quit 20 or 30 years ago. Another 15 percent of new lung cancer cases occur in people who have never smoked, with possible causes including radon, asbestos, Agent Orange and other herbicides, beryllium, nuclear emissions, diesel fumes, and other toxins.

Over the next six years, one million Americans will die from lung cancer, most within months of diagnosis. It is the leading cause of cancer death, responsible for nearly 30 percent of all cancer mortality, more than breast, prostate, colon, liver, melanoma, and kidney cancers combined.

Since Congress passed the National Cancer Act in 1971, the five-year survival rates for breast, prostate, and colon cancers have risen to 88 percent, 99 percent, and 65 percent respectively, primarily because of major funding investments in research and early detection for those cancers. Lung cancer's five-year survival rate is still at 15 percent, reflective of the persistent underfunding of research and early detection. Lung cancer now kills three times as many men as prostate cancer and nearly twice as many women as breast cancer.

■ Impact on Military and Veteran Populations

The Department of Defense (DOD) routinely distributed free cigarettes and included cigarette packages in K-rations until 1976. The 1997 Harris report to the Department of Veterans Affairs (VA) documented the higher prevalence of smoking and exposure to carcinogenic materials among the military and estimated costs to VA and TRICARE in the billions of dollars per year. For example, the percentage of Vietnam veterans who ever smoked is more than 70 percent, double the civilian "ever smoked" rate of 35 percent. Asbestos in

submarines, Agent Orange, Gulf War battlefield emissions, and other toxins are additional factors that have led to a 25 percent higher incidence and mortality rate for lung cancer among veteran populations.

A 2004 report by the Board on Health Promotion and Disease Prevention (HPDP) of the Institute of Medicine (IOM), "Veterans and Agent Orange: Length of Presumptive Period for Association Between Exposure and Respiratory Cancer (2004)," concluded that the presumptive period for lung cancer is 50 years or more. Another report issued in 2005 by the HPDP, "The Gulf War and Health: Volume 3, Fuels, Combustion Products and Propellants (2005)," concluded that there is sufficient evidence for an association between battlefield combustion products and lung cancer.

Lung cancer is an indolent cancer that takes decades to develop, and in most cases no symptoms present until the cancer is already at late stage. Thus, while the disease may initiate under circumstances encountered during service under the DOD, the disease burden will fall most heavily on VA, and to a lesser extent on TRICARE. Because of the predominance of late stage diagnoses, more than 60 percent of lung cancer patients die within the first year, and late stage treatment is more than twice as costly as early stage.

■ Justification

On October 26, 2006, the *New England Journal of Medicine* published the results of a 13-year study on CT screening of 31,500 asymptomatic people by a consortium of 40 centers in 26 states and 6 foreign countries. Lung cancer was diagnosed in 484 participants, 85 percent at stage 1 (versus 16 percent nationally) and the estimated 10-year survival rate for those treated promptly is 92 percent (versus a 15 percent 5-year survival rate nationally).

The benefits of this early detection and disease management protocol should be extended to veterans, especially those whose active duty service has placed them at higher risk for lung cancer.

■ Legislative History

Senate Report 108-087 on the Department of Defense Appropriations Bill, 2004 contains the following language:

"Lung Cancer Screening – The Committee urges the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to begin a multi-institutional lung cancer screening program with centralized imaging review incorporating state-of-the-art image processing and integration of computer assisted diagnostic tools."

Senate Report 109-286, Military Construction and Veterans Affairs and Related Agencies Appropriations Bill, 2007 contains the following language:

"Lung Cancer Screening – The Committee encourages the Secretary of Veterans Affairs to institute a pilot program for lung cancer screening, early diagnosis and treatment among high-risk veteran populations to be coordinated and partnered with the International Early Lung Cancer Action Program and its member institutions and with the designated sites of the National Cancer Institute's Lung Cancer Specialized Programs of Research Excellence. The Department shall report back to the Committee on Appropriations within 90 days of enactment of this act, on a proposal for this program."

■ Department of Energy (DOE) and Lung Cancer

Over the past eight years the DOE Office of Environment, Safety and Health has supported a medical screening program for DOE defense nuclear workers who were exposed to toxic and radioactive substances. The Worker Health Protection Program was originally authorized under Section 3162 of the 1993 Defense Authorization Act and has been funded through DOE appropriations. Currently more than 7,000 workers at seven different munitions plant sites are being screened free of charge annually for lung cancer. In FY 06, funding was increased to $14 million to cover an expansion of sites and the number of participants.

RECOMMENDATIONS:

VA should request and Congress should appropriate at least $3 million to conduct a pilot screening program for veterans at high risk of developing lung cancer.

VA should partner with the International Early Lung Cancer Action Program to provide early screening of veterans at risk.

Women Veterans:

The Department of Veterans Affairs (VA) must be prepared to meet the needs of the increasing numbers of women veterans seeking health-care services and ensure that its special disability programs are tailored to meet the unique health concerns of our newest generation of women veterans, especially those who have served in combat theaters.

In contrast to the overall declining veteran population in the United States, the female veteran population is increasing. According to VA, there are approximately 1.7 million women veterans comprising 7 percent of the total veteran population. VA estimates that by 2020 women veterans will comprise 10 percent of the veteran population.

As the number of women serving in the military continues to rise, we see increasing numbers of women veterans seeking VA health-care services. As of June 2006, there were nearly 400,000 women veterans enrolled in the veterans' health-care system. Women veterans comprise approximately 5 percent of all users of VA health-care services, and within the next decade, this figure is expected to double. The average female veteran is younger (estimated median age 46) than her male counterpart (estimated median age 60) and more likely to belong to a minority group. Additionally, according to the VA Women Veterans Health Program Office, as of August 31, 2006, approximately 70,000 women veterans served in military service in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) theaters of operations and have separated from service. Among the nearly 70,000 women having served in OEF/OIF, 37.2 percent, or 25,960, have received health care from VA since separation (up from 31.2 percent, or 13,693, approximately one year ago).

With increased numbers of women veterans seeking VA health care following military service, it is essential that VA is responsive to the unique demographics of this veterans' population and adjusts programs and services as needed to meet its changing health-care needs. As we see growth in the number of women veterans using VA health-care services, we also expect to see increased VA health-care expenditures for women's health programs.

The VA Veterans Health Administration (VHA) mandates that each facility, independent clinic, and community-based outpatient clinic (CBOC) ensures that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions, that is equal in quality to that provided to male veterans.

The Independent Budget veterans service organizations (IBVSOs) are concerned that although VA has markedly improved the way health care is provided to women veterans, privacy issues and other deficiencies still exist at some facilities. VA needs to monitor and enforce, at the Veterans Integrated Service Network (VISN) and local levels, the laws, regulations, and policies specific to health-care services for women veterans. Only then will women veterans receive high-quality primary and gender-specific care, continuity of care, and the privacy they expect and deserve at all VA facilities.

The model used for delivery of primary health care to women veterans using VA health-care services is variable. There has been a trend in the VHA away from comprehensive or full-service women's health clinics dedicated to both the delivery of primary and gender-specific health care to women veterans. According to VA, 46 percent of VA facilities surveyed provide care to women through mixed gender primary care teams and refer these patients to specialized women's health clinics for gender-specific care. In the mid-1990s, VA reorganized from a predominantly hospital-based care delivery model to an outpatient health-care delivery model focused on preventative medicine. The IBVSOs are concerned about the incidental impact of the primary care model on the quality of health care delivered by VA to women veterans. VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" noted that with the advent of primary care in VA, many women's clinics were dismantled and that women veterans were assigned to primary care teams on a rotating basis. Findings from the report indicate that this practice further reduces the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician will gain the clinical exposure necessary to develop and maintain expertise in women's health.

VA acknowledges, and the IBVSOs agree, that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care for women veterans. Or, in cases where there are relatively low numbers of women being treated at a given facility, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills in women's health. Likewise, we agree that the health-care environment directly affects the quality of care provided to women veterans and has a significant impact on the patient's comfort, feeling of safety, and sense of welcome.

According to VA researchers, although women veterans report that they prefer receiving primary and gender-specific health care from the same provider or clinic, in actuality their care is fragmented, with different components of their care being provided by different clinicians with varying degrees of coordination. Additionally, researchers report there are a number of barriers to delivering high-quality health care to women veterans. Specifically, insufficient funding for women's health programs, competing local or network priorities, limited resources for outreach, inability to recruit specialists, small women veterans' caseloads at certain locations, limited availability of after-hours emergency women's health services, and an insufficient number of clinicians skilled in women's health. The findings of a 2006 study indicated that military sexual trauma quadruples the risk of homelessness among women veterans.

Researchers made several recommendations to address these barriers, including concentrating women's primary care delivery to designated providers with women's health expertise within primary care or women's health clinics; enhancing provider skills in women's health; providing telemedicine access to experts to aid in emergency women's health-care decision making; and increasing communication and coordination of care for women veterans using fee-based or contracted care services. We are pleased that funding has been approved for VA researchers to study the impact of the practice structure on the quality of care for women veterans and fragmentation of care for women veterans including unmet health-care needs for women with chronic physical and mental health conditions.

VA, in recognition of the changing demographics in the veteran population and the special health-care needs of women veterans, has established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004, VHA's Office of Research and Development held a groundbreaking conference, "Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying the research priorities and infrastructure required to fill these gaps. In April 2005, a special solicitation was issued for research that will assess health-care needs of women veterans and demands on the VA health-care system in targeted areas, such as mental health and combat stress, military sexual trauma (MST), post-traumatic stress disorder (PTSD), homeless women veterans, and differences in era of service (e.g., Iraq versus Gulf War). An entire issue of the *Journal of General Internal Medicine* was dedicated to VA research and women's health in March 2006. Published findings include articles on the following topics: why women veterans choose VA health care; barriers to VA health care for women veterans; health status of women veterans; PTSD and increased use in certain VA medical care services; and PTSD and military sexual trauma.

The IBVSOs strongly encourage VA, as it takes steps to advance this agenda, to focus on research and programs that enhance VA's understanding of women veterans' health issues and ways to optimize health-care delivery and health outcomes for this patient population.

Equal access to quality mental health services is critical for women veterans, especially women veterans who have mental health conditions associated with serving in a combat theater or those who have suffered sexual trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel report rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted, and the IBVSOs agree, that it is "essential that VA staff recognize the importance of the environment in which care

is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 19 percent of the women screened between fiscal years 2002 and 2006 responded "yes" to experiencing military sexual trauma, compared to 1 percent of men screened. In response to these reports, VA established a committee to explore ways to address the mental health needs of women veterans and to improve mental health services to women who have experienced MST. In 2006, VA developed an MST support team under its mental health service to specifically work with MST coordinators in the field to better monitor tracking, screening, treatment, and training programs for MST. We still encourage the VHA to implement earlier recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including development of an MST provider certification program, providing separate subunits for inpatient psychiatry and other residential services, and improved coordination with the Department of Defense (DOD) on transition of women veterans.

Given the increasing role of women in combat and with more than 70,000 women having served in OEF/OIF combat theaters, we are pleased that VA's Women's Health Science Division of the National Center for PTSD is evaluating the health impact of combat service on women veterans, including the dual burden of exposure to traumatic events in the war zone and military sexual trauma. According to the center, although there is no current empirical data to verify MST is occurring in Iraq, there have been numerous reports in the popular press citing cases of sexual misconduct and anecdotal reports to health care workers. In the center's Women's Stress Disorder Treatment Team, of 49 returning female veterans, 20 (41 percent) report MST.

The center notes that anecdotal reports from OEF/OIF veterans suggest a number of unique concerns that have a more direct impact on women than their male counterparts returning from combat theaters, including lack of privacy in living, sleeping, and shower areas; lack of gynecological health care; impact of women choosing to stop their menstrual cycle; gender-specific differences in urinating leading to health concerns for women, including dehydration and urinary tract infection. There are also reported findings that suggest distinct differences at homecoming, including that women may be less likely to have their military service recognized or appreciated; possible differential access to treatment services; and possible increased parenting and financial stress. Additionally, women may be more likely to seek help for psychological difficulties.

The center is looking at gender differences in mental health, military sexual trauma in the war zone, and gender differences in other stressors associated with OEF/OIF service and homecoming. A number of research initiatives/projects are focused on treatment of PTSD in women, enhancing sensitivity toward and knowledge of women veterans and their health-care needs among VA staff, and military sexual trauma among Reserve components of the armed forces.

The IBVSOs are pleased that VA is attempting to address the needs of women veterans returning from combat theaters in a variety of ways and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OEF/OIF women veterans in anticipation of gender-specific health issues. Additionally, we understand that VA intends to hold a special conference in early 2007 to better assess the unique needs of this newest generation of combat veterans. These women will have an opportunity to share their personal experiences and concerns so that VA programs and services can be improved and tailored to their specific physical and mental health care needs.

The Women Veterans Health Program Office and the local women veterans program managers (WVPMs) have partnered with the VA Seamless Transition Office to provide information at National Guard, Reserves, and family member demobilization briefings on VA services and programs for women veterans. VA should continue to strengthen its partnership with the DOD to ensure a seamless transition for women from military service to veteran status. Improvements in sharing data and health information between the departments is essential to understanding and best addressing the health concerns of women veterans.

WVPMs and benefits coordinators are another key component to addressing the specialized needs of women veterans. These program directors and benefits coordinators are instrumental in the development,

management, and coordination of women's health and benefits services at all VA facilities.

Given the importance of this position, the IBVSOs are concerned about the actual amount of time WVPMs are able to dedicate to women veterans' issues and whether they have appropriate administrative support to carry out their duties. According to VA, 71 percent of all WVPMs serve in a collateral role. Only 20 percent reported they were allocated more than 20 administrative hours per week to fulfill their program responsibilities during the fiscal year. With increasing numbers of women veterans, VA WVPMs must have appropriate support staff and adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to these veterans is especially important because they tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In a period of fiscal austerity, VA hospital administrators have sought to streamline programs and make every possible efficiency. Often, smaller programs, such as programs for women veterans, are left at risk of discontinuation. The loss of a key staff member responsible for delivering specialized health-care services or developing outreach strategies and programs to serve the needs of women veterans can threaten the overall success of a program.

VA needs to ensure priority is given to women veterans' programs so quality health care and specialized services are equally available to women veterans as to male veterans. VA must continue to work to provide an appropriate clinical environment for treatment where there is a disparity in numbers, such as exists between women and men in VA facilities. Given the changing roles of women in the military, VA must also be prepared to meet the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters, suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must address the health issues that pose special problems for women. The IBVSOs also recommend that VA focus its women's health research on finding the health-care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan with the DOD to collect critical information about the health and health-care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for a women's health research agenda.

RECOMMENDATIONS:

VA must ensure laws, regulations, and policies pertaining to the health care of women veterans are enforced at VISN and local levels.

VA must ensure that priority is given to women veterans' programs and determine which health-care delivery model demonstrates the best clinical outcomes for women.

VA needs to increase its outreach efforts to women veterans, as women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

VA must ensure that clinicians caring for women veterans are knowledgeable about women's health, participate in ongoing education about the health-care needs of women, and are competent to provide gender-specific care to women.

VA must ensure that WVPMs are authorized appropriate support staff and sufficient time to successfully perform their program duties and to conduct outreach to women veterans in their communities.

VA must ensure that its specialized programs for post-traumatic stress disorder, spinal cord injury, prosthetics, and homelessness are equally available to women veterans as to male veterans.

VA should collaborate with the DOD to collect critical information about health and the health-care needs of women veterans to best identify strategic priorities for a women's health research agenda.

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Ending Homelessness Among Veterans:

All veterans deserve access to comprehensive, high-quality, and affordable health care; an income at a level sufficient for obtaining and maintaining permanent housing, food, health care, and other basic human needs; and permanent, safe, high-quality, and affordable housing. No veteran should experience homelessness.

In testimony presented to Congress in 2006, a Department of Veterans Affairs (VA) representative reported that the number of homeless veterans on the streets of America on any given night had decreased by nearly 25 percent over the previous five years, from about 250,000 to 190,000.

VA reports homeless veterans are mostly males (97 percent), and the vast majority are single, although service providers are reporting an increased number of veterans with children seeking their assistance. About half of all homeless veterans have a mental illness, and more than two-thirds suffer from alcohol or other substance abuse problems. Nearly 40 percent have both psychiatric and substance abuse disorders. VA reports the majority of women in homeless veteran programs have serious trauma histories, some life-threatening, and many of these women have been raped and have reported physical harassment while in the military.

According to VA, male veterans are 1.3 times as likely to become homeless as their nonveteran counterparts, and female veterans are 3.6 times as likely to become homeless as their nonveteran counterparts. Like their nonveteran counterparts, veterans are at high risk of homelessness because of having extremely low or no livable income, the extreme shortage of affordable housing, and a lack of access to health care.

Prior to becoming homeless, a large number of veterans at risk of homelessness have struggled with post-traumatic stress disorder or have addictions acquired during or worsened by their military service. These conditions can interrupt their ability to keep a job, establish savings, and in some cases, maintain family harmony. Veterans' family, social, and professional networks may have been broken as a result of extensive mobility while in service or lengthy periods away from their hometowns and their civilian jobs. These problems are directly traceable to their experience in military service or to their return to civilian society without having had appropriate transitional supports.

While most Americans believe our nation's veterans are well-supported, in fact many go without the services they require and are eligible to receive. According to VA, 1.5 million veterans have incomes that fall below the federal poverty level, including 634,000 with incomes below 50 percent of poverty. Neither VA nor its state and county departments are adequately funded to respond to these veterans' health, housing, and supportive services needs. Moreover, community-based and faith-based service providers also lack sufficient resources.

VA reports its homeless treatment and community-based assistance network serves 100,000 veterans annually. Community-based organizations (CBOs) serve 150,000 annually. With an estimated 500,000 veterans experiencing homelessness at some time during a year—VA reaching only 25 percent and CBOs 30 percent of those in need—undoubtedly a substantial number of homeless veterans do not receive much-needed services. Likewise, other federal, state, and local public agencies—notably housing and health departments—are not adequately responding to the housing, health-care, and supportive services needs of veterans. Indeed, it appears veterans fail to register as a target group for these agencies.

Despite the decrease in the number of homeless veterans over the past five years, many veterans still need help. Additionally, this population may be experiencing significant changes. Homeless veterans receiving services today appear to be aging, and the percentage of women veterans seeking services is growing. Moreover, combat veterans of Operation Iraqi Freedom, Operation Enduring Freedom, and the global war on terrorism are returning home and suffering from war-related conditions that may put them at risk for homelessness.

These men and women are beginning to trickle into the nation's community-based homeless veterans service provider organizations and need help—from mental health programs to housing, employment training, and job placement assistance. With greater numbers of women in combat operations, along with increased

identification of and a greater emphasis on care for victims of sexual assault and trauma, new and more comprehensive services are needed. Poverty, lack of support from family and friends, and unstable living conditions in overcrowded or substandard housing may also be contributing factors. In the next 10 years, significant increases in services over current levels will be needed to serve aging Vietnam veterans, women veterans, and combat veterans of America's current operations in Iraq and Afghanistan.

In addition to the recommendations listed below, Congress and the Administration should also consider findings and recommendations included in the 2006 annual report of the VA Advisory Committee on Homeless Veterans.

RECOMMENDATIONS:

Congress should increase appropriations for the VA Medical Services Account in order to strengthen the capacity of the VA Health Care for Homeless Veterans program to serve more homeless veterans; enable VA to increase its mental health and addiction services capacity; and enable VA to increase vision and dental care services to homeless veterans as required by law.

Congress must ensure homeless veterans' access to and utilization of mainstream health insurance and health services programs.

Congress should authorize and appropriate funds for competitive grants to community-based, faith-based, and public organizations to provide health and supportive services to homeless veterans placed in permanent housing.

Congress must develop a new source of funding for the health-care services needed to complement existing permanent housing and new permanent housing being developed for veterans experiencing long-term homelessness.

Congress should increase the authorization level of and appropriations for the Homeless Veterans Reintegration Program (HVRP). Funded by the U.S. Department of Labor (DOL), the HVRP is the only federal program wholly dedicated to providing employment assistance and competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans.

Congress should increase appropriations for the Veterans Workforce Investment Program (VWIP). Funded by the DOL, the VWIP provides to states competitive grants geared toward training and employment opportunities for veterans with service-connected disabilities, those with significant barriers to employment (such as homelessness), and recently separated veterans.

Congress should establish a Veterans Work Opportunity Tax Credit program. The program would provide an incentive for hiring homeless veterans by providing employers a tax credit equal to a percentage of the wage paid to the homeless or other low-income veteran.

Congress should increase the authorization level of and appropriations for the VA Homeless Provider Grant and Per Diem (GPD) program to meet the demands for transitional housing assistance. GPD provides competitive grants to community-based, faith-based, and public organizations to offer transitional housing or service centers for homeless veterans.

Congress should ensure that grantees under the Homeless Provider Grant and Per Diem program are reimbursed for services to homeless veterans at the same rate that VA reimburses states for domiciliary care services provided in state veterans' homes, without decrementing the GPD per diem rate based on other income streams.

Congress should increase appropriations for the therapeutic residence (TR) component of the Compensated Work Therapy (CWT) program, while ensuring that veterans receive the support they need. The CWT program helps veterans with disabilities to obtain competitive employment in the community and allows them to work in jobs they choose. The TR component provides transitional housing assistance to veterans with disabilities while they participate in the CWT program.

Congress should establish additional domiciliary care capacity for homeless veterans, either within the VA system or via contractual arrangements with community-based providers.

Congress should improve coordination between VA-supported Community Homelessness Assessment, Local Education, and Networking Groups and HUD Continuum of Care programs.

Congress should enhance the HUD-Veterans Affairs Supportive Housing Program, which provides permanent housing subsidies and case management services to homeless veterans with mental and addictive disorders, by appropriating funds for additional housing vouchers targeted to homeless veterans.

Congress should require applicants for HUD McKinney-Vento Homeless Assistance Act funds to develop specific plans for housing and services to homeless veterans. Organizations receiving HUD McKinney-Vento homeless assistance funds but not serving veterans should screen participants for military service and make referrals as appropriate to VA and homeless veterans service providers.

