

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

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS

FIRST SESSION

FEBRUARY 14, 2007

Serial No. 110-2

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

34-304

WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida	STEVE BUYER, Indiana, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
MICHAEL H. MICHAUD, Maine	DAN BURTON, Indiana
STEPHANIE HERSETH, South Dakota	JERRY MORAN, Kansas
HARRY E. MITCHELL, Arizona	RICHARD H. BAKER, Louisiana
JOHN J. HALL, New York	HENRY E. BROWN, JR., South Carolina
PHIL HARE, Illinois	JEFF MILLER, Florida
MICHAEL F. DOYLE, Pennsylvania	JOHN BOOZMAN, Arkansas
SHELLEY BERKLEY, Nevada	GINNY BROWN-WAITE, Florida
JOHN T. SALAZAR, Colorado	MICHAEL R. TURNER, Ohio
CIRO D. RODRIGUEZ, Texas	BRIAN P. BILBRAY, California
JOE DONNELLY, Indiana	DOUG LAMBORN, Colorado
JERRY McNERNEY, California	GUS M. BILIRAKIS, Florida
ZACHARY T. SPACE, Ohio	
TIMOTHY J. WALZ, Minnesota	

Malcom A. Shorter, *Staff Director*

SUBCOMMITTEE ON HEALTH

MICHAEL H. MICHAUD, Maine, *Chairman*

CORRINE BROWN, Florida	JEFF MILLER, Florida, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
PHIL HARE, Illinois	JERRY MORAN, Kansas
MICHAEL F. DOYLE, Pennsylvania	RICHARD H. BAKER, Louisiana
SHELLEY BERKLEY, Nevada	HENRY E. BROWN, JR., South Carolina
JOHN T. SALAZAR, Colorado	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

February 14, 2007

	Page	
The U.S. Department of Veterans Affairs Fiscal Year 2008 Health Budget	1	
OPENING STATEMENTS		
Hon. Michael H. Michaud, Chairman	1	
Prepared statement of Chairman Michael H. Michaud	32	
Hon. Jeff Miller, Ranking Republican Member	2	
Prepared statement of Congressman Miller	32	
Hon. Henry E. Brown, Jr., prepared statement of	33	
Hon. John T. Salazar, prepared statement of	34	
WITNESSES		
U.S. Department of Veterans Affairs, Michael J. Kussman, M.D., M.S., MACP, Acting Under Secretary for Health, Veterans Health Administra- tion	3	
Prepared statement of Dr. Kussman	34	
AMERICAN PSYCHIATRIC ASSOCIATION, JOSEPH T. ENGLISH, M.D., MEMBER, BOARD OF TRUSTEES, CHAIRMAN OF PSYCHIATRY, ST. VINCENT'S CATHOLIC MEDICAL CENTERS OF NEW YORK, PROFESSOR AND CHAIRMAN OF PSYCHIATRY, NEW YORK MEDICAL COLLEGE, AND COMMISSIONER, JOINT COMMISSION ON ACCREDITATION OF HEALTH- CARE ORGANIZATIONS		17
Prepared statement of Dr. English	40	
Friends of VA Medical Care and Health Research (FOVA), Gary Ewart, Director, Government Relations, American Thoracic Society	20	
Prepared statement of Mr. Ewart	45	
Iraq and Afghanistan Veterans of America, Patrick Campbell, Legislative Director	22	
Prepared statement of Mr. Campbell	49	
SUBMISSIONS FOR THE RECORD		
American Federation of Government Employees, AFL-CIO, statement	50	
American Legion, Shannon Middleton, statement	52	
American Veterans (AMVETS), David G. Greineder, statement	58	
Hon. Corrine Brown, a Representative in Congress from the State of Florida, statement	60	
Paralyzed Veterans of America, statement	60	
Hon. Cliff Stearns, a Representative in Congress from the State of Florida, statement	63	
Vietnam Veterans of America, John Rowan, Patricia Bessigano, and Thomas J. Berger, joint statement	63	
MATERIAL SUBMITTED FOR THE RECORD		
Post-Hearing Questions and Responses for the Record:		
Written questions for the record submitted to the VA follow:		
Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary for Health, Veterans Health Administration, letter dated March 7, 2007	74	
Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary for Health, Veterans Health Administration, letter dated February 28, 2007	82	
Hon. Henry E. Brown, Jr., attachment to Hon. Jeff Miller letter to Dr. Michael Kussman, dated February 28, 2007	87	

**THE U.S. DEPARTMENT OF VETERANS AFFAIRS
FISCAL YEAR 2008 HEALTH BUDGET**

THURSDAY, FEBRUARY 14, 2007

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

The Subcommittee met, pursuant to notice, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

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

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. We will begin this hearing. First of all this afternoon we would like to thank everyone for braving the little dusting of snow that we received last night and this morning to come here today. This is a very important issue.