Congress should authorize and appropriate funds for a targeted permanent housing assistance program for low-income veterans.

Congress should hold federal agencies accountable for complying with statutory requirements pertaining to making available surplus, excess, underutilized, and unutilized federal properties, including VA capital assets, to nonprofit, profit, and public organizations for development of permanent and transitional housing units for veterans experiencing homelessness.

Congress should ensure that all service members separating from the armed forces are assessed to determine their risk of homelessness and are provided with life skills training to help them avoid homelessness.

Congress should ensure that, in addition to correctional, residential health care, and other custodial facilities receiving federal funds (including Medicare and Medicaid reimbursement), VA facilities develop and implement policies and procedures to ensure the discharge of persons from such facilities into stable transitional or permanent housing and appropriate supportive services. Discharge planning protocols should include providing information about VA resources and assisting persons in applying for income security and health security benefits (such as supplemental security income, Social Security Disability Insurance, veterans disability compensation, and Medicaid) prior to release.

Congress should increase the authorization level of and appropriations for the Emergency Food and Shelter Program (EFSP) and add a homeless veterans service provider representative to the national and local EFSP boards. EFSP provides funds to community-based, faith-based, and public organizations to enable them to offer food, lodging, and mortgage, rental, or utility assistance to persons who are homeless or at risk of homelessness.

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LONG-TERM-CARE ISSUES

Obviously, the Department of Veterans Affairs (VA) has examined the data, considered alternatives, and developed several options for meeting the surging demand for long-term-care services. The aging of the veteran population and its subsequent increasing need for long-term care has been well documented for more than a decade by the Government Accountability Office (GAO), *The Independent Budget (IB)*, and by VA itself. However, if VA has a strategic plan for providing long-term care, it is a well kept secret.

In the absence of a comprehensive strategic plan for long-term care, VA is forced to adapt existing programs, services, and budgets to meet current and future demand. It is also forced to experiment with new ideas within existing budgets to meet the increasing need for these services. Shifting workload from institutional programs to noninstitutional programs can only help for so long. Eventually, aging will take its toll and a wave of veterans who were able to remain at home, with appropriate noninstitutional services, will need institutional nursing home care. The aging of the veteran population and the growing number of young severely injured combat veterans will eventually strain VA's long-term-care capacity to a point at which quality will begin to falter.

The burning questions remain the same. How will veterans receive the care they have earned and deserve without a strategic plan for their care? How will VA receive the long-term-care resources it requires today and tomorrow without a long-term-care strategic plan? How will VA convince the Office of Management and Budget and Congress to fund the resources it needs to meet growing demand without a strategic plan? How well can VA care for America's elderly and young severely wounded combat veterans without a strategic plan?

■ Long-Term-Care Strategic Plan Mandated by Congress

In the waning days of the 109th Congress, the House of Representatives and the Senate bundled a broad array of veterans' issues and passed Public Law 109-461, the "Veterans Benefits, Health Care, and Information Technology Act of 2006." Section 206 of the bill mandates the Secretary of Veterans Affairs to publish a strategic plan for the provision of long-term care within 180 days of the bill's enactment. VA's strategic plan must include cost and quality comparison analysis for all of VA's different levels of long-term care, detailed information about geographic distribution of services and gaps in care, and specific plans for working with Medicare, Medicaid, and private insurance companies to expand the availability of such care.

Additionally, Section 211 of the bill mandates VA to pay the cost of nursing home care provided by state veterans' homes to any veteran who has a service-connected disability rated 70 percent or more and is in need of such care and to any veteran for a service-connected condition that requires such care. The payment rate for this care will be governed by the prevailing rate in the geographic area.

The authors of *The Independent Budget* welcome this Congressional action, which requires VA to move forward in planning for the increasing needs of an aging veteran population. It is hoped that the 110th Congress will hold appropriate hearings to gather additional information from veterans about their long-term-care needs and desires.

■ The Aging of America's Veteran Population

VA has widely published data that describe an aging veteran population. VA's FY 2006–2011 Strategic Plan points out that the median age of all living veterans is 60 years. Other VA data say in the year 2000, approximately 10 million veterans were age 65 and older. Of that 10 million, approximately 5.4 million veterans were between 65 and 75 years of age, approximately 4 million were between 75 and 85, and approximately 540, 000 were 85 or older.

VA projections say that the veteran population age "85 or older" will increase by 110 percent between 2000 and 2020 and that this group of elderly veterans will peak in 2012 at 1.3 million, representing an increase of 143 percent over the total in 2000. VA's FY 2006–2011 Strategic Plan goes on to say that this large increase in the oldest segment of the veteran population has had, and will continue to have, significant ramifications on the demand for health-care services, particularly in the areas of long-term care.

Despite this VA data, VA's FY 2006–2011 Strategic Plan does not identify the needs of an aging veteran population as one of the Secretary's priorities. *VA's plan has no specific objectives or performance measures directly related to long-term care.* Regarding long-term care, Dr. Michael J. Kussman, Acting Under Secretary for Health says only, "The Veterans Health Administration (VHA) will expand its offerings of non-institutional alternatives to nursing home care and the capabilities of home-based care programs." Yet VA's 2006 Average Daily Census (ADC) data for noninstitutional care show a reduction in veterans served.

■ Disturbing VA Long-Term-Care Program Trend

Despite clear VA data that highlights the aging of the U.S. veteran population, VA's 2006 ADC data for its institutional care programs and its ADC data for its noninstitutional care programs show a reduction in the number of veterans served.

VA says little about the future direction of its nursing home care program, but VA is working to shift more of its long-term-care workload toward its noninstitutional care programs. For many veterans this is a positive policy, but for many other elderly veterans it is not. VA must be judicial in its decisions that guide veterans to home and community-based options for care. *The Independent Budget* authors are concerned that a constrained VA budget is forcing VA to downsize it nursing home capacity and turn to less expensive noninstitutional care in order to meet the growing demand for services. *VA must not substitute noninstitutional care for institutional (nursing home) care just because it is less expensive to do so in order to serve a greater number of veterans.*

■ VA Institutional Care

VA Nursing Home Expenditures/Venues of Care

VA's reported overall nursing home care expenditures in its three settings—VA-operated nursing homes, community nursing homes, and state veterans' nursing homes—increased from $2.3 billion in 2003 to nearly $3.2 billion in 2005 (GAO testimony 1/9/06). The percentage of patient workload provided in VA-operated nursing homes declined from 37 to 35 percent from 2003 to 2005. The percentage of workload in community nursing homes stayed about the same at 13 percent and the percentage of workload in state veterans' homes increased from 50 to 52 percent. (See table 1. LTC)

VA's Nursing Home Care Program

VA is a nationally recognized leader in providing quality nursing home care, but its ADC is being reduced each year. Congress has mandated that VA must maintain its nursing home ADC at the 1998 level of 13,391, but VA has not done so. VA's nursing home average daily census has continued to trend downward. VA has chosen to ignore the Congressional ADC mandate, and Congress has chosen to look the other way. Once again VA has failed to meet the Congressional ADC mandate.

Today, VA's long-term-care program focus is concentrated on expanding noninstitutional care programs. It seems that VA is hoping the financial stress of providing nursing home care will simply go away. However, demand for nursing home care will continue to increase because of expanding life expectancies. Plus, many elderly veterans who are safely utilizing noninstitutional

TABLE 1. LTC—NURSING HOME COMPARISON

(Dollars in Millions)

Nursing home setting	FY 2003	FY 2005	Change 2003–2005
VA-operated nursing homes	$ 1,697	$ 2,441	$ 743
Community nursing homes	$ 272	$ 352	$ 80
State veterans' nursing homes	$ 352	$ 382	$ 30
Total	**$ 2,321**	**$ 3,175**	**$ 853**

(NOTE: Data from GAO testimony 1/9/06.)

services today may not be able to tomorrow. VA must maintain a safe margin of nursing home beds that will meet the needs of America's oldest veterans and be capable of meeting the needs of other elderly veterans who can be expected to transition from VA noninstitutional care programs to nursing home care.

TABLE 2. LTC—AVERAGE DAILY CENSUS (ADC) VA'S NURSING HOME CARE PROGRAM

1998	13,391
2004	12,354
2005	11,548
2006	11,434
Increase/(Decrease)	(114)

(NOTE: ADC for 2006 is an unaudited number at this time.)

Special Program for Young Combat-Injured Veterans

VA must move forward in the development of institutional care programming for young Operation Iraqi Freedom and Operation Enduring Freedom veterans whose combat injuries are so severe that they are forced to depend on VA nursing home care. VA's current nursing home capacity is designed to serve elderly veterans, not young ones. VA must make every effort to create an environment for these veterans that recognizes they have different needs. VA leadership and VA planners must work to bring a new type of long-term-care program forward to meet these needs.

Young veterans must be surrounded by forward-thinking administrators and staff that can adapt to youthful needs and interests. The entire environment must be changed for these individuals, not just modified. For example, therapy programs, surroundings, meals, recreation, and policy must be changed to adapt to a younger, more vibrant resident.

Culture Change

VA has made a positive step forward by embracing the philosophy of "culture change" in the operation of its nursing home care program. The culture change movement for nursing home care is centered around such core concepts as autonomy, privacy, dignity, flexibility, and individualized services. Culture change is a departure from the medical model for nursing home care. VA's challenge to implement culture change throughout its nursing home care program is to develop and implement guidelines for management practices that make it possible for nursing home staff to truly understand and act on the personal care needs and lifestyle preferences of residents.

The culture change movement supports new thinking. It changes an old philosophy that operates in a medical model of service delivery where the veteran is seen as a patient. Instead, the new model called "culture change" refers to veterans as residents and works to create an environment that preserves dignity and promotes self respect. Culture change creates a home-like atmosphere with sufficient space and access to personal living space. The resident is involved in care planning, has a say in room and roommate selection, develops his or her own daily routine, and makes menu choices.

VA's Community Nursing Home Care Program

VA has contracts with more than 2,500 private community nursing homes located across the country. In 2005, the ADC for VA's community nursing home (CNH) program represented 13 percent of VA's total nursing home workload. VA's CNH program often brings care closer to where the veteran actually lives, closer to his or her family and personal friends. Since 1965, VA has provided nursing home care under contracts or basic ordering agreements. The CNH Program has maintained two cornerstones: some level of veteran choice in choosing a nursing home and a unique approach to local oversight of CNHs.

Veterans Health Administration Handbook 1143.2 provides instructions for initial and annual reviews of Community Nursing Homes and for ongoing monitoring and follow-up services for veterans placed in these facilities. The handbook updates new approaches to CNH oversight, first introduced in 2002, drawing on the latest research and data systems advances. At the same time, the VHA maintains monitoring of vulnerable veteran residents while enhancing the structure of its annual CNH review process.

TABLE 3. LTC—ADC VA'S COMMUNITY NURSING HOME PROGRAM

2004	4,302
2005	4,254
2006	4,395
Increase/(Decrease)	141

(NOTE: ADC for 2006 is an unaudited number at this time.)

TABLE 4. LTC— ADC STATE VETERANS' HOMES

2004	17,328
2005	17,794
2006	17,747
Increase/(Decrease)	(47)

(NOTE: ADC for 2006 is an unaudited number at this time.)

State Veterans' Homes

The state veterans' home program currently encompasses 130 nursing homes in 50 states and Puerto Rico. According to the GAO, half of VA's total nursing home workload in FY 2003 was provided in state veterans' homes. Dramatic reductions in the state veterans' home ADC were prevented when Congress refused to enact dramatic cuts to this program's budget as proposed by VA in its 2006 budget request. VA's projected ADC for state veterans' homes, under its proposed 2006 budget, would have fallen to 7,217 in 2006. VA now projects a state veterans' home ADC rate of 17,747 for 2006. VA's proposed 2006 long-term-care budget cuts would have decreased the state veterans' home ADC in 2006 by 10,530.

Fortunately, Congress realized the ramifications of VA's proposed 2006 long-term-care budget and its negative impact upon elderly veterans. VA's proposed 2006 long-term-care budget would have hurt veterans. The proposed 2006 VA budget also reflected little VA business acumen in light of GAO findings (GAO-05-65) that reported VA pays about one-third the cost of care in state veterans' nursing homes.

In 2005 the ADC for state veterans' homes represented 52 percent of VA's total nursing home workload. Veterans are concerned about VA's desire and ability to meet increasing demand for nursing home care because of previous proposed cuts to the state veterans' home program and because of the downward VA nursing home average daily census spiral.

The GAO is similarly concerned about VA's nursing home program. In its November 2004 report (GAO-05-65) the GAO pointed out several problems that prevent VA from having a clear understanding of its programs effectiveness. The GAO recommended that VA collect and report data for community nursing homes and state veterans' nursing homes on the numbers of veterans that have long and short stays. GAO also recommended that VA collect data on the number of veterans in these homes that VA is required to serve based on the requirements of the Veterans Millennium Health Care and Benefits Act, P.L. 106-117. The GAO believed that this information would assist VA to conduct adequate monitoring and planning for its nursing home care program.

Congress has shown its concern about VA's long-term-care planning as evidenced by its rejection of VA's proposals to halt construction and reduce per diem funding to state veterans' homes and to repeal nursing home capacity mandate under P.L. 106-117. Also, in July of 2005, Congress was asked to provide VA with an additional $1.997 billion for higher that expected health-care needs. Of this amount, $600 million was to be used to correct for the estimated cost of long-term care (VA press release July 14, 2005). Most recently, Congress has directed VA to develop a strategic plan for long-term care.

VA's lack of appropriate workload information gathering and data analysis has placed it in a weak position to do effective planning for the immediate and future long-term-care needs of America's veterans. While VA can only advise Congress about the program requirements necessary to meet these needs, it is its duty to do so. The Department of Veterans Affairs should be the advocate for veterans' long-term-care needs, not just the provider.

■ VA Noninstitutional Care

VA offers a spectrum of noninstitutional long-term-care services to veterans enrolled in its health-care system. In fiscal year 2003, 50 percent of VA's total long-term-care patient population received care in noninstitutional care settings. Veterans enrolled in the VA health-care system are eligible to receive a range of services that include home-based primary care, contract home health care, adult day health care, homemaker and home health aide services, home respite care, home hospice care, and community residential care.

In recent years VA has been increasing its noninstitutional (home and community-based) budget and services. However, more needs to be done in this area. VA must take action to ensure that these programs, mandated by the P.L. 106-117, are available in each VA network. In May of 2003, the GAO (GAO 03-487) reported: "VA service gaps and facility restrictions limit veterans' access to VA non-institutional care." The report stated that of the 139 VA facilities reviewed, 126 do not offer all of the six services mandated by the P.L. 106-117. In order to eliminate these service gaps, VA must survey each VA network to determine that all of its noninstitutional services are operational and readily available.

The Independent Budget supports the expansion of VA's noninstitutional long-term-care services and also supports the adoption of innovative approaches to expand this type of care. Noninstitutional long-term-care programs can sometimes obviate or delay the need for institutional care. Programs that can enable the aging veteran or the veteran with catastrophic disability to continue living in his or her own home can be cost effective and extremely popular. However, the expansion of these valuable programs should not come through a reduction in the resources that support more intensive institutional long-term care.

TABLE 5. LTC— ADC FOR VA NONINSTITUTIONAL CARE PROGRAMS PREVIOUSLY REPORTED BY VA

	2004	2005	2006	Increase/ (Decrease)
Home-based Primary Care	9,825	11,594	12,641	1,047
Contract Skill Home Care	2,606	3,075	2,490	(585)
VA/Contract Adult Daycare	1,493	1,762	1,304	(458)
Homemaker Health Aid Services	5,580	6,584	5,867	(717)
Community Residential Care	5,771	6,810	3,692	(3,118)
Home Respite	84	99	118	19
Home Hospice	164	194	427	233
Total Noninstitutional Care Programs	**25,523**	**30,118**	**26,539**	**(3,579)**

(NOTE: ADC for 2006 is an unaudited number at this time.)

Future Directions

The face of long-term care is changing, and VA continues to work within resource limitations to provide variations in programming that meets veterans' needs and choices. VA can be expected to modify existing programs and develop new alternatives as financial resources allow. New horizons for VA long-term care include the following:

- Continue "culture change" transformation to make nursing homes more homelike.
- Continued expansion of hospice and palliative care so VA can care for veterans and respect their choices for care at the end of life.
- Integration of young combat injured veterans into appropriately suited VA's long-term-care programs.
- Implementation, nationally, of a medical foster home program, that would provide veterans who can no longer safely reside in their own homes a homelike environment in their communities.
- Continued expansion of access to noninstitutional home and community-based care. VA's intent is to provide care in the least restrictive setting that is appropriate for the veteran's medical condition and personal circumstances.
- Further collaboration between the Geriatrics and Extended Care programs and those of the Office of Care Coordination/Home Telehealth to provide services that are tailored to an individual veteran's needs.

VA's Care Coordination Program

VA has been investing in a national care coordination program for the past three years. The program applies care and case management principles to the delivery of health care services with the intent of providing veterans the right care in the right place at the right time. Veteran patients with chronic diseases, such as diabetes, heart failure, post-traumatic stress disorder, and chronic pulmonary disease, are now being monitored at home using telehealth technologies.

Care coordination takes place in three ways: in veterans' homes, using home telehealth technologies; between hospitals and clinics, using videoconferencing technologies; and by sharing digital images among VA sites through data networks. Care coordination programs are targeted at the 2 to 3 percent of patients who are frequent clinic users and require urgent hospital admissions. Each patient in the program is supported by a care coordinator who is usually a nurse practitioner, a registered nurse or a social worker but other practitioners can provide the support necessary. There are also physicians who care-coordinate complex patients.

As veterans age and need treatment for chronic diseases VA's care coordination program has the ability to monitor a veteran's condition on a daily basis and provide early intervention when necessary. This early medical treatment can frequently reduce the incidence of acute medical episodes and in some cases prevent or delay the need for institutional or long-term nursing home care.

As America's aging veteran population grows older and older, care coordination will be a useful tool in VA's long-term-care arsenal that can enable aging veterans to remain at home or close to home as long as possible. Congress must assist VA in expanding this valuable program across the entire VA health-care system.

VA Long-Term Care for Veterans with Spinal Cord Injury/Disease (SCI/D)

Both institutional and noninstitutional VA long-term-care services designed to care for veterans with SCI/D require ongoing medical assessments to prevent when possible and treat when necessary the various secondary medical conditions associated with SCI/D. Older veterans with SCI/D are especially vulnerable and require a high degree of long-term and acute care coordination.

A major issue of concern is the fact that a recent VA survey indicated that in FY 2003 there were 990 veterans with SCI/D residing in non-SCI/D designated VA nursing homes. However, VA cannot identify the exact locations of these veterans. The special needs of these veterans often go unnoticed and are only discovered when the patient requires admission to a VA medical center for treatment.

VA must develop a program to locate and identify veterans with SCI/D who are receiving care in non-SCI/D designated long-term-care facilities and ensure that their unique needs are met. In addition, these veterans must be followed by the nearest VA SCI center to ensure they receive the specialized medical care they require. Veterans with SCI/D who receive VA institutional long-term-care services require specialized care from specifically trained professional long-term-care providers in an environment that meets their accessibility needs.

Currently, VA operates only four designated long-term-care facilities for patients with spinal cord injury or disease, and none of these facilities are located west of the Mississippi River. These facilities are located at Brockton, Massachusetts (25 staffed beds); Hampton, Virginia (52 staffed beds); Hines Residential Care Facility, Chicago, Illinois (28 staffed beds); and Castle Point, New Jersey (16 staffed beds). Unfortunately, these limited staffed (121 total) beds are usually filled, and there are waiting lists for admittance. These four VA SCI/D long-term-care facilities are not geographically located to meet the needs of a nationally distributed SCI/D veteran population.

Although the VA Capital Assets Realignment for Enhanced Services (CARES) initiative has called for the creation of additional long-term-care beds in four new locations (30 in Tampa, Florida; 20 in Cleveland, Ohio; 20 in Memphis, Tennessee; and 30 in Long Beach, California), these additional services are not yet available and would provide only 30 beds west of the Mississippi River. These new CARES long-term-care beds present an opportunity for VA to refine the paradigm for SCI/D long-term-care facility design and to develop a new SCI/D long-term-care staff training program. Additionally, VA is currently working with the Paralyzed Veterans of America to create an SCI/D long-term-care handbook that will identify the operational policies of SCI/D long-term care.

RECOMMENDATIONS:

VA must develop a strategic plan for long-term care that meets the current and future needs of America's veterans.

Congress must hold appropriate long-term-care hearings to learn the specific issues of concern for aging veterans. The information gleaned from these hearings must be used by VA as it moves forward in the development of a comprehensive strategic plan for long-term care.

Congress must provide the financial resources for VA to implement its long-term-care strategic plan.

VA must abide by P.L. 106-117's ADC capacity mandate for VA nursing home care and Congress must enforce its own requirement.

VA and Congress must continue to provide the construction/repair and per diem funding necessary to support state veterans' homes. Even though Congress has approved full long-term-care funding for eligibles in state veterans' homes under P.L. 106-117, it must continue to provide resources to support other veteran residents in these facilities and to maintain the infrastructure.

VA must do a better job of tracking the quality of care provided in VA contract community nursing homes.

VA must increase its capacity for noninstitutional, home, and community-based care, including assisted living.

VA must ensure that each noninstitutional program mandated by P.L. 106-117 is operational and available across the entire VA health-care system.

Serious geographical gaps exist in specialized long-term-care services for veterans with spinal cord injury or spinal cord disease. As VA develops its strategic plan for long-term care, it must include provisions to provide specialized nursing home capacity throughout the entire country. VA must start by implementing the CARES SCI/D long-term-care recommendations.

VA must develop a mechanism to locate and identify veterans with SCI/D residing in non-SCI/D long-term-care facilities.

VA should develop a VA nursing home care staff training program for all VA long-term-care employees who treat veterans with SCI/D.

VA must move forward in modifying its nursing home programs to meet the needs of younger combat-injured veterans.

ASSISTED LIVING

Assisted living can be a viable alternative to nursing home care for many of America's aging veterans who require assistance with the activities of daily living (ADLs) or the instrumental activities of daily living (IADLs). Assisted living offers a combination of individualized services, which may include meals, personal assistance, and recreation provided in a homelike setting.

In November of 2004, Secretary Principi forwarded a VA report to Congress concerning the results of its pilot program to provide assisted living services to veterans. The pilot program was authorized by the Mill Bill. The Assisted Living Pilot Program (ALPP) was carried out in VA's Veterans Integrated Service Network (VISN) 20. VISN-20 includes Alaska, Washington, Oregon, and the western part of Idaho.

VA's ALPP was implemented in seven medical centers in four states: Anchorage, Alaska; Boise, Idaho; Portland, Oregon; Roseburg, Oregon; White City, Oregon; Spokane, Washington; and Puget Sound Health Care System (Seattle and American Lake). The ALPP was conducted from January 29, 2003, through June 23, 2004, and involved 634 veterans who were placed in assisted living facilities.

VA's report on the overall assessment of the ALPP stated: *"The ALPP could fill an important niche in the continuum of long-term care services at a time when VA is facing a steep increase in the number of chronically ill elderly who will need increasing amounts of long-term care."*

Some of the main findings of the ALPP report include:

- *ALPP veterans showed very little change in health status over the 12 months post-enrollment.* As health status typically deteriorates over time in a population in need of residential care, one interpretation of this finding is that the ALPP may have helped maintain veterans' health over time.
- *The mean cost per day for the first 515 veterans discharged from the ALPP was $74.83, and the mean length of stay in an ALPP facility paid for by VA was 63.5 days.*
- *The mean cost to VA for a veteran's stay in an ALPP facility was $5,030 per veteran. The additional cost of case management during this time was $3,793 per ALPP veteran.*
- Veterans were admitted as planned to all types of community-based programs licensed under state Medicaid-waiver programs: 55 percent to assisted living facilities, 30 percent to residential care facilities, and 16 percent to adult family homes.
- *The average ALPP veteran was a 70-year-old unmarried white male who was not service-connected, was referred from an inpatient hospital setting, and was living in a private home at referral.*
- *ALPP enrolled veterans with varied levels of dependence in functional status and cognitive impairment:* 22 percent received assistance with between four and six ADLs at referral, a level of disability commonly associated with nursing home care placement; 43 percent required assistance with one to three ADLs; while 35 percent received no assistance.
- *Case managers helped ALPP veterans apply for VA Aid and Attendance and other benefits to help cover some of the costs of staying in an ALPP facility at the end of the VA payment period.*
- *Veterans were very satisfied with ALPP care.* The highest overall scores were given to VA case managers (mean: 9.02 out of 10), staff treatment of residents (8.66), and recommendation of the facility to others (8.54). The lowest scores were given to meals (7.95) and transportation (7.82).
- *Vendors are quite satisfied with their participation in ALPP with a mean score of almost 8 (of 10).*
- *Case managers were very satisfied with ALPP.* Case managers described the program as very important for meeting the needs of veterans who would otherwise "fall in between the cracks."

Secretary Principi's cover letter that conveyed the ALPP report to Congress stated that VA is not seeking authority to provide assisted living services, believing this is primarily a housing function. The authors of *The*

Independent Budget (IB) disagree and believe that housing is just one of the services that assisted living provides. Supportive services are the primary commodities of assisted living, and housing is just part of the mix. VA already provides housing in its domiciliary and nursing home programs, and an assisted living benefit should not be prohibited by VA on the basis of its housing component.

■ CARES and Assisted Living

Secretary Principi's final CARES decision document and the VA's CARES Commission recommended utilizing VA's enhanced-use leasing authority as a tool to attract assisted living providers. The enhanced-use lease program can be leveraged to make sites available for community organizations to provide assisted living in close proximity to VA medical resources. The Fort Howard, Maryland, project is a good example of a partnership between a private developer and VA.

The authors of *The Independent Budget* concur with this CARES recommendation and the application of VA's enhanced-use lease program in this area. However, the IB authors believe that any type of VA enhanced-use lease agreement for assisted living, or any other projects must be accompanied with the understanding that veterans have first priority for care or other use.

RECOMMENDATIONS:

While assisted living is not currently a benefit that is available to veterans, even though some veterans have eligibility for nursing home care, the authors of *The Independent Budget* believe Congress should consider providing an assisted living benefit to veterans as an alternative to nursing home care.

VA's ALPP report seems most favorable and appears to be an unqualified success. However, *The Independent Budget* authors believe that to gain further understanding of how the ALPP program can benefit veterans, it should be replicated in at least three VISNs with a high percentage of elderly veterans.

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VA MEDICAL AND PROSTHETIC RESEARCH

Funding for Medical and Prosthetic Research:

Funding for Department of Veterans Affairs (VA) Medical and Prosthetic Research is inadequate to support the full range of programs needed to meet current and future health challenges facing veterans. Additionally, VA's aging research facilities are in urgent need of renovations and repairs.

VA medical care is touted as an industry leader—its dynamic transformation to this position validated by consistent scores higher than the private sector in patient satisfaction surveys, a cost efficiency with better health outcomes, and cutting-edge information technology. But this success could not have been realized without the premier research program that the VA administers. VA medical and prosthetic research is a national asset that attracts high-caliber clinicians to practice medicine and conduct research in VA healthcare facilities. The resulting environment of medical excellence and ingenuity, developed in conjunction with collaborating medical schools, benefits every veteran receiving care at VA and ultimately benefits all Americans.

VA research is patient oriented, focusing entirely on prevention, diagnosis, and treatment of conditions prevalent in the veteran population. More than three-quarters of VA researchers are clinicians that provide direct patient care to veterans. As a result, the Veterans Health Administration, as the largest integrated medical care system in the world, has a unique ability to translate progress in medical science directly to improvements in clinical care.

VA leverages the taxpayer's investment via a nationwide array of synergistic partnerships with the National Institutes of Health and other federal research funding agencies, for-profit industry partners, nonprofit organizations, and academic affiliates. This highly successful enterprise demonstrates the best in public-private cooperation. However, a commitment to steady and sustainable growth in the annual research and development appropriation is necessary for maximum productivity.

For decades, VA has failed to request—and Congress has failed to mandate—construction funding sufficient to maintain, upgrade, and replace VA's aging research facilities. The result is a backlog of research sites in need of minor and major construction funding and researchers are often stymied by the lack of state-of-the-art facilities. Cutting-edge research demands cutting-edge facilities. Congress and VA must work together to establish a funding mechanism designated for research facility maintenance and improvements until this backlog is addressed.

MEDICAL AND PROSTHETIC RESEARCH

(In Thousands)

FY 2007	$412,000
FY 2008 Administration Request	$411,000
FY 2008 *Independent Budget* Recommendation	$480,000

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Medical and Prosthetic Research Account:

Inadequate funding has jeopardized VA Research and Development's status as a national leader. Significant growth in the annual Research and Development appropriation is necessary to continue to achieve breakthroughs in health care for its current population and to develop new solutions for its most recent veterans.

The Department of Veterans Affairs (VA) strives for improvements in treatments for conditions long prevalent among veterans such as diabetes, spinal cord injury, substance abuse, mental illnesses, heart diseases, infectious diseases, and prostate cancer. VA is equally obliged to develop better responses to the grievous conditions suffered by veterans of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), such as extensive burns, multiple amputations, compression injuries, and mental stress disorders. These returning OEF/OIF veterans have high expectations for returning to their active lifestyles and combat. The seamless mental and physical reintegration of these soldiers is a high priority, but still a difficult challenge that the VA Research program can address.

Despite high productivity and success, funding for VA medical and prosthetic research has not kept pace with other federal research programs or with funding for VA medical care. The VA research program has done an extraordinary job leveraging its modest $412 million appropriation into a $1.7 billion research enterprise that hosts multiple Nobel laureates and produces an exceedingly competitive number of scientific papers annually. VA research awards are currently capped at $125,000, significantly lower than comparable federal research programs. However, VA investigators would be unable to compete for additional funding from other federal sources without the initial awards from the Medical and Prosthetic Research Account.

VA has a distinctive opportunity to recreate its health-care system and provide progressive and cutting-edge care for veterans through genomic medicine. As the largest integrated health-care system in the world with an advanced and industry-leading electronic health record system and a dedicated population for sustained research, ethical review, and standard processing, VA is the obvious choice to lead advances in genomic medicine. Innovations in genomic medicine will allow VA:

- to reduce drug trial failure by identifying genetic disqualifiers and allowing treatment of eligible populations;
- to track genetic susceptibility for disease and develop preventative measures;

- to predict response to medication; and
- to modify drugs and treatment to match an individual's unique genetic structure.

Additional increases are necessary for continued support of new initiatives in neurotraumas, including head and cervical spine injuries; wound and pressure sore care; pre- and post-deployment health issues with a particular focus on post-traumatic stress disorder; and the development of improved prosthetics and strategies for rehabilitation from polytraumatic injuries.

The projected biomedical research and development inflation index (BRDPI) for FY 2007 is 3.4 percent, which necessitates a $14.008 million increase over FY 2007 funding. To ensure that VA Research continues to attract high-caliber investigators, annual award amounts must be reevaluated and adequately increased to compete with other federal research programs. The IBVSOs recommend a phased increase to accommodate the significant costs associated with updating this cap. In FY 2008, Congressional direction to increase the award limit accompanied by adequate funding so as not to reduce awards will demonstrate our nation's commitment to researchers working to help veterans.

The new VA genomic medicine project represents a monumental advancement in the future of the VA Medical and Prosthetic Research program and in the future of America's health-care system. This endeavor will require sustained increases for VA research funding in the coming years. A VA pilot program involving 20,000 individuals and 30,000 specimens provides estimates that approximately $1,000 will be necessary for each specimen. The estimated costs for VA's genomic pilot program and support for current research endeavors complete the additional funding request of *The Independent Budget* recommendations.

RECOMMENDATION:

The Independent Budget veterans service organizations (IBVSOs) recommend an FY 2008 appropriation of at least $480 million. This appropriation offsets the higher costs of established research resulting from biomedical inflation and wage increases.

Research Facilities Consistent with Scientific Opportunity:

Many Department of Veterans Affairs (VA) research facilities are outdated and in need of repair or renovation.

In May 2004, Secretary of Veterans Affairs Anthony J. Principi approved the Capital Asset Realignment for Enhanced Services (CARES) Commission report that called for implementation of the VA Under Secretary of Health's Draft National CARES Plan for VA research. This plan recommended $87 million to renovate existing research space.

In House Report 109-95 providing appropriations for FY 2006, Congress expressed concern that "equipment and facilities to support the research program maybe be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive." It noted, "more resources may be required to ensure that research facilities are properly maintained to support the Department's research mission." To assess VA's research facility needs, Congress directed VA to conduct a comprehensive review of its research facilities and report to Congress on the deficiencies found, along with suggestions for correction.

In anticipation of the completion of this report, the House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs proposed $12 million dedicated to renovating and upgrading VA medical research facilities within the Minor Construction budget. *The Independent Budget* veterans service organizations believe Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet

both immediate and long-term needs. Congress should also use the VA report as the basis for prioritizing allocation of such funding to ensure that the most urgent needs are addressed first. For these purposes, *The Independent Budget* recommends $45 million.

RECOMMENDATIONS:

Congress should establish and appropriate a funding stream specifically for research facilities, using the VA assessment to ensure that amounts provided are sufficient to meet both immediate and long-term needs.

Congress should also use the VA report as the basis for prioritizing allocation of $45 million to ensure that the most urgent needs are addressed first.

Attracting and Retaining a Quality VHA Nursing Workforce:

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis.

■ Nursing Workforce

The Veterans Health Administration (VHA) has the largest nursing workforce in the country with nearly 61,000 employees in nursing, including registered nurses (RNs), licensed practical nurses (LPNs), and other nursing personnel. Maintaining a strong nursing workforce is essential to providing high-quality health care to our nation's sick and disabled veterans. Unfortunately, the country at large is continuing to experience a shortage of nursing personnel. Likewise, VHA staffing levels are frequently so marginal that any loss of staff can result in a critical staffing shortage and present significant clinical challenges. Staffing shortages can result in the cancellation or delay of surgical procedures and closure of intensive care beds. It also can cause diversions of veterans to private sector facilities at great cost. This situation is complicated by the fact that the Department of Veterans Affairs (VA) has downsized inpatient capacity in an effort to provide more services on an outpatient/ambulatory basis. The remaining inpatient population is generally sicker, has lengthier hospital stays, and requires more skilled nursing care.

The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the veterans' health-care budget crisis. Because the VA health-care budget has not kept up with rising health-care costs, the situation grows more critical each fiscal year. Inadequate funding has resulted in sporadic hiring freezes across the country. These hiring freezes have had a negative impact on the VA nursing workforce as nurses have been forced to assume non-nursing duties due to shortages of ward secretaries and other key support personnel. These staffing deficiencies impact both patient programs and VA's ability to retain an adequate nursing workforce.

National Commission on VA Nursing

VHA's Succession Strategic Plan for Fiscal Year (FY) 2006–2010 states, "VHA faces significant challenges in ensuring it has the appropriate workforce to meet current and future needs. These challenges include continuing to compete for talent as the national economy changes over time and recruiting and retaining health care workers in the face of significant anticipated workforce supply and demand gaps in the health care sector in the near future. These challenges are further exacerbated by an aging federal workforce and an increasing percentage of VHA employees who receive retirement eligibility each year."

Like other health-care employers, VHA must actively address those factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. In addition, it is essential adequate funds are appropriated for recruitment and retention programs for the nursing workforce.

In 2002, the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and address the future of the nursing profession within the Department of Veterans Affairs (VA). The commission developed the desired future state for VHA nursing and recommendations to achieve that vision.

The executive summary of the commission report states:

> Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses comprise the largest proportion of healthcare providers in the Department of Veterans Affairs. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

Simultaneously, the Office of Nursing Service developed a strategic plan to guide national efforts to advance nursing practice within VHA and engage nurses across the system to participate in shaping the future of VA nursing practice. This strategic plan embraces six patient-centered goals. These goals encompass and address many of the recommendations of the VA Nursing Commission, as well as the findings in current literature.

1. **Leadership Development:** This goal focuses on supporting and developing new nurse leaders and creating a pipeline to continuously "grow" nursing leaders throughout the organization. The objective is to operationalize the High Performance Development Model for all levels of nursing personnel. This goal also addresses issues related to the nursing Professional Qualification Standards and the Nurse Professional Standards Board as discussed in the commission report.

2. **Technology and System Design:** This goal focuses on creating mechanisms to obtain and manage clinical and administrative data to empower decision making. The objective is to develop and enhance systems and technology to support nursing roles. The commission report highlighted the importance of nursing input in the development stage of new technologies for patient care.

3. **Care Coordination and Patient Self-Management:** This strategic goal focuses on promoting and recognizing innovations in care delivery and facilitating care coordination and patient self-management. The objectives are to strengthen nursing practice for the provision of high-quality, reliable, timely, and efficient care in all settings and to enhance the use of evidence-based nursing practice. This goal also encompasses recommendations from the commission related to the work environment of VA nurses.

4. **Workforce Development:** This goal focuses on improving the recognition of and opportunities for the VA nursing workforce. Areas of emphasis are as follows:

   - utilization: to maximize the effective use of the available workforce;
   - retention: to retain a qualified and highly skilled nursing workforce;
   - recruitment: to recruit a highly qualified and diverse nursing staff into the VHA; and
   - outreach: to improve the image of nursing and promote nursing as a career choice through increased collaboration with external partners.

This goal also includes an emphasis on the importance of striving for the values exhibited by the philosophy of the Magnet Recognition Program of the American Nurses Credentialing Center. The commission report addresses all of these areas as critical to the future of VA nursing.

5. **Collaboration:** This goal focuses on forging relationships with professional partners within VA, across the federal community, and in public and private sectors. The objective is to strengthen collaborations in order to leverage resources, contribute to the knowledge base, offer consultation, and lead the advancement of the profession of nursing for the broader community. The priorities of this goal align with VHA's Vision 2020 and the commission recommendations related to collaboration and professional development.

6. **Evidence-Based Nursing Practice:** This goal focuses on identifying and measuring key indicators to support evidence-based nursing practice. The objective is to develop a standardized methodology to collect data related to nursing-sensitive indicators of quality, workload, and performance within VHA facilities, which will be integrated into a standardized national database. The commission report applauded VA's progress to date related to this goal.

The VHA, in its assessment of current and future workforce needs, identifies RNs as the number one priority in recruitment, with LPNs and nursing assistants also among the top 10 occupations with critical recruitment needs. Recommendations from this workforce assessment include implementing the commission's recommendations, enhanced new employee induction programs, and supervisory training. Additionally, the plan recommends continuing support of employee education programs, implementation of new initiatives for student (including high school outreach) recruitment, and improving the retention of trainees as permanent employees. Finally, the VHA recommends the continuing need to maintain a national recruitment program with innovative approaches and effective outcomes.

The Independent Budget veterans service organizations support the commission's recommendations, the VA's Office of Nursing Service's strategic plan, and the *VHA Workforce Succession Strategic Plan FY 2006–2010 (October 2005)*. We strongly urge Congress to develop a budget for VA health care that will allow the VHA to invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles. The commission's legislative and organizational recommendations are a blueprint for the reinvention of VA nursing. The VA model will serve as a foundation for the creation of a care delivery system that meets the needs of our nation's sick and disabled veterans and those providing their care.

In an attempt to address issues impacting registered nurses in the workplace, the Nurses Organization of Veterans Affairs (NOVA), a professional organization of more than 35,000 RNs employed by VA, conducts a biennial survey of its membership. The 2005 membership survey identified an adequate budget for the VHA as the legislative issue most important to NOVA members, followed by patient safety, locality pay, and the nursing shortage.

Members identified their greatest challenges as computerized charting and adequate computers. Respondents noted that problems with bar code medication administration equipment can lead to frustration with this technology, although it has reduced medication errors. NOVA nurses identified salaries competitive with the private sector as having the highest impact on recruitment, followed by flexible work schedules and adequate staffing. Because many VA nurses are eligible to retire now, or will become eligible in the next five years, the top enticement to stay in VHA nursing was flexible working hours. Only 37.5 percent of NOVA members believed VHA nursing salaries to be competitive with the private sector, and even fewer, 20.4 percent, indicated their facility would meet the criteria for Magnet Hospital designation. Last, the survey included several questions about the legislative process. Educating legislators was identified as important for improving the image of VA nursing.

RECOMMENDATIONS:

VA should establish recruitment programs that enable the VHA to remain competitive with private sector marketing strategies.

Congress must provide sufficient funding to support programs to recruit and retain critical nursing staff.

ADMINISTRATIVE ISSUES

Volunteer Programs:

The Veterans Health Administration (VHA) volunteer programs are so critical to the mission of service to veterans that these volunteers are considered "without compensation" employees.

Since its inception in 1946, the Department of Veterans Affairs Voluntary Service (VAVS) has donated in excess of 677.7 million hours of volunteer service to America's veterans in the Department of Veterans Affairs (VA) health-care facilities. As the largest volunteer program in the federal government, the VAVS program is composed of more than 350 national and community organizations. The program is supported by a VAVS National Advisory Committee composed of 60 major veterans, civic, and service organizations, including *The Independent Budget* veterans service organizations and seven of their subordinate organizations, which report to the VA Under Secretary for Health.

With the recent expansion of VA health care for patients in a community setting, additional volunteers have become involved. They assist veteran patients by augmenting staff in such settings as hospital wards, nursing homes, community-based volunteer programs, end-of-life care programs, foster care, and veterans' outreach centers.

During FY 2006, VAVS volunteers contributed a total of 12,411,687 hours to VA health-care facilities. This represents 5,967 full-time employee equivalent (FTEE) positions. These volunteer hours represent more than $234.8 million if VA had to staff these volunteer positions with FTEEs.

VAVS volunteers and their organizations annually contribute millions of dollars in gifts and donations in addition to the value of the service hours they provide. The annual contribution made to VA is estimated to be $50.4 million. These significant contributions allow VA to assist direct patient care programs, as well as support services and activities that may not be fiscal priorities from year to year.

Monetary estimates aside, it is impossible to calculate the amount of caring and sharing that these VAVS volunteers provide to veteran patients. VAVS volunteers are a priceless asset to the nation's veterans and to VA.

The need for volunteers is increasing dramatically as additional demands are being placed on VA staff. Health care is changing, which means there is opportunity for new and nontraditional roles for volunteers. New services are also expanding through community-based outpatient clinics that create additional personnel needs. It is vital that the VHA keep pace with utilization of this national resource.

At national cemeteries, volunteers provide military honors at burial services, plant trees and flowers, build historical trails, and place flags on graves for Memorial Day and Veterans Day. More than 381,000 hours have been contributed to better the final resting places and memorials that commemorate veterans' service to our nation.

RECOMMENDATION:

VHA facilities should designate a staff person with volunteer management experience to be responsible for recruiting volunteers, developing volunteer assignments, and maintaining a program that formally recognizes volunteers for their contributions.

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Contract Care Coordination:

The Department of Veterans Affairs (VA) should ensure an integrated program of continuous care and monitoring for veterans who receive at least some of their care from private, community-based providers at VA expense.

Current law authorizes VA to contract for non-VA health care (on a fee or contract basis) and scarce medical specialists only when VA facilities are incapable of providing necessary care to veterans, when VA facilities are geographically inaccessible to veterans, and in certain emergency situations. *The Independent Budget* veterans service organizations (IBVSOs) agree that contract care should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans who are enrolled in VA care. We have consistently opposed proposals seeking to contract for health care provided by non-VA providers on a broader basis than this. Such proposals, ostensibly seeking to expand VA health-care services into additional areas and serving larger veteran populations, ultimately only serve to dilute the quality and quantity of VA services for new as well as existing veteran patients.

Currently VA spends approximately $2 billion each year on purchased care outside the walls of VA. Unfortunately, VA is not able to track this care, its related costs, outcomes, or veteran satisfaction levels, and VA has no consistent process for veterans receiving contracted-care services to ensure that:

- effective care is delivered by certified, fully licensed or credentialed providers;
- continuity of care is properly monitored by VA and that patients are directed back to the VA health-care system for follow-up when necessary;
- veterans' medical records are properly updated with contract provider and pharmaceutical information; and
- the process is part of a seamless continuum of services to facilitate improved health status and veterans' access to necessary care.

To ensure a full continuum of health-care services, it is critical that VA implement a program of contract care coordination that includes integrated clinical, record, and claims information for veterans referred to community-based providers at VA expense. Preferred pricing allows VA medical facilities to save money when veterans use non-VA medical services by receiving network discounts through a preferred pricing program. However, VA currently has no system in place to direct veteran patients to any participating preferred provider network (PPO) providers so that VA could:

- receive a discounted rate for the services rendered;
- use a mechanism to refer patients to credentialed and certified providers; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs), when a veteran inadvertently uses a PPO provider, not all facilities have taken advantage of the cost savings that are available to them. Therefore, in many cases, VA has paid more for contracted medical care than is required. We are pleased that, in response to this realization, the VA made participation in the Preferred Pricing Program mandatory for all VAMCs beginning in October 2005. As a result of mandatory facility participation, VA will likely yield $34.9 million in savings for fiscal year 2007. Despite the significant overall savings achieved through this program (more than $65 million to date), there are several major changes that can be made to improve the access, quality, and cost of contracted VA care.

The Preferred Pricing Program is the foundation upon which a more proactive managed care program should be established that will not only save significantly more money in the purchased care programs, but, more important, will provide VHA a mechanism to fully integrate veterans' community-provided medical care into the VHA health-care system. By partnering with an experienced managed-care contractor, VA can define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value.

Components of the program should include the following:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost-effectiveness. Additionally, the care coordination contractor should require providers to meet specific requirements, such as the timely communication of clinical information to VA, proper and timely submission of electronic claims, meeting VA established access standards, and complying with director's performance standards.

- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical needs, the care coordination contractor addresses both appropriateness of care and continuity of care. The result could be a truly integrated seamless health-care delivery system.

- Improved veteran satisfaction through integrated, efficient, and appropriate health-care delivery across VA and non-VA components of the continuum of care.

- Optimized workload for VA facilities and affiliates while costs for non-VA care are better controlled.

Currently, many veterans are disengaged from the VA health-care system when receiving medical services from private nonparticipating physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care. The IBVSOs believe it is important for VA to develop an effective care coordination model that achieves its health-care and financial objectives. Doing so will improve patient care quality, optimize the use of VA's increasingly limited resources, and prevent overpayment when utilizing community contracted care.

Current law allows VA to contract for non-VA health-care (on a fee basis) and scarce medical specialty contracts only when VA facilities are incapable of providing the necessary care, when VA facilities are geographically inaccessible to the veteran, and in certain emergency situations. The IBVSOs support a limited VA contract care coordination effort that includes integrated clinical and claims information for veterans referred to community-based providers at VA expense.

However, VA contracted care should be used judiciously in the specific circumstances mentioned so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all veterans. The IBVSOs have consistently opposed proposals seeking to contract out health care provided by non-VA providers on a broad basis. Such proposals, ostensibly seeking to expand VA health-care services into broader areas serving additional veteran populations, in the end only dilute the quality and quantity of VA services for new as well as existing veterans.

Approximately one year ago VA announced "Project HERO," and indicated its goal to be consonant with the ideas expressed by the IBVSOs in improving VA contract care coordination. On closer examination, we concluded this initiative to be ill-considered and potentially dangerous to the continued integrity and availability of specialized health-care services within the VA system. Accordingly we opposed that project, and it was withdrawn. Recent information provided by VA on a new initiative to improve contracting for veterans' care outside VA facilities seems pointed in a direction consistent with our views on this topic. We look forward to further developments in this initiative and will support it to the extent it remains consistent with our goals while neither expanding the gross level of contract care nor eroding the quality of health-care services available within VA facilities for sick and disabled veterans.

RECOMMENDATIONS:

VA should establish a phased-in, contracted care coordination program that incorporates the preferred pricing program discussed above and is based on principles of sound medical management.

Veterans who receive care outside VA, at VA expense and authorization, should be required to participate in the care coordination model. This program should be tailored to VA and veterans' specific needs.

Contract care should be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care, are geographically inaccessible to the veteran, and in certain emergency situations, and should be managed so as

not to endanger VA facilities' ability to maintain a full range of specialized inpatient and outpatient services for all enrolled veterans.

VA should engage an experienced contractor willing to go "at risk" to implement and manage a care coordination program that will deliver improvements in medical management, access, timeliness, and cost efficiencies. VA and the contractor should jointly develop identifiable measures to assess program results and share these results with stakeholders, including the IBVSOs. Care should be taken to ensure inclusion of important affiliates in this program.

The components of a care coordination program should include claims processing, medical records management, and centralized appointment scheduling. VA should also implement a call center or advice line for veterans who are referred outside the VA health-care system for consultations and specialized care.

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Federal Supply Schedule for Pharmaceuticals:

The Department of Veterans Affairs (VA) must maintain and protect the ability to achieve pharmaceutical discounts through the Federal Supply Schedule for Pharmaceuticals (FSS-P).

A number of states and the District of Columbia have recently considered legislation that would tie Medicaid drug prices to the discounted prices now contained in the FSS-P. Passage of any legislation mandating that FSS-P pricing be opened to Medicaid programs could threaten VA's ability to receive discounted pricing because vendor contracts contain a clause allowing their cancellation in this event. Legislation considered during recent sessions of Congress that would tie the new Medicare Part D Prescription Drug Benefit to the FSS-P and VA drug discounts by referencing these reduced prices as a target for obtaining Part D drugs, is of even greater concern.

Prior experience, most notably with Medicaid drug provisions contained in the Omnibus Budget Reconciliation Act of 1990 (PL 101-508), has demonstrated that if these types of legislative initiatives are enacted, VA's pharmaceutical discounts could be diluted and costs increased, harming both the VA health-care system and veterans.

Under the FSS-P, VA purchases, on behalf of itself and other federal entities through contracts with responsible vendors, approximately 24,000 pharmaceutical products annually. These purchases are made at discounts ranging from 24 to 60 percent below drug manufacturers' most favored nonfederal, nonretail customer pricing. Since VA's pharmaceutical purchases are now roughly $4 billion annually, the loss of these discounts would dramatically increase the costs of pharmaceuticals, as well as the cost of providing care, to an already underfunded health-care system. These added costs could also be passed on to veterans in the form of dramatically higher copayments.

RECOMMENDATION:

Congress and the Administration need to address pharmaceutical cost-related issues in a manner that does not result in a reduction of veterans' benefits or threaten discounts VA currently receives under the FSS-P.

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Fee-Basis Care:

The extent of its decentralized structure, complex legislative authority, and the inadequate funding to local VA facilities for fee-basis care continue to erode the effectiveness of this necessary health-care benefit.

Fee-basis care allows eligible service-connected veterans who live in areas that are geographically inaccessible to Department of Veterans Affairs (VA) medical facilities or who need specific services unavailable at VA to use private sector clinicians at VA expense. Additionally, veterans authorized for fee-basis care generally are required to choose their own medical providers.

Veterans who are approved by VA to utilize fee-basis care are sometimes unable to secure treatment from a community provider because of VA's regulated level of payment for medical services. We are especially concerned that service-connected disabled veterans who are authorized to use fee-basis care are at times required by the only provider in their community to pay for the care up-front. In these instances, veterans must pay for the medical care they need and then seek reimbursement from VA. Furthermore, because VA pays at the Medicare rate or will at times approve only a portion of the costs of medical services or inpatient hospital days of care provided in community health-care facilities, veterans who must pay for their care up front and then seek reimbursement from VA end up paying for part of their care.

We applaud VA for addressing existing variability in processing a fee-basis claim, which affects the timeliness to pay a claim, by initiating improvements to its business practice. While software improvements to increase program efficiency and regulatory changes to improve program effectiveness have been delayed, we believe VA leadership must continue to provide the support needed to achieve the goals of these initiatives.

RECOMMENDATIONS:

When VA preauthorizes fee-basis care for a veteran, VA should coordinate with the chosen health-care provider for both the veteran's care and payment of medical services. Service-connected veterans should not be required to negotiate payment terms with private providers for authorized fee-basis care or pay out of pocket for such services.

VA should continue to pursue the regulatory changes needed for its payment methodology to provide equitable payments for care veterans receive in the community.

With support from VA leadership, a standard business practice for efficient and timely processing of claims for fee-based care should be established.

VA Physician and Dentist Pay Reform:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that Department of Veterans Affairs (VA) clinical professional and labor stakeholders were not consulted or permitted to be involved in establishing their new pay system and that the new system may not have achieved its purposes as an effective tool for recruitment and retention.***

In 2004, Congress passed the Department of Veterans Affairs Personnel Enhancement Act, Public Law 108-445. This new law reformed the pay and performance system used by VA in employment of its physicians and dentists. In 2003, in a legislative hearing before the House Committee on Veterans' Affairs, VA testified that the system was "in a critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future." This legislative proposal was the VA health-care system's top legislative goal for the 108th Congress. Enactment of this proposal was supported by the major veterans organizations, including the

IBVSOs, who expressed their support for VA to be given new pay authority to attract and retain the best physicians and dentists for the care of sick and disabled veterans into the future.

VA worked for more than one year to implement this significant new legislation, whose rules became effective in January 2006. This act is the most significant reform of a pay system for VA employees since the enactment of the Civil Service Reform Act in 1978, and it represents the first real change in physician pay since 1991.

Congress stated its intention for VA to work closely in conjunction with stakeholders in fashioning the new pay system. Senate Report 108-357, supporting the purposes of the act, stated: "Finally, the Committee bill requires that practicing physicians have a significant role in making recommendations to the Secretary or his or her designee as to the appropriate levels of salaries paid to members of their professions. Physicians and dentists are at the front-lines of medicine; they know what is needed to provide care for veterans. This provision advances the tradition of cooperation among labor and management in the Federal sector, particularly within the healthcare environment."

The IBVSOs remain concerned about whether VA met clear Congressional intent in that regard. Stakeholders from the VA medical, dental, and labor sectors have reported that they have not been consulted or involved in establishing the new pay system, which was completed in the summer of 2006 and established new compensation rates for 14,000 VA physicians and 700 VA dentists and oral surgeons. We have been informed that essentially none of those required consultations occurred, that some pay tiers and bands were set arbitrarily, that proposed pay reductions in some disciplines were made in direct contravention of the intent of Congress, and that a number of deserving specialties essentially received no pay adjustment as a result of implementation.

We urge VA to engage labor and professional associations that remain concerned about the new pay and performance system to ensure it gains their continuing cooperation as VA manages this new pay policy. As indicated in the Senate legislative report, VA physicians and dentists are essential caregivers, educators, and researchers in the VA health-care system. This act was intended for their benefit, to attract them to VA careers and to sustain them in providing outstanding care to veterans. We would hope these purposes would have been transparent and that VA would want to involve representatives of professions in establishing and managing their pay system. We urge VA to do so and also to examine whether additional deserving physician and dentist groups should receive additional pay in accordance with this new authority.

RECOMMENDATIONS:

The IBVSOs urge VA to actively engage labor and professional associations that remain concerned about the new pay and performance system, to ensure it gains their cooperation as VA manages and refines this approach to pay the current clinician workforce. We also urge the Secretary and Under Secretary for Health to review this program to ensure its overriding goal was in fact met—to relieve the "critical situation with increasing needs of veterans for health care while our current pay system leaves us in a very noncompetitive position for recruiting the staff we need today and into the future."

Should the Secretary discover that the new pay system lacks essential elements to enable VA to meet its recruitment and retention goals, we recommend the Secretary propose legislation to Congress, or take regulatory action, to remedy this problem.

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Challenges in VA Information Technology:

The Independent Budget ***veterans service organizations (IBVSOs) are concerned about the Secretary's decision to centralize all information technology (IT) in the Department of Veterans Affairs (VA) because of a likely deleterious impact on health-care quality.***

In *The Independent Budget for Fiscal Year 2007*, the IBVSOs expressed concern about the status of IT in VA. For years, some of VA's approaches, budgets, policies and initiatives in information technology have been controversial, wasteful, and, ultimately, unworkable. Many fell into disuse and were cancelled (i.e., "HRLinks"). One memorable initiative, "CoreFLS," collapsed amidst its trial implementation in 2003. Over a period of years, Congressional committees applied increasing pressure on VA officials to affix accountability for IT failures and waste. These efforts included demands to centralize IT budget and authority in one chief information officer (CIO) who would report to the Secretary; to apply more acute, detailed and timely reporting requirements; and, in general to provide more acute scrutiny in VA IT practices, initiatives, policies, and expenditures. The CoreFLS catastrophe triggered a number of investigations and resulted in the resignation of several officials, a shakeup of assignments, and cancellation of contracts. The CoreFLS incident brought new energy to the calls for VA IT reform.

In 2006, VA experienced a unique and disastrous event when in May it was discovered that a single laptop computer in the personal residence of a VA data analyst, which contained personal and sensitive information on the entire American veteran population and all currently serving military active duty personnel, was stolen. Although the computer and its data were subsequently recovered, and while the FBI made a determination that the sensitive data in this recovered computer had not been breached by the thieves, this incident generated new concerns about the security of personal information, not only in VA but across the federal government and large private businesses. Several committees of Congress demanded improvements in data security and data management on a large scale to prevent a recurrence in any federal department or agency of such an outrageous breach of personal information held by the government.

Soon after the theft, the former Chairman of the House Committee on Veterans' Affairs introduced legislation that would centralize information control, flow, security, planning, programming, budgeting, and resources, to a new "Under Secretary for Information Security," an official who would serve as a peer to the two existing VA Under Secretaries (for Health and Benefits). This bill, similar to a bill introduced in 2005 based on prior IT conditions in VA, quickly passed the House unanimously but generated no companion bill in the Senate.

The House and Senate Veterans' Committees approved legislation at the end of the 109th Congress that enacts some of the security and notification provisions in the latest IT bill, but the IBVSOs believe it is important to note that Congress did not agree to statutorily mandate centralization of the management of all IT in VA. Nevertheless, the VA Secretary announced late in 2006 his intention to carry forward his earlier decision to centralize the IT security function by adding to it the IT development function as an additional centrally controlled activity. Thus, as this *Independent Budget* is being presented, IT functions, resources, and personnel are being collected across the three VA administrations and numerous staff offices and are now being consolidated under one official in VA central office, the Assistant Secretary for Information Management—in effect, VA's "chief information officer." Despite the outrage expressed by many veterans service organizations over the theft of veterans' personal data, the IBVSOs remain concerned that centralizing all vital IT functions presents new challenges and may result in unfortunate consequences.

The IBVSOs acknowledge that a number of problems have plagued VA's IT programs and that better means need to be employed to keep VA from wasting resources on frivolous ideas or applications or investing in large-scale initiatives that are unsupported by the field staffs who ultimately must implement them (such as in the HRLinks and CoreFLS failures). We certainly agree that IT security, especially that involving personally identifiable records of veterans, must be paramount in VA's actions. We deplore the theft of VA computers containing sensitive data. Nevertheless, the IBVSOs are convinced that whatever course is taken to reform IT at the departmental "enterprise" level, the Veterans Health Administration's seminal accomplishments that established the world's foremost computerized patient care records system should not be compromised at the expense of central control.

The VA health-care system has been developing a unique VA computerized patient care record system for more than 30 years. The most important and lasting value of the VHA's automated system is that it was conceived and developed by VA clinical, research, and informatics specialists—those who actually deliver VA health care every day in VA facilities. The current version of this system, based on the VHA's self-developed VistA software, sets the standard for electronic medical records in the United States and has been publicly praised by the President as a model for all health-care providers. In fact, VistA, available free of charge in the public domain, is being imported into a number of U.S. and foreign health-care systems. Recently the government of West Virginia contracted with a private company to install VistA in all public hospitals in that state.

The existence of computerized patient care records enables the VHA to provide better and more efficient health care, and VistA empowers VA, uniquely, to avoid medical mistakes that are routinely made by other providers in the private and public sectors. Given that the Institute of Medicine estimates that avoidable medical mistakes cost 90,000 lives annually, it is no exaggeration to say VistA saves veterans' lives.

The VHA's health-care quality improvements over the past decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on the Accreditation of Healthcare Organizations, the National Quality Forum and the Agency for Health Care Quality, and Research of the Department of Health and Human Services. For the first time in history, mainstream media and press are reporting VA health care's high quality as news. Reports in 2006 in such publications as *Business Week and Time Magazine* have clearly documented VA's rise in quality and efficiency, in no small measure because of the advent and universal employment of VistA in VA patient care. While the IT accomplishments alone certainly did not improve VA health care, the integration of IT with VA's enrollment, laboratory, radiology, pharmacy, scheduling, personnel, logistics, management, and reporting systems has uniquely enabled VA to deliver and coordinate care as never before—and to do so at a level well beyond existing capabilities of other public and private providers. We believe the VHA's IT system is inseparable from its clinical care system.

Given the degree of success evident in the VHA, the authors of *The Independent Budget* cannot find justification for centralizing VHA IT to a non-VHA environment. One reason VHA IT has been so successful is that the Under Secretary controls and manages the IT programming and budget for the VHA, while thousands of clinical and other personnel involved in delivering direct health care also serve as software developers, subject matter experts on technical evaluation panels, and thus substantive advisors, to achieve an IT system that supports the delivery of coordinated clinical care—care that they themselves largely manage. Without IT integration to this degree, we contend that the VHA would never have been able to double patient enrollment since 1995, nor to significantly reduce the cost of care, while improving quality.

The IBVSOs do not believe a VA "data czar" can manage VHA IT with the same degree of success or with the same sensitivities that the VHA has achieved with its current approach. We feel certain that this will be true with respect to the next generation of VHA software, HealtheVet, a web-enabled system already well into its developmental and planning phase, overseen by VHA clinicians. We acknowledge that centralization of any governmental or business function can be made to save dollars; however, these dollar savings in the case of the VHA may come at a cost of eroded quality of care to sick and disabled veterans with an inevitable overlay of new bureaucracy from centralization. Removing field facility personnel, especially clinical caregivers and management personnel, from the planning and development of clinical IT could doom future developments to mediocrity and ultimate decline. We understand that the current acting Under Secretary for Health has been assigned to lead a task group in examining how to balance VHA's special clinical interests in IT versus the Secretary's decision to centralize management, development, budget, and administration of IT systemwide. We are anxious to learn how the VHA will be able to sustain its excellence in IT development in the bureaucratic environment of Washington, DC.

Dr. Jonathan C. Javitt, former IT advisor to President Bush, testified as follows at a Congressional hearing on September 28, 2005:

> The centralization of VHA's electronic health records program is likely to have a disastrous effect on the continued success of

> that program; which President Bush identified as the only place IT has really shown up in health care, a terrible effect on the morale of VA care providers; and on the system's productivity. Worst, it will damage the health of our nation's Veterans to whom we owe so much.

The IBVSOs believe Dr. Javitt's analysis is still as correct as when he stated it.

Motivated by the computer theft, the Secretary has decided to restructure IT to give a departmental CIO more authority. The Secretary retains authority to empower the current CIO with additional responsibility, including some of the ideas embedded in the arguments that would centralize IT completely. The current CIO exercises authority delegated by the Secretary and mandated by the Chief Information Officer Act codified in Title 40, United States Code. Nevertheless, VHA's relative IT independence from strong central control is a success story. We believe this unique progress should be sustained by enabling the VHA, with the Under Secretary for Health in the lead, to retain its current authority in IT planning, development, programming, operations, and budgeting for computerized patient care records systems.

The IBVSOs are concerned that total centralization would retard the creative elements that so characterize VHA's current IT environment and its future viability. VA clinicians have high motives toward investigation, research, and teaching. VHA's IT environment feeds innovation and creative applications to solve difficult and complex problems in clinical care, particularly in the university-affiliated environment. How long will such an environment be sustained if major development decisions on VHA IT are being made in Washington and managed through a centralized bureaucracy? We believe such potentially opposing forces will be difficult to reconcile.

In summary, the IBVSOs remain highly skeptical of total centralization of IT in VA, particularly for its likely deleterious impacts on the VHA, VistA and HealtheVet, and on veterans served by the VHA. We are concerned that centralization may rupture the strong, vital link that has been established between quality of VA health care and VHA IT programs supporting that quality.

RECOMMENDATIONS:

Given the recent Congressional decision to improve IT security and accountability but to decline to statutorily centralize all control over IT, VA should proceed with great caution in centralizing all aspects of information technology.

To ensure VA remains in the forefront of quality health-care providers, the VHA should be provided the means to continue investing in and refining VistA, while developing the next generation of clinical information technologies that will aid health-care delivery to the nation's veterans.

Veterans Affairs Physician Assistant:

The position of physician assistant advisor to the Under Secretary for Health should be a full-time employee equivalent (FTEE).

The Department of Veterans Affairs (VA) is the largest single federal employer of physician assistants (PAs), with approximately 1,574 PA FTEE positions. Since the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) directed that the Under Secretary of Health appoint a PA advisor to his office, VA has continued to assign this duty as a part-time field employee, as collateral administrative duties in addition to their clinical duties. *The Independent Budget* has requested for five years that this position be a FTEE within the Veterans Health Administration. In addition, in Senate Appropriations language in 2002 and again in 2003, it was requested and ignored.

The VA Under Secretary for Health has consistently refused to establish this important FTEE, and despite numerous requests from members of Congress, the veterans service organizations, and professional PA associations, VA has maintained this position as part-time, field-based with a very limited travel budget. This important occupation's representative has not been appointed to any of the major health-care VA strategic planning committees, has been ignored in the entire planning on seamless transition, and was not utilized during the emergency disaster planning and VA response to Hurricane Katrina.

PAs in the VA health-care system were the providers for approximately 8.7 million veteran visits in FY 2004; and PAs work in primary care, ambulatory care clinics, emergency medicine, and in 22 other medical and surgical specialties. PAs are a vital part of VA health-care delivery, and *The Independent Budget* supports the inclusion of a PA advisor in VA headquarters' Patient Care Services, FTEE in very close proximity to Washington, DC, which was the intent of the law. We urge Congress to enact and fund this FTEE within the budget for FY 2008 and to ensure the position is in Washington, DC.

The Independent Budget veterans service organizations fully support Congress legislatively correcting this long-standing problem.

RECOMMENDATION:

Congress should legislatively mandate the Veterans Affairs physician assistant advisor to the Under Secretary for Health as a FTEE within VA, allowing the PA consultant to become fully integrated into VHA policy management and health-care planning.

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Construction Programs

The Department of Veterans Affairs (VA) construction budget has, for the past few years, been dominated by the Capital Asset Realignment for Enhanced Services (CARES) process.

CARES is a systemwide, data-driven assessment of VA's capital infrastructure. It aimed to identify the needs of veterans to aid in the planning of future and realignment of current VA facilities to most efficiently meet those needs. It was not just a one-time evaluation, but also the creation of a process and framework to continue to determine veterans' future requirements.

Throughout the entire CARES process, *The Independent Budget* veterans service organizations (IBVSOs) were highly supportive, as long as VA emphasized the "ES"—enhanced services—portion of the acronym.

■ CARES Timeline

- 2001—CARES pilot study in Network 12 (Chicago, Illinois; Wisconsin; and Upper Michigan) completed.
- 2002—Phase II of CARES began in all other networks of VA individually, to be compiled in the Draft National CARES Plan.
- 2003—August: Draft National CARES Plan submitted to CARES Commission to review and gather public input.
- 2004—February: VA Secretary receives CARES Commission recommendations.
- 2004—May: VA Secretary announces his decision on CARES, but calls for additional "CARES Business Plan Studies" at 18 sites throughout the country.

These CARES Business Plan Studies are available on VA's CARES website, www.va.gov/cares. As of December 2006, only 10 of these studies have been completed, despite VA's stated June 2006 deadline. The IBVSOs look forward to the final results so that implementation of these important plans can go forward.

The IBVSOs believe that all decisions on CARES should be consistent with the CARES decision document and its established priorities, or with the findings of the CARES review commission that largely confirmed those priorities. Proposed changes or deviation from the plan should undergo the same rigorous data validation as the original projects.

CARES was intended to be an apolitical, data-driven process that looked out for the best interest of veterans throughout the entire system. We are certainly pleased that the Secretary and members of Congress are interested in the future of VA capital facilities, but we urge all involved to maintain consistency with the apolitical process that, as agreed to by all parties—stakeholders included—would provide the best way to determine future VA infrastructure needs to sufficiently care for all veterans. This was the hallmark of the CARES plan.

Throughout the CARES process, the IBVSOs were greatly concerned with the underfunding of the construction budget. Congress and the Administration did not devote many resources to VA's infrastructure, preferring to wait for the final results of CARES. In past *Independent Budgets* we warned against this, pointing out that there were a number of legitimate construction needs identified by local manager of VA facilities. A number of facilities were authorized, including House passage of the "Veterans Hospital Emergency Repair Act," but funding was never appropriated, with the ongoing CARES review being used as the primary excuse.

At the time, the IBVSOs argued that a de facto moratorium on construction was unnecessary because of our conviction that a number of these projects needed to go forward and that they would be fully justified in any future plans produced through CARES. Despite this reasonable argument, funding never came, and VA lost progress on hundreds of millions of dollars that otherwise would have been invested to meet the system's critical infrastructure needs.

The IBVSOs continue to believe that this deferral of all major VA construction projects was poor policy. In the five-plus years the process took, construction and maintenance improvements lagged far beyond what the system truly needed. With CARES nearly complete, funding has not yet been proposed by the Administration nor approved by Congress to address the very large project backlog that has grown.

We note that in its final hours in December 2006, the 109th Congress enacted Public Law 109-461, an act that included authorizations for fiscal years 2006 and 2007 for a number of VA major projects and capital leases that had been backlogged, some for a number of years. While relieved by this action, the IBVSOs remain concerned that VA's construction needs are not being fully addressed by Congress or the Administration. Also, while these projects have been approved through the authorizing legislation, it is important to note that, under law, they cannot commence without specific appropriations. Given that the VA is operating on a Continuing Resolution rather than its expected regular appropriation, at the time this *Independent Budget* is being published, VA is unable to proceed with this critically needed construction.

In July 2004, VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. In his testimony, he noted that CARES "reflects a need for additional investments of approximately $1 billion per year for the next five years to modernize VA's medical infrastructure and enhance veterans' access to care." Since that statement, however, the amount actually appropriated by Congress for VA major medical facility construction has fallen far short of that goal; in fiscal year 2007, the administration recommended a paltry $399 million for major construction.

After that five-year de facto moratorium and without additional funding coming forth, VA facilities have an even greater need than they did at the start of the CARES process. Accordingly, we urge the Administration and the Congress to live up to the Secretary's words by making a steady investment in VA's capital infrastructure to bring the system up to date with the needs of 21st century veterans.

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MAJOR CONSTRUCTION ACCOUNT

For major construction, the IBVSOs recommend $1.602 billion in funding. This includes funding for the projects on VA's priority list, advanced planning, and for construction costs for a number of new national cemeteries in accordance with the NCA strategic plan.

MAJOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES	$1,400,000
Master Planning	20,000
Advanced Planning	45,000
Asbestos	5,000
Claims Analyses	3,000
Judgment Fund	2,000
Hazardous Waste	2,000
National Cemetery Administration	95,000
Staff Offices	5,000
Historic Preservation	25,000
TOTAL	**$1,602,000**

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MINOR CONSTRUCTION ACCOUNT

For minor construction, the IBVSOs recommend a total of $541 million, the bulk of which will go toward the more than 100 minor construction projects identified by VA in its five-year capital plan in fiscal year 2008.

MINOR CONSTRUCTION ACCOUNT RECOMMENDATIONS

Category	Funding (Dollars in thousands)
CARES/Non-CARES	$450,000
National Cemetery Administration	40,000
Veterans Benefits Administration	35,000
Staff	6,000
Advanced Planning	10,000
TOTAL	**$541,000**

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Inadequate Funding and Declining Capital Asset Value:

The Department of Veterans Affairs (VA) does not have adequate provisions to protect against deterioration and declining capital asset value.

The last decade of underfunded construction budgets has led to a reduction in the recapitalization of VA's facilities. Recapitalization is necessary to protect the value of VA's capital assets by renewing the physical infrastructure to ensure safe and fully functional facilities. Failure to adequately invest in the system will result in its deterioration, creating even greater costs down the road.

As in past years, we continue to cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). The PTF noted that in the period from 1996–2001, VA's recapitalization rate was 0.64 percent, which corresponds to an assumed building life of 155 years. When maintenance and restoration are factored into VA's major construction budget, VA annually invests less than 2 percent of plant replacement value in the system. The PTF observed that a minimum of 5 to 8 percent per year is necessary to maintain a healthy infrastructure and that failure to adequately fund could lead to unsafe, dysfunctional settings.

RECOMMENDATION:

Congress and the Administration must ensure that there are adequate funds for major and minor construction so that VA can properly reinvest in its capital assets to protect their value and ensure that health care can be provided in safe and functional facilities long into the future.

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Increase Spending on Nonrecurring Maintenance:

The deterioration of many Department of Veterans Affairs (VA) properties requires increased spending on nonrecurring maintenance.

A Pricewaterhouse study looked at VA facilities management and recommended that VA spend at least 2 to 4 percent of its plant replacement value on upkeep. Nonrecurring maintenance (NRM) consists of small projects that are essential to the proper maintenance and to the preservation of the lifespan of VA's facilities. Examples of these projects include maintenance to roofs, replacement of windows, and upgrades to the mechanical or electrical systems.

Each year, VA grades each medical center, creating a facility condition assessment (FCA). These FCAs give a letter grade to various systems at each facility and assign a cost estimate associated with repairs or replacement. The latest FCAs have identified $4.9 billion worth of necessary repairs in projects with a letter grade of "D" or "F." F's must be taken care of immediately, and D's are in need of serious repairs or represent pieces of equipment reaching the end of their usable life. Most of these projects would be reparable using NRM funds.

Another concern with NRM is with how it is allocated. NRM is under Medical Facilities of the Medical Care Account and is distributed to various VISNs through the Veterans Equitable Resource Allocation (VERA) process. While this does move the money toward the areas with the highest demand for health care, it tends to move money away from facilities with the oldest capital structures, which generally need the most maintenance. It also could increase the tendency of some facilities to use maintenance money to address shortfalls in medical care funding.

RECOMMENDATIONS:

VA should spend $1.6 billion on NRM to make up for the lack of proper funding in previous years and to keep VA on the right track with maintenance for the future.

VA must also resist the temptation to dip into NRM funding for health-care needs, as this could lead to far greater expenses down the road.

High-Risk Buildings:

Veterans and staff continue to occupy buildings known to be at extremely high risk because of seismic deficiencies.

The Independent Budget veterans service organizations continue to be concerned with the seismic safety of the Department of Veterans Affairs (VA) facilities. The July 2006 Seismic Design Requirements report noted the existence of 73 critical VA facilities that, based on Federal Emergency Management Agency definitions, are at a "moderately high" or greater risk of seismic incident. Twenty-four of these have been deemed "very high" risk, the highest standard.

To address the safety of veterans and employees, VA includes seismic corrections in its annual list of projects to Congress. In conjunction with the Capital Asset Realignment for Enhanced Services process, progress is being made on eight of these facilities. More is needed, and, accordingly, funding will need to increase.

For efficiency, most seismic correction projects should also include patient care enhancements as part of their total scope. Seismic correction typically includes lengthy and widespread disruption to hospital operations; it would be prudent to make medical care improvements at the same time to minimize disruptions in the future. While this approach is the most practical for the delivery of health care and services as well as for cost-effectiveness, it also results in higher upfront project costs, which would require an increase in the construction budget.

RECOMMENDATIONS:

Congress must appropriate adequate construction funding to correct these critical seismic deficiencies.

VA should schedule facility improvement projects concurrently with seismic corrections

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Establishing a Program for Architectural Master Plans:

Each Department of Veterans Affairs (VA) medical center needs to develop a detailed master plan.

This year's construction budget should include at least $20 million to fund architectural master plans. Without these plans, the Capital Asset Realignment for Enhanced Services (CARES) medical benefits will be jeopardized by hasty and short-sighted construction planning.

The Independent Budget veterans service organizations believe that each VA medical center should develop a facility master plan to serve as a clear roadmap to where the facility is going in the future. It should be an inclusive document that includes multiple projects for the future in a cohesive strategy.

In many cases, VA plans construction in a reactive manner. Projects are funded first and then fitted onto the site. Each project is planned individually and not necessarily with respect to other ongoing projects or ones planned for the future. It is essential that each medical center has a plan that looks at the big picture to efficiently utilize space and funding. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. Master plans would prevent short-sighted construction that restricts, rather than expands, future options.

Every new project in the master plan is a step in achieving the long-range CARES objectives. These plans must be developed so that all future projects can be prioritized, coordinated, and phased. They are essential to efficiently use resources, but also to minimize disruption to VA patients and employees. Medical priorities, for example, must be adjusted for construction sequencing. If infrastructure changes must precede new construction, master plans will identify this so that schedules and budgets can be adjusted. Careful phasing is essential to avoid disrupting the

delivery of medical care, and the correct planning of such will ensure that cost estimates of this phased-construction approach will be more accurate.

There may be cases, too, where master planning will challenge the original CARES decisions, whether due to changing demand, unidentified needs, or other cause. If CARES, for example, calls for the use of renovated space for a relocated program, and a more comprehensive examination, as part of a master plan, later indicates that the site is impractical, different options should be considered. Master plans will help to correct and update invalid planning assumptions.

VA must be mindful that some CARES plans involve projects constructed at more than one medical center. Master plans, as a result, most coordinate the priorities of both medical centers. Construction of a new SCI facility, for example, might be a high priority for the "gaining" facility, but a lower priority for the "donor" facility. It may be best to fund and plan the two actions together, even though they are split between two different facilities.

Another essential role of master planning is its use to account for three critical programs that VA left out of the initial CARES process: long-term care, severe mental illness, and domiciliary care. Because these were omitted, there is a strong need for a comprehensive plan, and a full facility master plan will help serve as a blueprint for each facility's needs in these essential areas.

VA must ensure that each medical center develops and continues to work on long-range master plans to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruptions to patient care.

RECOMMENDATIONS:

Congress must appropriate $20 million to allow each VA medical facility to develop architectural master plans to serve as roadmaps for the future.

Each facility master plan should address long-term care, including plans for those with severe mental illness, and domiciliary care programs, which were omitted from the CARES process.

VA must develop a format for these master plans so that there is standardization throughout the system, even though planning work will be performed by local contractors in each Veterans Integrated Service Network.

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Plan for Long-Term Care and Mental Health Needs:

The Department of Veterans Affairs (VA) must develop a strategic plan for the infrastructure needs of long-term care and mental health programs.

The initial Capital Asset Realignment for Enhanced Services (CARES) plan did not take long-term care or the mental health considerations of veterans into account when making recommendations. We were pleased that the CARES Review Commission recognized the need for proper accounting of these critical components of care in VA's future infrastructure planning. However, we continue to await VA's development of a long-term care strategic plan to meet the needs of aging veterans. The commission recommended that VA "develop a strategic plan for long-term care that includes policies and strategies for the delivery of care in domiciliary, residential treatment facilities and nursing homes, and for older seriously mentally ill veterans."

Moreover, the commission recommended that the plan include strategies for maximizing the use of state veterans' homes, locating domiciliary units as close to patient populations as feasible, and identifying freestanding nursing homes as an acceptable care model. In absence of that plan, VA will be unable to determine its future capital investment strategy for long-term care.

VA must take a proactive approach to ensure that the infrastructure and support networks needed by veterans will be there for them in the future.

The Independent Budget veterans service organizations also concur with the CARES Commission's

recommendations that VA take action to ensure consistent availability of mental health services across the system to include mental health care at community-based clinics along with the appropriate infrastructure to match demand for these specialized services. This is important in light of the growing demand for these types of services, especially among those returning from overseas in the wars in Iraq and Afghanistan.

RECOMMENDATIONS:

VA must develop a long-term care strategic plan to account for the needs of aging veterans now and into the future. This should include care options for older veterans with serious mental illnesses.

VA must also develop plans to provide for the infrastructure needs associated with mental health-care services, especially with the unprecedented current need for these services, and the likely tremendous long-term needs of our returning service members.

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Empty or Underutilized Space at Medical Centers:

The Department of Veterans Affairs (VA) must not use empty space inappropriately.

Studies have suggested that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it, and these secondary impacts greatly increase construction expense and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs for different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary costs, the renovation can end up costing more and producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for more modern needs. Most of these Bradley-style buildings were designed before the widespread use of air-conditioning and the floor-to-floor heights are very low. Accordingly, it's impossible to retrofit them for modern mechanical systems. They also have long,

narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

RECOMMENDATION:

VA should develop a plan for addressing its excess space in nonhistoric properties that are not suitable for medical or support functions due to their permanent characteristics or locations.

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Updating and Expanding VA Design Guides:

The Department of Veterans Affairs (VA) must continue to develop and revise facility design guides for spinal cord injury/spinal cord dysfunction (SCI/D).

With the largest health-care system in the United States, VA has an advantage in its ability to develop, evaluate, and refine the design and operation of its many facilities. Every new clinic's design can benefit from lessons learned from the construction and operation of previous clinics. VA also has the unique opportunity to learn from medical staff, engineers, and from its users—veterans and their families—as to what their needs are, allowing them to generate improvements to future designs.

As part of this, VA provides design guides for certain types of facilities that provide care to veterans. These guides are rough tools used by the designers, clinicians, staff, and management during the design process. These design guides, which are viewable on the Facilities Management web page, cover a variety of types of care.

These design guides, due to modernization of equipment and lessons learned at other facilities, should be revised regularly. Some of the design guides have not been updated in more than a decade, despite the massive transition of the VA health-care system from an inpatient-based system. *The Independent Budget* veterans service organizations (IBVSOs) understand that VA intends to regularly update these guides, and we would urge that increased funding be allocated to the Advanced Planning Fund to revise and update these essential guides.

As in past years, the IBVSOs would note the need for guides for long-term care at SCI/D centers. It is important that these guides be separate from the guides that call for acute care as the needs of the two are dramatically different.

These facilities must be less institutional in their character with a more homelike environment. Rooms and communal space should be designed to accommodate patients who will be living at these facilities for a long time. They must include simple ideas that would improve the daily life of these patients. Corridor length should be limited. They should include wide areas with windows to create tranquil places or areas to gather. Centers should have courtyard areas where the climate is temperate and indoor solariums where it is not. We believe that a complete guideline for these facilities would also include a discussion of design philosophies that emphasize the quality of life of these patients, and not just the specific criteria for each space. Because the type of care these patients need is unique, it is essential that this type of design guidance is available to contracted architects.

RECOMMENDATIONS:

VA must revise and update their design guides on a regular basis.

VA should develop a long-term care design guide for SCI/D centers to accommodate the special needs of these unique patients.

Preservation of VA Historic Structures:

The Department of Veterans Affairs (VA) extensive inventory of historic structures must be protected and preserved.

VA has an extensive inventory of historic structures, which highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected, and preserved because of their importance.

Most of these facilities are not suitable for modern patient care, and, as a result, a preservation strategy was not included in the Capital Asset Realignment for Enhanced Services process. As a first step in addressing its responsibility to preserve and protect these buildings, VA must develop a comprehensive program for these historic properties.

VA must make an inventory of these properties, classifying their physical condition and their potential for adaptive reuse. Medical centers, local governments, nonprofit organizations, or private sector businesses could potentially find a use for these important structures that would preserve them into the future.

The Independent Budget veterans service organizations recommend that VA establish partnerships with other federal departments, such as the Department of the Interior, and with private organizations, such as the National Trust for Historic Preservation. Their expertise would be helpful in creating this new program.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly for preservation's sake. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. We would point to the partnership between the Department of the Army and the National Trust for Historic Preservation as an example of how VA could successfully manage its historic properties.

P.L. 108-422, the Veterans Health Programs Improvement Act, authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property. We applaud its passage and encourage its use.

RECOMMENDATION:

VA must begin a comprehensive program to preserve and protect its inventory of historic properties.

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Career and Occupational Assistance Programs

The relationship between veterans, disabled veterans, and work is vital to public policy in today's environment. People with disabilities, including disabled veterans, often encounter barriers to their entry or reentry into the workforce and lack accommodations on the job; many have difficulty obtaining appropriate training, education, and job skills. These difficulties, in turn, contribute to low labor force participation rates and high levels of reliance on public benefits. At present funding levels, our public eligibility and entitlement programs cannot keep pace with the resulting demand for benefits.

In recent years there has been an increased reliance on licensing and certification as a primary form of competency recognition in many career fields. This emphasis on licensing and certification can present significant, cumbersome, and unnecessary barriers for transitioning military personnel seeking employment in the civilian workforce. These men and women receive exceptional training in their particular fields while on active duty, yet in most cases these learned skills and trades are not recognized by nonmilitary organizations. Efforts to enhance civilian awareness of the quality and depth of military training should be made to reduce or eliminate licensing requirements and employment barriers. We are encouraged by the continued emphasis now being placed on employment and not just the counseling portion of vocational rehabilitation.

In response to criticism of the Vocational Rehabilitation and Employment (VR&E) Service, former Department of Veterans Affairs Secretary Anthony Principi formed the Vocational Rehabilitation and Employment Task Force. The Secretary's intent was to conduct an "unvarnished top to bottom independent examination, evaluation, and analysis." The Secretary asked the task force to recommend "effective, efficient, up-to-date methods, materials, metrics, tools, technology, and partnerships to provide disabled veterans the opportunities and services they need" to obtain employment. In March 2004, the task force released its report recommending needed changes to the VR&E service. *The Independent Budget* continues to support the recommendations of the task force, and we look forward to continued implementation of these recommendations.

VOCATIONAL REHABILITATION AND EMPLOYMENT

Vocational Rehabilitation and Employment Funding:

Congressional funding for the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) services must keep pace with veteran demand for VR&E services.

The VR&E program provides services and counseling necessary to enable service disabled veterans with employment handicaps to prepare for, find, and maintain gainful employment in their communities. The program also provides independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their reentry back to private life. The program further offers educational and vocational counseling to service members and veterans recently separated from active duty. These services are also available to dependents of veterans who meet certain eligibility requirements.

The Office of Management and Budget (OMB) evaluates the average cost of placing a service-connected veteran in employment at $8,000 as calculated by dividing VR&E program obligations by the number of veterans rehabilitated. However, OMB calculations do not include a provision for inflation, increased student tuition costs, and the number of veterans who drop out of the VR&E program or enter interrupt status of their rehabilitation plan. Comparisons to other vocational programs are not appropriate since nonfederal dollars are excluded when calculating their cost to place an individual in employment status.

Many veterans are facing significant challenges when they return home from the current global war on terrorism. These large numbers of regular military, National Guard, and Reserves are creating tens of thousands of new veterans, many of whom are eligible for VR&E programs. At present funding levels, VR&E programs cannot keep pace with the current and future demand for VR&E benefits.

RECOMMENDATION:

Congress must provide the funding level to meet veteran demand for VA VR&E programs.

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VR&E Staffing Levels Inadequate:

Staffing levels of the Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service are not sufficient to meet the needs of our nation's veterans in a timely manner.

The VA VR&E Service is charged with the responsibility to prepare disabled veterans for suitable employment and provide independent living services to those veterans who are seriously disabled and are unlikely to secure suitable employment at the time of their entry into the program. However, VR&E must begin to strengthen its program due to the increasing number of service members returning from Afghanistan and Iraq with serious disabilities. These veterans require both vocational rehabilitation and employment services. There is no VA mission more important during or after a time of war than to enable injured military personnel to have a seamless transition from military service to a productive life after serving their country.

Success in the transition of disabled veterans to meaningful employment relies heavily on VA's ability to provide vocational rehabilitation and employment services in a timely and effective manner. Unfortunately, the demands and expectations being placed on the VR&E Service are exceeding the organization's current capacity to effectively deliver a full continuum of comprehensive programs. The service has been experiencing a shortage of staff nationwide because of insufficient

funding, which, as a result, has caused delays in providing VR&E services to disabled veterans, thus reducing the veteran's opportunity to achieve successful rehabilitation and employment.

To increase emphasis on employment, the service has begun an initiative titled "Coming Home To Work" as an early outreach effort to provide VR&E services to eligible service members pending medical separation from active duty at military treatment facilities. This and other new programs will require additional staff to maintain efforts nationwide. It is imperative that VA increase VR&E staffing levels to meet the increasing demand our nation's veterans have for services. The following facts further confirm these problems.

Currently, there are 89,000 veterans in the various phases of VR&E programs compared to 70,000 in FY 2000. This number is expected to increase as more service members return from the conflicts in Iraq and Afghanistan. Nineteen-thousand veterans have ended their participation in the VA rehabilitation program. Of these, 63.3 percent successfully completed the program, of which 48.9 percent ended with employment and 14.4 percent ended with achieving their goal of independent living.

For many years, *The Independent Budget* veterans service organizations have criticized VR&E Service programs and complained that veterans were not receiving suitable vocational rehabilitation and employment services in a timely manner. Many of these criticisms remain of concern, including the following:

- inconsistent case management with lack of accountability for poor decision making;
- delays in processing initial applications due to staff shortages and large caseloads;
- declaring veterans rehabilitated before suitable employment is retained for at least six months; and
- inconsistent tracking of electronic case management information systems.

RECOMMENDATION:

VA needs to strengthen its Vocational Rehabilitation and Employment program to meet the demand of disabled veterans, particularly those returning from the conflicts in Afghanistan and Iraq, by providing a more timely and effective transition into the workforce.

Follow-up on Referrals to Other Agencies for Entrepreneur Opportunities:

Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service staff should follow up with veterans who are referred to other agencies to ensure that the veteran's entrepreneur opportunities have been achieved.

VR&E has expanded its efforts toward fostering awareness and opportunities for self-employment by signing memorandums of understanding with the Department of Labor, the Small Business Administration, and The Veterans Corporation and SCORE. They have also implemented the Five Track Employment Process, which places emphasis on self-employment as a potential for gainful employment. VR&E has further included self-employment in standardized operation materials, online employment sources, and information guides. However, VR&E must follow up with veterans who were referred to other agencies for entrepreneur opportunities and reassess their employment needs if they were not successful.

RECOMMENDATION:

VR&E staff must follow up with veterans after being referred to other agencies for self-employment to ensure that the veteran's entrepreneur opportunities have been successfully achieved.

VR&E Revision of Procedural Manuals:

The Department of Veterans Affairs Vocational Rehabilitation and Employment (VR&E) Service must continue to revise its procedural manuals to keep current with changes in laws and regulations.

VR&E is currently working on revising its procedure manuals, which have been neglected for several years. Four of the seven chapters have been revised leaving three parts still to be updated. In addition to revising the content of the manuals, VR&E must establish an ongoing routine for revising its manuals to be consistent with changes in laws, regulations, and policies.

RECOMMENDATION:

The VR&E manual must be routinely revised to remain current with present as well as future changes in laws, regulations, and policies.

VR&E Contract Counselors:

The Department of Veterans Affairs (VA) needs to improve the oversight of contract counselors to ensure that veterans are receiving the full array of Vocational Rehabilitation and Employment (VR&E) programs and services in a timely and compassionate manner.

VA's Strategic Plan for FY 2006–2011 reveals that VA plans to continue the utilization of contractors to supplement and complement services provided by VR&E staff. However, *The Independent Budget* veterans service organizations are concerned about the quality of services provided by contract counselors, which may be contributing to the problem of veterans dropping out of their VR&E program before completion or going into interrupt status in their rehabilitation plan.

A survey conducted by the Veterans Benefit Administration Office of Performance Analysis & Integrity conducted in 2003 supports this concern. The survey concluded that "VA staff counselors were consistently rated higher than contractor counselors on the majority of issues addressed by their survey." VA counselors were viewed to be more concerned about the individual's needs and goals and were likely to be more caring and compassionate.

RECOMMENDATIONS:

VR&E Service staff must improve the oversight of contract counselors to ensure veterans are receiving the full array of services and programs in a timely and compassionate manner.

The VR&E Service should improve case management techniques and use state-of-the-art information technology.

The VR&E Service must increase the success rate of their program above the current 67 percent to meet its goal of 80 percent by 2011.

The VR&E Service needs to use results-based criteria to evaluate and improve employee performance.

VA needs to streamline eligibility and entitlement to VR&E programs to provide earlier intervention and assistance to disabled veterans.

The VR&E Service needs to identify and address why veterans drop out of its VR&E program prior to completion or choose to interrupt their rehabilitation plans.

The VR&E Service must place higher emphasis on academic training, employment services, and independent living to achieve the goal of rehabilitation of severely disabled veterans.

The VR&E Service should follow up with rehabilitated veterans for at least two years to ensure that the rehabilitation and employment placement plan has been successful.

VA needs to develop resource centers that focus on obtaining and maintaining gainful employment for veterans. The program needs to prepare veterans for interviews, offer assistance creating resumes, and develop proven ways of conducting job searches.

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Transition Assistance Programs Inadequate:

The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) do not adequately serve service members.

The Departments of Defense (DOD), Labor (DOL), and Veterans Affairs (VA) provide transition-assistance workshops to separating military personnel through TAP and DTAP. These programs generally consist of a three-day briefing on employment and related subjects, and veterans' benefits.

DTAP, however, has been largely relegated to a "stand-alone" session. Typically, a DTAP participant does not benefit from other transition services, nor does he or she automatically see a Vocational Rehabilitation and Employment (VR&E) Service representative.

The number of military members being separated annually remains high (more than 200,000 as projected by the DOD). These numbers continue to grow as large numbers of separating service members are returning from the global war on terrorism. Many have been on "stop loss," prevented from leaving military service on their scheduled date, and they depart military service soon after their return. It is imperative that these soon-to-become veterans are not overlooked during their rapid transition to civilian life. Additionally, tens of thousands of National Guardsmen and Reservists have been called to active duty for the current conflict. No coherent program exists for them to receive transition services at demobilization. In some ways, they face even more difficult employment problems after being ripped from their civilian employment to serve the nation. Though protections exist, separating service members need detailed information on these protections and the benefits of service as well as information on other opportunities they may have available. *The Independent Budget* veterans service organizations (IBVSOs) believe TAP/DTAP must continue to provide their important services as recommended by the VR&E Task Force in March 2004 and expand them to Guardsmen and Reservists returning from combat.

The IBVSOs are encouraged that the VR&E Service is in the process of restructuring DTAP. However, we are concerned that too little is still being done for transitioning disabled veterans and we will continue to monitor the changes and progress in DTAP.

RECOMMENDATIONS:

Congress should pass legislation ensuring the eligibility of all disabled veterans on a priority basis for all federally funded employment and training programs.

VA should assign primary responsibility for DTAP within the Veterans Benefits Administration to the VR&E Service and designate a specific DTAP manager.

The DOD should work closely with the DOL to ensure detailed transition services are provided at the demobilization station or other suitable site for demobilizing National Guardsmen and Reservists.

The DOD should ensure that separating service members with disabilities receive all of the services provided under TAP as well as the separate DTAP session by the VR&E Service.

Whenever practical, the DOD should make preseparation counseling available for members being separated prior to completion of their first 180 days of active

duty unless separation is due to a service-connected disability when these services are mandatory.

The House and Senate Veterans' Affairs Committees should conduct oversight hearings regarding the implementation of P.L. 107-288 to ensure the President's National Hire Veterans Committee fulfills the following purposes:

> Raise employer awareness of the advantages of hiring separating service members and veterans; facilitate the employment of separating service members and veterans through America's Career Kit, the National Electronic Labor Exchange; and direct and coordinate departmental, state, and local marketing initiatives.

Congress should provide the DOL adequate funding to enforce Uniformed Services Employment and Reemployment Rights Act provisions.

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Licensing and Certification:

Recently separated service members should have the opportunity to take licensing and certification examinations without a period of retraining.

Men and women of the armed forces acquire extensive knowledge and job skills, via military training and work experience, which are transferable to an array of civilian occupations. Along with technical proficiencies, service members offer intangible qualities like leadership skills and strong work ethics that are eagerly sought in the national job market as well as in other branches of government.

Yet an untold number of separating service members miss immediate opportunities to obtain good, high-paying jobs because of civilian licensure and certification requirements. Much of the lengthy and expensive training necessary for such certification is redundant to, and in some cases modeled on, military training.

This inefficient and costly waste of valuable human resources is unfair to veterans, an impediment to businesses that need skilled workers, and ultimately a burden upon the national economy due to delayed job creation, consumer spending, and unnecessary unemployment compensation insurance payments.

RECOMMENDATION:

To eliminate such artificial hurdles to employment in the private sector, the Department of Defense in partnership with the Department of Labor (DOL) should develop programs that track military training requirements and how they compare to those needed for licensing and certification in the civilian workforce. Additionally, the DOL should work with states and local governments and the private sector to enhance civilian awareness of the quality and depth of military training and to eliminate superfluous licensing requirements and employment barriers.

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Training Institute Inadequately Funded:

The National Veterans Training Institute (NVTI) lacks adequate funding to fulfill its mission.

The NVTI was established to train federal and state veterans' employment and training service providers. Primarily, these service providers are Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) specialists. DVOP/LVER specialists are located throughout the country at various locations, such as state workforce centers, Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Service offices, VA medical centers, Native American trust territories, military installations, and other areas of known concentrations of veterans or transitioning service members.

DVOP/LVER specialists help veterans make the difficult and uncertain transition from military to civilian life. They help provide jobs and job training opportunities for disabled and other veterans by serving as intermediaries between employers and veterans. They maintain contacts with employers and provide outreach to veterans. They also develop linkages with other agencies to promote maximum employment opportunities for veterans.

The NVTI was established in 1986 and authorized in 1988 by P.L. 100-323. It is administered by the Department of Labor Veterans Employment and Training Service through a contract with the University of Colorado at Denver. The NVTI curriculum covers an array of topics that are essential to DVOP/LVER specialists' ability to assist veterans in their quest to obtain and maintain meaningful employment. Such topics include courses to develop the following:

- core professional skills,
- media marketing skills,
- case management skills,
- investigative techniques,
- quality management skills, and
- grants management skills.

Certain DVOP/LVER specialists may be required to participate in employment programs involving other state and federal agencies. The NVTI helps prepare DVOP/LVER specialists for their roles in such programs as the VR&E Service and the Transition Assistance Program (TAP). The NVTI curriculum also includes information and training on the Uniformed Services Employment and Reemployment Rights. The NVTI offers Department of Defense employees TAP management training through reimbursable agreements under the Economy Act (at actual cost of training). The NVTI also offers a Resource and Technical Assistance Center, a support center, and repository for training and resource information related to veterans' programs, projects, and activities. *The Independent Budget* veterans service organizations are concerned because, after several years of level funding, appropriations for the NVTI for FY 2005 actually decreased. This reduction compromises the ability of the institute to provide quality training to those individuals serving veterans.

RECOMMENDATION:

Congress must fund the NVTI at an adequate level to ensure training is continued as well as expanded to state and federal personnel who provide direct employment and training services to veterans and service members in an ever-changing environment.

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Performance Standards:

Performance standards in the Veterans Employment and Training Service (VETS) system need to be uniform and consistent.

The enactment of the Jobs for Veterans Act (P.L. 107-288) has resulted in significant improvements in employment services to veterans and is showing a positive impact on veteran employment outcomes. However, while progress is being made, there are still no clear and uniform performance standards that can be used to compare one state to another or even one office to another office within one state.

In 2002, VETS began reporting performance outcomes that measured the "entered employment rate" and "employment retention rate" of veterans by state. However, the report lists percentages only, not actual numbers of veterans hired or served. Federal contractors must also file a "veterans hired" report annually. However, this report does not include all veterans employed and is only applicable to employers with federal contracts exceeding $25,000. The Bureau of Labor Statistics also has a number of reports available on the Department of Labor (DOL) website; however, none of them differentiate between disabled veterans, nondisabled veterans and nonveterans. It is clear that the Department of Labor needs to develop a standardized performance measure system and develop a centralized, national research database with this information.

Furthermore, despite these reporting requirements, the VETS headquarters and regional administrators have almost no authority to reward a good job or impose sanctions for poor performance. The only real authority is the seldom-used power to recapture funds when a state has acted in a way contrary to law. VETS is authorized to provide cash and other incentives to individuals who are most effective in assisting veterans, particularly disabled veterans, find work. However, this recognition is only for individuals and not entities. It would be practical if Congress would amend the Jobs for Veterans Act so entities (such as career one-stops) can be recognized and rewarded for exceeding the standards by providing them with additional funding.

In 2004 the VETS performance measures were applied to veterans served by the Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff members as well. For several years, many have expressed a need for qualification standards to be put in place for both DVOP and LVER staff. In 2005 there was draft legislation proposed that would require the Secretary of the Department of Labor to establish such professional qualifications for employment in the two programs. While this concept is certainly welcomed and broadly supported, the legislation did not explain exactly how VETS would implement the new qualification standards.

The heart and soul of VETS efforts is the dedicated DVOPs and LVERs tasked with facing the employment challenges of hard-to-place veterans. For decades, DVOPs and LVERs have been the cornerstone of employment services for veterans. It is important for states to continue to be required to hire veterans for these positions. Part of this reason is that these individuals are veterans advocating for veterans. After all, DVOP and LVER staff are the front-line providers for services to veterans. They are the individuals who provide a smooth transition of service members from the military to the civilian workforce.

We must never lose sight of the fact that veterans continue to need the special job training and services that VETS provides within the Department of Labor. Shifting VETS to VA will not improve the employment and training needs of veterans. The DOL knows the job market and skills required to fill jobs beyond any other executive department. Furthermore, it is unclear as to exactly how VA would effectively run the program that so naturally suits the DOL. VA does not have the capacity or the assets to support employment programs. Therefore, the IBVSOs recommend that VETS remain a function of the Department of Labor.

RECOMMENDATIONS:

VETS should compile, and make available to the public, a state-by-state, standardized performance measure system on the hiring of veterans on all levels.

Congress should amend the Jobs for Veterans Act so that entities (such as career one-stops) can be recognized and rewarded with additional funding.

Congress needs to continue work on crafting legislation that will provide meaningful DVOP and LVER qualification standards, provide the Secretary with the authority and direction to implement the standards, and keep VETS within the Department of Labor.

The National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) honors veterans with final resting places that commemorate their service to our nation. *The Independent Budget* veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families despite funding challenges, aging equipment, and the increasing workload of new cemetery activations.

The NCA currently maintains more than 2.7 million gravesites at 124 national cemeteries in 39 states and Puerto Rico. At the end of 2007, 66 cemeteries will be open to all interments; 16 will accept only cremated remains and family members of those already interred; and 43 will only perform interments of family members in the same gravesite as a previously deceased family member.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the global war on terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 102,000 in 2006 to 117,000 in 2009. It is expected that one in every six of these veterans will request burial in a national cemetery.

NCA ACCOUNT

The Independent Budget recommends an operations budget of **$218 million** for the NCA for fiscal year 2008 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions:

1. to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites;
2. to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application;
3. to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries;
4. to award a presidential certificate and furnish a United States flag to deceased veterans; and
5. to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of the national cemeteries.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget. Volume 2 of the independent study provides a systemwide comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. Headstones and markers must be cleaned, realigned, and set. Stone surfaces of columbaria require cleaning, caulking, and grouting, and the surrounding walkways must be maintained. Grass, shrubbery, and trees in burial areas and other land must receive regular care. Additionally, cemetery infrastructure, i.e., buildings, grounds, walks, and drives must be repaired as needed. According to the study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The IBVSOs were encouraged that the NCA earmarked $28 million for the National Shrine Commitment for fiscal year 2007. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA has responsibility for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries.

The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the nation's commitment to all veterans who have served their country honorably and faithfully.

FY 2008 NATIONAL CEMETERY ADMINISTRATION

(Dollars in Thousands)

FY 2007 Administration Request	$160,733
FY 2007 *IB* Recommendation	$213,982
FY 2008 *IB* Recommendation	
Administrative Services	$168,335
Shrine Initiative	$ 50,000
Total FY 2008 *IB* Recommendation	**$218,335**

RECOMMENDATIONS:

Congress should provide **$218 million** for fiscal year 2008 to offset the higher costs related to increased workload, additional staff needs, general inflation and wage increases, and an enhanced national shrine initiative.

Congress should include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

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The State Cemetery Grants Program:

Heightened interest in the State Cemetery Grant Program (SCGP) results in stronger state participation and complements the National Cemetery Administration (NCA) mission.

The State Cemetery Grants Program (SCGP) complements the NCA mission to establish gravesites for veterans in those areas where the NCA cannot fully respond to the burial needs of veterans. Several incentives are in place to assist states in this effort. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including design, construction, and administration. In addition, new equipment, such as mowers and backhoes, can be provided for new cemeteries. Since 1978, the Department of Veterans Affairs has more than doubled acreage available and accommodated more than a 100 percent increase in burials.

The State Cemetery Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served. The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas not currently served by a national cemetery.

States remain, as before enactment of the Veterans Benefits Improvements Act of 1998, totally responsible for operations and maintenance, including additional equipment needs following the initial federal purchase of equipment. The program allows states in concert with the NCA to plan, design, and construct top-notch, first-class, quality cemeteries to honor veterans.

To help provide reasonable access to burial options for veterans and their eligible family members, *The Independent Budget* recommends $37 million for the SCGP for fiscal year 2008. The availability of this funding will help states establish, expand, and improve state-owned veterans cemeteries.

RECOMMENDATIONS:

Congress should fund the SCGP at a level of $37 million and encourage continued state participation in the program.

Congress should recognize the increased program interest by the states and provide adequate funding to meet planning, design, construction, and equipment expenses.

The NCA should continue to effectively market the SCGP.

Veterans' Burial Benefits:

Veterans' families do not receive adequate funeral benefits.

There has been serious erosion in the value of burial allowance benefits over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a small fraction of what they covered in 1973, when the federal government first started paying burial benefits for our veterans.

In 2001 the plot allowance was increased for the first time in more than 28 years, to $300 from $150, which covers approximately 6 percent of funeral costs. *The Independent Budget* recommends increasing the plot allowance from $300 to $745, an amount proportionally equal to the benefit paid in 1973, and expanding the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

In the 108th Congress, the allowance for service-connected deaths was increased from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. Clearly, it is time this allowance was raised to make a more meaningful contribution to the costs of burial for our veterans. *The Independent Budget* recommends increasing the service-connected benefit from $2,000 to $4,100, bringing it back up to its original proportionate level of burial costs.

The nonservice-connected benefit was last adjusted in 1978, and today it covers just 6 percent of funeral costs. *The Independent Budget* recommends increasing the nonservice-connected benefit from $300 to $1,270.

RECOMMENDATIONS:

Congress should increase the plot allowance from $300 to $745 and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.

Congress should increase the service-connected benefit from $2,000 to $4,100.

Congress should increase the nonservice-connected benefit from $300 to $1,270.

Congress should enact legislation to adjust these burial benefits for inflation annually.

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SOLDIERS RETURNING FROM IRAQ AND AFGHANISTAN: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits

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EXECUTIVE SUMMARY:

This paper analyzes the long-term needs of veterans returning from the Iraq and Afghanistan conflicts, and the budgetary and structural consequences of these needs. The paper uses data from government sources, such as the Veterans Benefit Administration Annual Report. The main conclusions of the analysis are that:

(a) the Veterans Health Administration (VHA) is already overwhelmed by the volume of returning veterans and the seriousness of their healthcare needs, and it will not be able to provide a high quality of care in a timely fashion to the large wave of returning war veterans without greater funding and increased capacity in areas such as psychiatric care;

(b) the Veterans Benefits Administration (VBA) is in need of structural reforms in order to deal with the high volume of pending claims; the current claims process is unable to handle even the current volume and completely inadequate to cope with the high demand of returning war veterans; and

(c) the budgetary costs of providing disability compensation benefits and medical care to the veterans from Iraq and Afghanistan over the course of their lives will be from $350–$700 Billion, depending on the length of deployment of U.S. soldiers, the speed with which they claim disability benefits and the growth rate of benefits and healthcare inflation.

Key recommendations include: increase staffing and funding for veterans medical care particularly for mental health treatment; expand staffing and funding for the "Vet Centers," and restructure the benefits claim process at the Veterans Benefit Administration.

This paper was prepared for the Allied Social Sciences Association Meetings in Chicago, January, 2007. The views expressed here are solely those of the author and do not represent any of the institutions with which she is affiliated, now or in the past.

Introduction

The New Year has brought with it the grim fact that 3,000 American soldiers have been killed so far in Iraq. A statistic that merits equal attention is the unprecedented number of U.S. soldiers who have been injured. As of September 30, 2006, more than 50,500 U.S. soldiers have suffered non-mortal wounds in Iraq, Afghanistan and nearby staging locations—a ratio of 16 wounded servicemen for every fatality.[1] This is by far the highest killed-to-wounded ratio in U.S. history. For example,

[1] Department of Veterans Affairs, Office of Public Affairs, "America's Wars," September 30, 2006. This document shows that the number of non-mortal woundings in the Global War on Terror (combining Iraq, Afghanistan and surrounding duty stations) as of 9/30/06 was 50,508 compared with 2,333 deaths in battle plus 707 other deaths in theater. The comparison numbers for previous conflicts are as follows: Desert Storm/Desert Shield: 1.2 wounded per fatality; Vietnam: 2.6 wounded per fatality; Korea: 2.8 wounded per fatality; World War II: 1.6 wounded per fatality; World War I: 1.8 wounded per fatality; Civil War (union): .7 wounded per fatality; War of 1812: .5 wounded per fatality; American Revolution: .7 wounded per fatality. Note: the VA defines non-mortal wounded as those who are "medically evacuated from theatre." The Pentagon has several definitions, but the daily casualty reports on its website use a narrower definition referring to those wounded by shrapnel, bullets, and so forth. Using this narrow definition, the Iraq conflict has a ratio of 8 wounded per fatality—still much higher than any previous war in U.S. history.

in the Vietnam and Korean wars there were 2.6 and 2.8 injuries per fatality, respectively. World Wars I and II had fewer than 2 wounded servicemen per death.[2]

While it is welcome news and a credit to military medicine that more soldiers are surviving grievous wounds, the existence of so many veterans, with such a high level of injuries, is yet another aspect of this war for which the Pentagon and the Administration failed to plan, prepare and budget. There are significant costs and requirements in caring for our wounded veterans, including medical treatment and long-term healthcare, the payment of disability compensation, pensions and other benefits, reintegration assistance and counseling, and providing the statistical documentation necessary to move veterans seamlessly from the Department of Defense payroll into Department of Veterans Affairs medical care, and to process VA disability claims easily.

To date, 1.4 million U.S. servicemen have been deployed to the Global War on Terror (GWOT), the Pentagon's name for operations in and around Iraq and Afghanistan.[3] The servicemen who have been officially wounded are a small percentage of the veterans who will be using the veteran's administration medical system. Hundreds of thousands of these men and women will be seeking medical care and claiming disability compensation for a wide variety of disabilities that they incurred during their tours of duty.[4] The cost of providing such care and paying disability compensation is a significant long-term entitlement cost that the U.S. will be paying for the next 40 years.[5]

The objective of this paper is to examine the structural and budgetary requirements for caring for the returning war veterans from Iraq and Afghanistan, in terms of U.S. capacity to pay disability compensation, provide high quality medical care, and provide other essential benefits. The paper grew out of a previous paper that was co-authored in January 2005 with Columbia University professor Joseph Stiglitz, in which the overall costs of the war in Iraq were estimated to exceed $2 trillion. One of the long-term costs cited in that paper was the cost associated with providing healthcare and disability benefits to veterans.[6] This paper expands on that topic.

Unlike the previous paper,[7] this study does not differentiate between veterans returning from Iraq, or Afghanistan or adjacent locations (such as Kuwait, an important staging post for Iraq) in the GWOT, for three reasons. First, nearly one-third of the servicemen involved in the war have been deployed two or more times and many of them have served both in Iraq and Afghanistan, and/or other locations.[8] Second, the data available from the VA does not distinguish between the wars in

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[2] Ibid.

[3] As of September 30, 2006, 1,406,281 unique service members have been deployed to the wars in Iraq and Afghanistan, according to the Department of Defense, Defense Manpower Data Center, and "Contingency Tracking System." The Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, November 2006 uses the number 1.4 million (as of November 2006). The Veterans Benefits Administration (VBA) lists 1,324,419 unique servicemen deployed to GWOT as of May 2006 (prepared by VBA/OPA&I, 7/20/06).

[4] Based on an analysis of the first Gulf War in 1991, using the Gulf War Veterans Information System (GWVIS August 2006, chart on "Gulf War Veteran Outpatient Stays"), there were 297,125 veterans from that conflict who used VA medical care, or 48.4%. If the same percentages of Iraq/Afghan veterans use VA medical care then VA should expect approximately 700,000 new patients from the 1.4 million existing servicemen. Increasing the number of unique servicemen deployed will increase medical and disability usage.

[5] Veterans' disability pay is an entitlement program, like Medicare and Social Security. Once a veteran has been approved to receive disability pay, he or she is entitled to receive an annual payment and cost-of-living adjustments. The average age of a servicemen is about 25 years of age, therefore given current life expectancy rates, 40 years is a reasonable amount of years to project payment of benefits, even assuming the veteran does not claim for some years following the period of service.

[6] Bilmes, Linda and Stiglitz, Joseph, *The Economic Costs of the Iraq War: An Appraisal Three Years After the Beginning of the Conflict*, NBER Working Paper 12054 (*http://www.nber.org/papers/w12054*), February 2006. The long-term budgetary costs associated with veterans health and disability cited in that paper ranged from $77bn to $179bn (depending on the length of the war), based on a population of 550,000 unique Iraqi war veterans. After we published this paper, a number of veteran's organizations including the American Legion and Veterans for America, contacted us in appreciation of our highlighting the needs of veterans. Veterans for America has particularly encouraged further research to understand the needs of the returning GWOT veteran's community.

[7] The Bilmes/Stiglitz cost of war paper did not include the costs of Afghanistan or other areas outside of Iraq in the GWOT. Had we included those costs, the total cost of war would have increased by 15–20%.

[8] As of 9/30/06, some 421,206 (30%) of 1,406,281 unique service members had been deployed twice or more to the wars in Iraq and Afghanistan. Army Times, December 11, 2006, page 14, from the Department of Defense, Defense Manpower Data Center, "Contingency Tracking System."

Iraq and Afghanistan. Third, for the purposes of estimating the long-term costs of taking care of the returning veterans it does not matter where they served. However it is worth noting that the overwhelming majority of the deaths and injuries incurred in the GWOT have been in Iraq. Among those listed as wounded on the Pentagon's casualty reports, more than 95% have been injured in Iraq.[9]

This paper will analyze the following aspects of the returning veterans' needs.

1. Disability compensation
   - Projected Cost
   - Backlog of Pending Claims
2. Medical care
   - Capacity issues
   - Projected Cost
   - Veterans Centers
   - Transitioning from the Department of Defense to VA care
3. Overall assessment of U.S. readiness to meet its obligations to veterans
4. Recommendations

Methodology

All statistics used in this paper are from government sources, including publications of the Veterans Benefit Administration (VBA), Veterans Health Administration (VHA), and other VA offices, as well as from the Congressional Budget Office, the Government Accountability Office, the Department of Defense, and Congressional testimony. The numbers are based on the servicemen involved in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, Afghanistan) unless otherwise noted.

The cost and structural requirements for returning veterans will depend on several factors, including the number of U.S. troops stationed in the region and how long they are deployed; the rate of claims and utilization of health resources by returning troops, and the rate of increase in disability payment and healthcare costs over time. The model developed allows the user to vary these assumptions and may be obtained with permission from the author's website. The current analysis has been performed under three "base" scenarios that reflect, broadly the three options now under consideration for the war.

- *Low Scenario*: The low scenario assumes that the U.S. begins withdrawing troops in 2007 and that all U.S. servicemen are home by 2010. This pattern is roughly in parallel with the recommendations of the bipartisan Baker Commission that reported to President Bush in November 2006. This scenario assumes that *we will not deploy any new troops beyond the 1.4 million already participating in the war*. It assumes that 44% of U.S. troops will claim for disability payment over a period of years, with 87% of claims granted, following the same claims pattern as the first Gulf War in 1991.[10] The low scenario assumes that soldiers will initially receive the VA's 2005 average recurring benefit and that the annual rate of increase will be 2.8% to reflect a cost-of-living adjustment only. (As opposed to the actual growth rate over the past 10 years which is 6.1%). The medical usage in this scenario is based on the lowest possible uptake of medical care and a rate of increase that is below the historical rate of healthcare inflation. In short, this scenario shows the absolute basement level—the lowest possible cost of providing medical care and disability benefits to soldiers returning from Iraq and Afghanistan under the most optimistic assumptions.
- *Moderate Scenario*: The moderate scenario is based on the current course of the war. This scenario uses the Congressional Budget Office's expected deployment figures, which would involve a gradual drawdown of troops but maintain a small U.S. force in the region through 2015. Under this scenario, the total unique servicemen involved in the conflict will be 1.7 million, that is, 300,000 additional troops rotated in over the period of years. Nearly 20,000 new troops are regularly deployed into the two war zones each month, before any "surge" or escalation of

[9] As of 12/28/06, the DoD website listed 22,565 wounded in Operation Iraqi Freedom and 1,084 wounded in Operating Enduring Freedom (Afghanistan). As noted previously, this is a narrower definition of injuries than the one used by the Veterans Administration, which lists 50,508 nonmortal woundings as of 9/30/06.

[10] Using the claims patterns from Gulf War I is almost certainly too conservative because that war was much shorter and relied primarily on aerial bombardment, whereas the current wars involve long deployments and ground warfare. However it provides a baseline for the current Iraq/Afghan wars.

the conflict is considered.[11] This scenario uses the first Gulf War as the basis for predicting the level of troops who will claim disability benefits, the rate of approval of the claims, and the utilization of medical resources. However a growth rate of 4.4% is projected for claims benefits, half way between the base cost-of-living adjustment and the actual growth rate of 6.1%.

- *High "Surge" Scenario*: This scenario assumes that troop levels will surge in 2007 and that the total participation in the war over time will eventually reach 2 million unique servicemen by 2016. It also models the potential that half the veterans claim disability payments, which is a reasonable possibility given the ferocity of the conflict and the number of second and third deployments. This model also looks at the impact of growth in claims benefit payments and healthcare costs based on the actual growth rates over the past 10 years. If the U.S. decides to increase troops and all trends on disability and healthcare continue as they have in the past, this model presents the resulting cost consequences.

The costs estimated in this study are budgetary costs to the U.S. government directly associated with the payment of disability benefits and medical treatment for returning OIF/OEF war veterans. The costs do not include the interest payments on the debt that is being incurred in borrowing money to finance the war. Future cash flows were discounted at a rate of 4.75% reflecting current long-term U.S. borrowing rates.

1. *Disability Compensation*

There are 24 million living veterans, of whom roughly 11% receive disability benefits. Overall, in 2005 the U.S. currently paid $23.4 billion in annual disability entitlement pay to veterans from previous wars, including 611,729 from the first Gulf War, 916,220 from Vietnam, 161,512 Korean War veterans, 356,190 World War II veterans and 3 veterans of World War I.[12]

All 1.4 million servicemen deployed in the current war effort are potentially eligible to claim some level of disability compensation from the Veterans Benefits Administration. Disability compensation is a monetary benefit paid to veterans with "service-connected disabilities"—meaning that the disability was the result of an illness, disease or injury incurred or aggravated while the soldier was on active military service. Veterans are not required to seek employment nor are there any other conditions attached to the program. The explicit congressional intent in providing this benefit is "to compensate for a reduction in quality of life due to service-connected disability" and to "provide compensation for average impairment in earnings capacity." The principle dates back to the Bible at Exodus 21:25, which authorizes financial compensation for pain inflicted by another.[13]

Disability compensation is graduated according to the degree of the veteran's disability, on a scale from 0 percent to 100 percent, in increments of 10%. Annual benefits range from a low of $1,304 per year for a veteran with a 10% disability rating to about $44,000 in annual benefits for those who are completely disabled.[14] The average benefit is $8,890 although this varies considerably; Vietnam veterans average about $11,670.[15] Additional benefits and pensions are payable to veterans with severe disabilities. Once deemed eligible, the veteran receives the compensation payment as a mandatory entitlement for the remainder of their lives, like Medicare and Social Security.

There is no statute of limitations on the amount of time a veteran can claim for most disability benefits. The majority of veteran's claims are within the first few years after returning, but some disabilities do not surface until years later. The VA is still handling hundreds of thousands of new claims from Vietnam era veterans for post-traumatic stress disorder and cancers linked to Agent Orange exposure.

The process for ascertaining whether a veteran is suffering from a disability, and determining the percentage level of a veteran's disability, is complicated and lengthy. A veteran must apply to one of the 57 regional offices of the Veterans Benefits Administration (VBA), where a claims adjudicator evaluates the veteran's service-connected impairments and assigns a rating for the degree to which the veteran

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[11] Footnote: Analysis of DMDC's Contingency Tracking System shows 57,462 new first-time deployments between June 2006 and September 2006, an average 19,154 per month.

[12] Ibid, page 33, "Benefits delivery network," RCS 20–0221.

[13] See Veterans Benefits Administration "Annual Benefits Report" (ABR), 2005, page 17 for definition of disability compensation and see VA Disability Compensation Program, *Legislative History*, VA Office of Policy, Planning and Preparedness 2004 for principles behind the program.

[14] Ibid, page 24, lists $1,304 for 10% and $31,611 for 100%, but those with 100% disability also receive additional payments that combined result in an annual payment of approximately $44,000.

[15] Ibid, page 33.

is disabled. For veterans with multiple disabilities, the regional office combines the ratings into a single composite rating. If a veteran disagrees with the regional office's decision he or she can file an appeal to the VA's Board of Veterans Appeals. The Board makes a final decision and can grant or deny benefits or send the case back to the regional office for further evaluation. Typically a veteran applies for disability in more than one category, for example, a mental health condition as well as a skin disorder. In such cases, VBA can decide to approve only part of the claim—which often results in the veteran appealing the decision. If the veteran is still dissatisfied with the Board's decision to grant service connection or the percentage rating, he or she can further appeal it to two even higher levels of decision-makers.[16]

Most employees at VA are themselves veterans, and are predisposed to assisting veterans obtain the maximum amount of benefits to which they are entitled. However, the process itself is long, cumbersome, inefficient and paperwork-intensive. The process for approving claims has been the subject of numerous GAO studies and investigations over the years. Even in 2000, before the current war, GAO identified longstanding problems in the claims processing area. These included large backlogs of pending claims, lengthy processing times for initial claims, high error rates in claims processing, and inconsistency across regional offices.[17] In a 2005 study, GAO found that the time to complete a veteran's claim varied from 99 days at the Salt Lake City regional office to 237 days at the Honolulu, Hawaii office.[18]

The backlog of pending claims has been growing since 1996. In 2000, VBA had a backlog of 69,000 pending initial compensation claims, of which one-third had been pending for more than 6 months.[19] Today, due in part to the surge in claims from the Iraq/Afghan wars, VBA has a backlog of 400,000 claims.[20] VBA now takes an average of 177 days (6 months) to process an original claim, and an average of 657 days (nearly 2 years) to process an appeal.[21] This compares unfavorably with the private sector healthcare/financial services industry, which processes an annual 30 billion claims in an average of 89.5 days per claim, including the time required for claims that are disputed.[22]

Projected Demand for Benefits among OIF/OEF Veterans

It is difficult to predict with certainty the number of veterans from the two current wars who will claim for some amount of disability. The first Gulf War provides a baseline number although the Iraq and Afghanistan war has been longer and has involved more ground warfare than the Desert Storm conflict, which relied largely on aerial bombardment and 4 days of intense ground combat. However, in both conflicts, a number of veterans were exposed to depleted uranium that was used in anti-tank rounds fired by U.S. M1 tanks and U.S. A10 attack aircraft. Many disability claims from the first Gulf War stem from exposure to depleted uranium, which has been implicated in raising the risk of cancers and birth defects. Gulf War veterans also filed disability claims related to exposures to oil well fire pollution, low-levels of chemical warfare agents, experimental anthrax vaccines, and experimental anti-chemical warfare agent pills called pyridostigmine bromide, the anti-malaria pill Lariam, skin diseases, and disorders from living in the hot climate,[23] which are likely to be cited in the current conflict. However, the number of disability claims in the Iraq/Afghan wars is likely to be higher due to the significantly longer length of soldier's deployments, repeat deployments, and heavier exposure to urban combat.

Following the Gulf War the criteria for receiving benefits were widened by Congress based on evidence of widespread toxic exposures.[24] The same criteria for healthcare and benefits eligibility still apply to veterans of the Iraq and Afghanistan

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[16] GAO, "Veterans Benefits Administration: Problems and Challenges Facing Disability Claims Processing," GAO Testimony before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, May 18, 2000.

[17] Ibid.

[18] "Veterans Benefits: Further Changes in VBA's Field Office Structure could help improve disability claims processing," GAO–06–149, December 2005.

[19] Ibid.

[20] The VBA's backlog of pending claims was 399,751 as of December 9, 2006 (VBA Monday Morning Workload Report).

[21] The average time to process a claim is 177 days as of 9/06 and average time to process an appeal is 657 days (VA Performance and Accountability Report FY 2006).

[22] Bearing Point, Health Care/Financial Services industry report, September 14, 2006.

[23] Veterans for America, interview with Paul Sullivan, program director, 11/06.

[24] "Veterans Benefits Improvement Act of 1994" (Public Law 103–446) and "Persian Gulf War Veterans Act of 1998 (P.L. 105–277).

wars.[25] Forty-four percent of those veterans filed disability claims for a variety of conditions and 87% were approved.[26] The U.S. currently pays about $4 billion annually in disability payments to veterans of Desert Storm/Desert Shield.[27]

Of the 1.4 million U.S. servicemen who have so far been deployed in the Iraq/Afghan conflicts, 631,174 have been discharged as of September 30, 2006. Of those 46% are in the full-time military and 54% are reservists and National Guardsmen.[28] Therefore the total population that is potentially eligible for disability benefits is this number (631,174). To date 152,669 servicemen have applied for disability benefits and of those, 104,819 have been granted, 34,405 are pending and 13,445 have been rejected. This implies an approval rate of 88% to date.[29]

We have estimated the cost of providing disability benefits to veterans under three scenarios. Under the low scenario, we expect that as in the first Gulf War, 44% of the current veterans will eventually claim disability, with an approval rate of 87%. We estimate that the remaining 900,000 troops will be discharged in equal installments over the next 4 years bringing all U.S. troops home by 2010. We expect the same percentage of these troops to claim for disabilities, with the same approval rate, within a further 5 years. We have assumed that on average, claims are lower than average rate, at the lower rate of new claimants from the first Gulf War of $6,506.[30] This is probably an excessively conservative assumption because it projects the same rate of serious injuries as occurred in Gulf War I, when in fact we already know that more than the actual rate of serious injuries is much higher.[31]

The moderate scenario assumes that the war continues through 2014 with a total deployment of 1.7 million over the course of the war, and with gradually reduced deployment. It assumes that a slightly higher percentage of eligible veterans (50%) make claims, which is more realistic given deployment lengths. This scenario uses the actual average VA benefit payment of $8,890. It assumes the rate of increase in benefits is 4.4%, midway between the mandatory Cost of Living Adjustment and the actual 10-year growth rate of 6.1%. The high scenario models the impact of a surge in forces bringing the total unique deployments to 2 million. It assumes 50% of eligible forces claim benefits and a rate of 6.1% increase, which is the actual rate over the past 10 years. It further assumes a higher rate of medical inflation (10% vs. 8% in the low and moderate scenarios).

Table 1: Long-term Cost of Veterans Disability Benefits[32]

Scenario	Low	Moderate	High
Disability Benefits ($bn)	67.63	109.98	126.76

Backlog of Pending Disability Claims

The issue is not simply cost but also efficiency in providing disabled veterans with their benefits. In addition to all the problems detailed above, the Iraq and Afghan war veterans are filing claims of unusually high complexity (see table 3). To date, the backlog of pending claims from these recent war veterans is 34,000, but the vast majority of servicemen from this conflict have not yet filed their claims. Even without the projected wave of claims, the VA has an overall backlog of 400,000, including thousands of Vietnam era claims. Including all pending claims and other paper-

[25] In fact, the VA does not distinguish, for the purpose of claims processing, between the end of the first Gulf War and the present conflict (38 USC section 101(33) defines the Gulf War as starting on August 2, 1990, and continuing until either the President or the Congress declares an end to it and 38 CFR 3.317 defines the locations of the conflict).

[26] For Gulf War, the total claims filed to date are 271,192, of which 205,911 have been approved, 20,382 were denied and 34,899 are still pending (GWVIS, August 2006, p. 7: Granted Service Connection + Denied Service Connection + Claims Pending).

[27] Gulf War total annual payment $4.3 billion (Ibid., VBA, ABR 2005 pp. 33).

[28] VHA, Office of Public Health and Environmental Hazards, November 2006.

[29] VBA "Compensation and Benefit Activity among Veterans Deployed to the GWOT," July 20, 2006, obtained under Freedom of Information Act by the National Security Archive at George Washington University.

[30] Ibid, ABR 2005, p. 33.

[31] Of the 50,508 non-mortally wounded soldiers in OIF/OEF there are at least 10,000 serious injuries such as brain injuries, spinal and amputations, according to DoD sources. See also Wallsten and Kosec, AEI–Brookings Working Paper 05–19, September 2005, estimate of 20% serious brain injuries, 6% amputees and 24% other serious injuries.

[32] The figures in Table 1 represent the present value of disability benefits over 40 years for eligible veterans projected under the three scenarios described.

work, the VA's backlog has increased from 465,623 in 2004 to 525,270 in 2005 to 604,380 in 2006.[33]

The fact that the VBA is largely sympathetic to the plight of disabled veterans should not obscure the fact that this system is already under tremendous strain. If only one-fifth of the returning veterans who are eligible claim in a given year, and the total claims reaches a high of 38% effective rate (44%–88% approval rate), the number of likely claims at the VBA over the next 10 years can be expected to rise from 104,819 to more than 600,000.[34] (See table 2).

Table 2: Projected Increase in Disability Claims (moderate scenario)

Disability Benefits	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Discharged		118,758	118,758	118,758	118,758	118,758	118,758
cum		*118,758*	*237,517*	*356,275*	*475,034*	*593,792*	*712,551*
Eligible claimants							
Existing discharged non-claimants	526,355	526,355	526,355	526,355	526,355	526,355	526,355
Newly discharged	—	118,758	237,517	356,275	475,034	593,792	712,551
Total potential claimants		645,113	763,872	882,630	1,001,389	1,120,147	1,238,906
Claim rate	22%	22%	27%	33%	38%	44%	44%
New claims	—	140,312	207,678	287,958	381,154	487,264	538,924
Current beneficiaries	104,819	104,819	104,819	104,819	104,819	104,819	104,819
Total claims (number)	104,819	245,131	312,497	392,777	485,973	592,083	643,743
Total claims ($bn)	**0.93**	**2.27**	**2.89**	**3.63**	**4.49**	**5.47**	**5.95**

If nothing is done to address the problem, the claims backlog will continue to grow throughout the period of the war, along with growing inequity between different regional offices. A key question is: what is a reasonable amount of time for the U.S. to make a disabled veteran wait for a disability check? This paper proposes several actions that could reduce the length of time for processing from zero to 90 days. (Described in more detail in section 4: Recommendations). These include: (a) greater use of the "Vet Centers" to provide assistance for veterans to file their claims, (b) automatically granting all or some of the claims, with subsequent audits to deter fraud, and (c) streamlining and technologically upgrading the claims system into a "fast track" where veterans receive a quick decision on most claims.

2. *Veterans Medical Care Shortfall*

The VA's Veterans Health Administration provides medical care to more than 5 million veterans each year. This care includes primary and secondary care, as well as dental, eye and mental healthcare, hospital inpatient and outpatient services. The care is free to all returning veterans for the first 2 years after they return from active duty; thereafter the VA imposes co-payments for various services, with the amounts related to the level of disability of the veteran.[35]

The VA has long prided itself on the excellence of care that it provides to veterans. In particular, VA hospitals and clinics are known to perform a heroic job in areas such as rehabilitation. Medical staff is experienced in working with veterans and provides a sympathetic and supportive environment for those who are disabled. It is therefore of utmost importance that the quality of care be maintained as the demand for it goes up.

However, the demand for VA medical treatment is far exceeding what the VA had anticipated. This has produced long waiting lists and in some cases simply the absence of care. To date, 205,097, or 32% of the 631,174 eligible discharged OEF/OIF veterans have sought treatment at VA health facilities. These include 35% of the eligible active duty servicemen (101,260) and 31% of the eligible Reservists/Guards (103,837). To date, this number represents only 4% of the total patient visits at VA facilities—but it will grow. According to the VA, "As in other cohorts of military veterans, the percentage of OIF/OEF veterans receiving medical care from the VA and the percentage of veterans with any type of diagnosis will tend to increase over time as these veterans continue to enroll for VA healthcare and to develop new health problems."[36]

The war in Iraq has been noteworthy for the types of injuries sustained by the soldiers. Some 20% have suffered brain trauma, spinal injuries or amputations; an-

[33] VBA's "Monday Morning Report" of pending claims and other work performed at regional offices, cites: 11/25/06: 604,380; 11/26/05: 525,270; 11/27/04: 465,623.

[34] This projection based on the moderate scenario described previously, based on 1.7 million unique servicemen and CBO troop deployment figures through 2014.

[35] 38 USC section 1710.

[36] VHA, Office of Public Health and Environmental Hazards, November 2006, Ibid, p. 14.

other 20% have suffered other major injuries such as amputations, blindness, partial blindness or deafness, and serious burns.

However, the largest unmet need is in the area of mental healthcare. The strain of extended deployments, the stop-loss policy, stressful ground warfare and uncertainty regarding discharge and leave has taken an especially high toll on soldiers. Thirty-six percent of the veterans treated so far—an unprecedented number—have been diagnosed with a mental health condition. These include PTSD, acute depression, substance abuse and other conditions. According to Paul Sullivan, a leading veterans advocate, "The signature wounds from the wars will be (1) traumatic brain injury, (2) post-traumatic stress disorder, (3) amputations and (4) spinal chord injuries, and PTSD will be the most controversial and most expensive."[37] (See Table 3.)

Table 3: VHA Office of Public Health, November 2006

Frequency of Possible Diagnoses Among Recent Iraq and Afghan Veterans		
	(n = 205,097)	
Diagnosis (Broad ICD–9 Categories)	**Frequency***	**%**
Infectious and Parasitic Diseases (001–139)	21,362	10.4
Malignant Neoplasms (140–208)	1,584	0.8
Benign Neoplasms (210–239)	6,571	3.2
Diseases of Endocrine/Nutritional/Metabolic Systems (240–279)	36,409	17.8
Diseases of Blood and Blood Forming Organs (280–289)	3,591	1.8
Mental Disorders (290–319)	73,157	35.7
Diseases of Nervous System/Sense Organs (320–389)	61,524	30.0
Diseases of Circulatory System (390–459)	29,249	14.3
Disease of Respiratory System (460–519)	36,190	17.6
Disease of Digestive System (520–579)	63,002	30.7
Diseases of Genitourinary System (580–629)	18,886	9.2
Diseases of Skin (680–709)	29,010	14.1
Diseases of Musculoskeletal System/Connective System (710–739)	87,590	42.7
Symptoms, Signs and Ill Defined Conditions (780–799)	67,743	33.0
Injury/Poisonings (800–999)	35,765	17.4

*Hospitalizations and outpatient visits as of 9/30/2006; veterans can have multiple diagnoses with each healthcare encounter.

A veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 205,097.

Additionally, far more returning Iraqi war veterans (than those in previous conflicts) are likely to seek such help, in part due to awareness campaigns run by veteran's organizations through the press. There is no reliable data on the length of waiting lists for returning veterans, but even the VA concedes that they are so long as to effectively deny treatment to a number of veterans. In the May 2006 edition of Psychiatric News, Frances Murphy, M.D., the Under Secretary for Health Policy Coordination at VA, said that mental health and substance abuse care are simply not accessible at some VA facilities. When the services are available, Dr. Murphy asserted that, "waiting lists render that care virtually inaccessible."[38]

The VA curiously maintains that it can cope with the surge in demand, despite much evidence to the contrary. For the past 2 years, the VA ran out of money to provide healthcare. In FY 2006, the VA was obliged to submit an emergency supplemental budget request for $2 billion, which included $677 million to cover an unexpected 2% increase in the number of patients (half of which were OIF/OEF patients), $600 million to correct its inaccurate estimate of long-term care costs, and $400 million to cover an unexpected 1.2% increase in the costs per patient due to medical inflation. The previous year, (FY 2005), VA requested an additional $1 billion, of which one-quarter was for unexpected OIF/OEF needs and remainder was related to overall under-estimation of patient costs, workload, waiting lists, and dependent care. The GAO analysis of these shortfalls concluded that they were due to the fact that VA was modeling its projections based on 2002 data, before the war in Iraq began.[39]

The budget shortfalls and the statement by Dr. Murphy suggest that the volume of veterans returning from Iraq and Afghanistan will not be able to obtain the healthcare they need, particularly for mental health conditions. Such veterans are at high risk for unemployment, homelessness, family violence, crime, alcoholism,

[37] Paul Sullivan, Program Director of Veterans for America, 12/23/06 interview.
[38] Frances Murphy, May 2006, *Psychiatric News*.
[39] GAO–06–430R, "VA Health Care Budget Formulation," pp. 18–20.

and drug abuse, all of which impose an additional human and financial burden on the nation. In addition, many of these social services are provided by state and local governments which are already under tremendous strain.

Projected Medical Costs

The number of veterans who will eventually require treatment can be estimated using a baseline of the utilization during the first Gulf War, in which the VA is providing medical care to 48% of veterans. The average annual cost of treating veterans in the system is now $5,000,[40] although it is difficult to know whether the more grievous injuries and disabilities of the current conflict will drive up costs per patient.

The costs of providing medical care have been calculated under the three scenarios. Under the low scenario, under which the U.S. will deploy no new troops, the ceiling for medical care is 48% of OIF/OEF veterans. If half of all veterans eventually seek medical treatment from the VA that will produce a demand of some 700,000 veterans. However, due to the fact that veterans are eligible for free care during the first 2 years after discharge, we can expect a wave of returning war veterans within 2 years of their discharge date. Additionally, since active duty veterans claim medical care at a higher rate (than Guards/Reservists) and have been deployed in more of the most hazardous front-line task come home, we can expect that the average cost of treating such veterans increases as well as a high level of demand.[41]

If the demand for medical care increases as projected to some 700,000 or more veterans, there is a serious risk that the VA, which is already overwhelmed, will be unable to meet the medical needs of returning OIF/OEF veterans. Additional staff is needed in important areas such as brain trauma units and mental health. The VA also needs to expand systems such as triage nursing, to help leverage scarce medical resources.

Even assuming that no more troops are deployed, the long-term cost of treating returning veterans will reach $208 billion. This however assumes that the supply of healthcare exists to treat them. If the number of troops continues to grow as in the moderate then cost of providing lifetime care rises to $315 billion. The annual budget payment under this scenario will reach $3bn by 2010 and more than double by 2014. (See Table 4.)

Table 4: Projected Cost of Providing VA Medical Care (moderate scenario)[42]

MEDICAL COSTS	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total Discharged	631,174	749,932	868,691	987,449	1,106,208	1,224,966	1,343,725	1,462,483	1,581,242
% OIF/OEF veterans seeking care	32.50%	33.96%	35.49%	37.09%	38.76%	40.50%	42.32%	44.23%	46.22%
Total OIF/OEF veterans seeking care	205,132	254,696	308,305	366,224	428,731	496,123	568,711	646,827	730,822
Cost/medical claim	$ 5,000	$ 5,400	$ 5,832	$ 6,299	$ 6,802	$ 7,347	$ 7,934	$ 8,569	$ 9,255
Total cost ($bn)	1.0	1.4	1.8	2.3	2.9	3.6	4.5	5.5	6.8
NPV	**$315.23**								

However, these scenarios are conservative in assuming that only half of the returning veterans will eventually seek medical treatment from the VA and that the level of healthcare inflation will remain constant at 8%. Under a worst-case scenario, if troops levels rise to 2 million and if health inflation rises to the double-digit levels experienced during the 1990s, we can expect the total cost of providing lifetime medical care to veterans to reach $600bn.[43]

Veterans Centers

How can the VA possibly handle the number of returning troops who require care, as well as their families, especially for mental health conditions? Perhaps the most creative and successful innovation in the VA in the past two decades has been the introduction of the "Vet Centers"—207 walk-in storefront centers where veterans or their families can obtain counseling and reintegration assistance. The centers, operated by VA's "Readjustment Counseling Service" are popular with veterans and their families and—at a total cost of some $100m per year—provide a highly cost-

[40] This amount is calculated by estimating the budget 2006 supplemental budget request for OIF/OEF veterans per additional patient, using the GAO analysis in GAO–06–430R.

[41] VHA, Office of Public Health and Environmental Hazards, Ibid.

[42] The NPV is calculated over 40 years, at a discount rate of 4.75%, with a peak rate of 50% veterans claiming care by 2016.

[43] High scenario assuming 10% medical inflation rate.

effective option for veterans who are not in need of acute medical care. The Vet Centers are particularly helpful for families, for example they provide a venue for a soldier's spouse to seek guidance if the veteran is showing mental distress but will not seek help. They also supply bereavement counseling to surviving families of those killed during military service. And they offer a friendlier environment often staffed with recent OEF/OIF combat veterans and other war veterans—unlike VA regional offices which tend to be stuffy, bureaucratic offices located in downtown locations.[44]

To date, 144,000 veterans have sought assistance at these centers.[45] However the demand for their services is threatening their ability to provide care. Vet Center managers recently surveyed by Congress said that in 50% of the Centers, the increasing workload is affecting their ability to treat veterans. Some 40% of the Vet Centers have directed veterans for whom individualized therapy would be appropriate into group therapy, and more than one-quarter of the Centers have limited or plan to limit family therapy. Nearly 17% have established waiting lists (or are in the process of setting them up).[46]

Currently the centers do not assist veterans in filing disability claims, but provided that the facility had sufficient secure storage space to handle such documents, there is no reason why they could not. The VA has recommended hiring an additional 1,000 claims adjudicators—who could be placed in the Vet Centers (an average of 5 each) to help veterans figure out how to claim. The cost of expanding the number of centers, hiring additional staff and placing more claims adjudicators in the centers is minimal.

Transition from DoD Payroll to VA Care

One of the chief bottlenecks in the current system is the soldier's transition from the DoD payroll into the VA benefit system. There are three primary ways that a soldier makes this transition.

A veteran who is discharged regularly, and has some level of disability will typically have to wait 6 months before receiving his or her disability check from the VA. This is a period during which the veterans, particularly those in a state of mental distress, are most at risk for serious problems, including suicide, falling into substance abuse, divorce, losing their job, or becoming homeless.

A second route is to exit via the "Benefits Delivery at Discharge" (BDD) program. This successful program allows soldiers to process their claims up to 6 months prior to discharge, so they can begin receiving benefits as soon as they leave the military. However, the use of this route has become much more difficult due to the extended deployments, the use of "stop-loss" orders, and the resulting unpredictability about when a soldier will be discharged. Additionally, this program is not available to Reservists and Guardsmen, who comprise 40% of the forces in Iraq and Afghanistan. The VBA claim denial rate is twice as high for Reserve and Guard veterans, possibly due in part to their lack of access to BDD.[47] Consequently the usage of this apparently better route has not been increasing as would have been expected.[48]

For veterans who are more seriously wounded, the process is more complicated as they transition from medical facilities run by DoD into medical facilities run by the VA. For example a wounded veteran may be treated initially at Walter Reed Army Hospital and then transferred to a VA facility. Veterans experience some difficulties in securing the maximum amount of disability benefits at discharge during such transitions, due to a lack of compatibility between the DoD and VA paperwork and tracking systems. The VA complains that the records they receive from DoD are delayed or contain errors, in many cases it is the situation where the data that is tracked is not compatible. This not only creates unnecessary problems in moving veterans through the system but it also makes it more difficult for the data to be analyzed in medical and other studies.

Additionally there are the problems caused by the Pentagon's poor accounting system. GAO investigators have found that DoD pursued hundreds of battle-injured soldiers for payment of non-existent military debts—because DoD financial systems erroneously reported that they were indebted. For example, one Army Reserve Staff Sergeant, who lost his right leg below the knee, was forced to spend 18 months disputing an erroneously recorded debt of $2,231 which prevented him from obtaining

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[44] Opinion based on conversations with veterans organizations.

[45] Vet Center costs document, page 3B–11.

[46] October 2006 report issued by the House Veterans Affairs Committee, testimony by Vet Center managers.

[47] Active Duty denial rate is 7.6 percent compared with National Guard and Reserve denial rate of 17.8 percent. See Footnote 28.

[48] Congressional testimony of Jack McCoy, VBA, March 16, 2006, http://www.va.gov/OCA/testimony/hvac/sdama/060316JM.asp and a VA fact sheet indicate 26,000 BDD claims in 2003, 39,000 in 2004, and 46,000 in 2005. http://www1.va.gov/opa/fact/tranasst.asp.

a mortgage to purchase a home. Another staff sergeant who suffered massive brain damage and PTSD had his pay stopped and utilities turned off because the military erroneously recorded a debt of $12,000. Hundreds of injured soldiers may be in this situation.[49]

Overall Assessment and Cost

Overall the U.S. is not adequately prepared for the influx of returning servicemen from Iraq and Afghanistan. There are three major areas in which it is not prepared: claims processing capacity for disability benefits; medical treatment capacity, in terms of the number of healthcare personnel available at clinics throughout the country, particularly in mental health; and third, there is no preparation for paying the cost of another major entitlement program.

As discussed earlier, the backlog in claims benefit is already somewhere between 400,000 and 600,000. Unless major changes are made to this process, the number of claims pending and requiring attention will reach some 750,000 within the next 2 years and the pendency period will increase proportionately, resulting in more veterans falling though the cracks that could have been avoided. In addition, veterans whose claims reach different centers in different parts of the country will have widely different experiences, proving highly unfair to those who just happen to be located in areas of greater backlog.

The quality of medical care is likely to continue to be high for veterans with serious injuries treated in VA's new polytrauma centers. However, the current supply of care makes it unlikely that all facilities can offer veterans a high quality of care in a timely fashion. Veterans with mental health conditions are most likely to be at risk because of the lack of manpower and the inability of those scheduling appointments to distinguish between higher and lower risk conditions. If the current trends continue, the VA is likely to see demand for healthcare rising to 750,000 veterans in the next few years, which will overwhelm the system in terms of scheduling, diagnostic testing, and visiting specialists, especially in some regions.[50]

The cost of providing disability benefits and medical care, even under the most optimistic scenario that no additional troops are deployed and the claims pattern is only that of the previous Gulf War, would suggest that at a minimum the cost of providing lifetime disability benefits and medical care is $350 billion. If the number of unique troops increases by another 200,000 to 500,000 over a period of years, this number may rise to as high as nearly $700bn. (See Table 5.) The funding needs for veterans' benefits thus comprise an additional major entitlement program along with Medicare and Social Security that will need to be financed through borrowing if the U.S. remains in deficit. This will in turn place further pressure on all discretionary spending including that for additional veterans' medical care.

Table 5: Total Veterans Disability and Medical Costs[51]

	LOW	MODERATE	HIGH
Disability	67.6	109.5	126.8
Medical	282.2	315.2	536.0
TOTAL ($Bn)	349.8	424.7	662.8

In the Context of the Overall Costs of the War

Veteran's disability benefits and medical care are two of the most significant long-term costs of the war. As shown in our previous analysis of the costs of the war, the war has both budgetary and economic costs. This paper focuses only on the budgetary costs of caring for veterans. It does not take into account the value of lives lost, or effectively lost due to grievous injury. Nor does it take into account the economic impact of the large number of veterans living with disabilities who cannot engage in full economic activities.[52]

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[49] GAO–06–494, "Hundreds of Battle-Injured GWOT Soldiers Have Struggled to Resolve Military Debts."

[50] However, the availability of medical care may vary significantly by region.

[51] Total lifetime costs over 40 years, discounted at 4.75% under scenarios described.

[52] This paper considers only the budgetary costs of veterans care. Standard economic theory would treat disability benefits as a transfer payment and deduct these from the economic and social loss associated with veteran's reduced economic lives. This was the methodology used in (stiglitz paper).

Recommendations

(a) Medical Care

The Veterans Health Administration will not be able to sustain its high quality of care without greater funding and increased capacity in areas such as psychiatric care and brain trauma units. In addition, more funding should be provided for readjustment counseling services by social workers at the Vet Centers. Even doubling the amount of funding for counseling at the Vet Centers is a small amount compared to the funds now being requested for additional recruiting of new soldiers.

(b) Disability Claims Backlog

There are at least three potential methods of reducing the number of pending claims. Perhaps the easiest would be to "fast track" returning Iraq and Afghan war veteran's claims in a single center staffed with a highly experienced group of adjudicators who could provide most veterans with a decision within 90 days. At a minimum, all simple claims could be dispatched in this manner. During the past decade, private sector health insurance companies have reengineered their processes and adopted technologies, such as new automated data capture and document processing systems that have dramatically improved their ability to handle large volumes of information. This has allowed the industry to bring the average claim processing time down to 89.5 days. For example, the firm Noridian used technology to enable operators to process four to five times more claims in the same amount of time as under their old system, and to speed the form retrieval process for better customer service.[53]

The VA has proposed a more typically governmental solution of adding 1,000 more claims adjudicators. Even apart from the cost of $80m or so of adding these personnel, the question is whether adding additional personnel to a cumbersome system is the best possible way to speed up transactions and improve service. A better idea would be to expand the Vet Centers to offer some assistance in helping veterans figure out their disability claims. The 1,000 claims experts could be placed inside the Vet Centers (5 per center), thus enabling veterans and their families to obtain quick assistance for many routine claims. Vet Centers would only require minor modifications (secure storage space, additional computers and offices) to fill this role.

The best solution might be to simplify the process—by adopting something closer to the way the IRS deals with tax returns. The VBA could simply approve all veterans' claims as they are filed—at least to a certain minimum level—and then audit a sample of them to weed out and deter fraudulent claims. At present, nearly 90 percent of claims are approved. VBA claims specialists could then be redeployed to assist veterans in making claims, especially at VA's "Vet Centers." This startlingly easy switch would ensure that the U.S. no longer leaves disabled veterans to fend for themselves.

The cost of any solution that reduced the backlog of claims is likely to be an increased number of claims, and a quicker pay-out. If 88% of claims were paid within 90 days instead of the 6 months to 2 years currently required, the additional budgetary cost is likely to be in the range of $500m in 2007.

Conclusions

President Bush is now asking for more money to spend on recruiting in order to boost the size of the Army and deploy more troops to Iraq. But what about taking care of those same soldiers when they return home as veterans? The number of veterans who are returning home with injuries or disabilities is large and growing. We have not paid careful enough attention, or devoted sufficient resources, to planning for how to take care of these men and women who have served the nation.

There has been a tendency in the media to focus on the number of U.S. deaths in Iraq, rather than the volume of wounded, injured, or sick. This may have led the public to underestimate the deadliness and long-term impact of the war on civilian society and the government's pocketbook. Were it not for modern medical advances and better body armor, we would have suffered even more loss of life.

One of the first votes facing the new Democratic-controlled Congress will be yet another "supplemental" budget request for $100+ billion to keep the war going. The last Congress approved a dozen such requests with barely a peep, afraid of "not supporting our troops." If the new Congress really wants to support our troops, it should start by spending a few more pennies on the ones who have already fought and come home.

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[53] KM World, June 1999.

Limitations of Data

This paper has been prepared based on the best available data from VA sources, CBO, GAO, and veterans organizations. Reconciling this data has therefore been done to try to generate realistic estimates, but is not precise. It is also difficult to predict with certainty the uptake in the military of benefits and medical care. In all cases this study has been done conservatively, for example it is entirely possible that after the length and grueling nature of this war, that a much higher number—perhaps ⅔ of returning veterans—would seek disability benefits and/or healthcare and the estimates in this paper prove too low.

Issues Not Addressed

This paper has not attempted to address the cost of taking care of wounded and disabled Iraqi soldiers in Iraq. A number of studies have estimated the fatalities in Iraq, but there are few studies of the number of injuries among the Iraqi military. As the U.S. continues to place an emphasis on developing the Iraqi military to replace it, it is worth asking what the cost to that country will be of providing medical care and any kind of long-term benefits to those who are fighting. This study excludes VBA benefits such as education, insurance, vocational rehabilitation, and home loan guaranty programs. This study also excludes private, state, and local healthcare, disability, and employment benefits for returning veterans.

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