This will be the first of many hearings in the 110th Congress for the Veterans' Affairs Health Subcommittee. I would like to welcome my Ranking Member, Congressman Jeff Miller of Florida, and say that I look forward to working with you in a bipartisan manner as we deal with Veterans Affairs issues over the next couple of years. We have a lot on our plate, and I know that by working together, we will be able to accomplish a great deal this year.

I would also like to welcome our first panel of witnesses; Dr. Michael Kussman, who is the acting Under Secretary for Health. He is accompanied by Joel Kupersmith, who is the Chief Research and Development Officer, as well as Dr. Katz, who is the Deputy Chief PCS Officer for Mental Health, and Mr. Paul Kearns, who is the Chief Financial Officer.

The Veterans Health Administration is responsible for the health and well-being of our nation's veterans. There are no other agencies in government that will affect our veterans more than this agency. We have an aging veterans population. We also have a new generation entering the system, with unique needs like mental health, traumatic brain injury, and others from service in Iraq and Afghanistan.

We are here today to learn if this budget can meet all these needs. The request is an increase of 6 percent over the last year's funding. We have heard from the Independent Budget group and from other veterans service organizations that more money is needed for veterans. This request includes increases in fees, and copay-

ments as well. It also includes a cut in medical and prosthetic research that we will have to address.

That being said, I believe that this request is a good starting point for us, and I think we can move forward to create a budget that we all can consider a success. And let me be clear. I do not measure success by the dollars spent or dollars saved; I measure the success in the number of veterans receiving the highest possible quality care in a timely manner. We look forward to hearing your testimony today, and having a frank discussion about meeting the needs of our veterans.

[The statement of Mr. Michaud appears on pg. 32.]

Mr. MICHAUD. And with that, I would like to turn to Ranking Member Miller, if you have an opening statement.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I have an opening statement that I would like to submit for the record. It is lengthy, but I do want to bring a couple things to the Committee's attention.

First, congratulations on becoming the Chairman of the Subcommittee. I know that we will work together in a true form of bipartisanship. The only thing that would sound better would be if it was Chairman Miller.

[Laughter.]

We have already begun the dialogue, and I look forward to many good working times with you.

Today we are on the floor debating a very important resolution, for those that support it and those that oppose it, but we also meet today to discuss some very important issues here that we need to talk about. I am pleased to say that the Administration proposes this year a record \$36.6 billion for VA healthcare for fiscal year 2008. This is the largest amount that any Administration has ever requested, and it is a 6 percent increase over the request for fiscal year 2007.

Last year, this Committee uncovered weaknesses in the process that VA was using to develop its healthcare budget. This year's budget submission doesn't assume savings from management efficiencies that the U.S. Government Accountability Office (GAO) recently reported, did not materialize last year.

The Administration requests \$3 billion for mental health service, including \$360 million to continue implementation of mental health initiatives that began in 2005 to address deficiencies and gaps in services. While this amount is substantial, last September, GAO reported that the VA had not used all its mental health funds that were allocated in 2005. I believe, as I am sure the Chairman does, that we must have a better handle on how much, and in what way the VA is spending its resources to meet the emerging demand for mental health services, especially post-traumatic stress disorder (PTSD).

VA must plan for and fund those programs that have been identified as particularly relevant to the needs and requirements of our soldiers.

Three years ago, the Capital Asset Realignment for Enhanced Services (CARES) Commission identified, and if I may, a point of

personal privilege in my statement, the Florida Panhandle as underserved for inpatient care. In fact, it is the only market in VISN 16 without a medical center. The absence of a VA inpatient facility continues to be one of the biggest concerns to the over 100,000 veterans who live in my congressional district. Currently, many of these veterans have to travel to Mississippi for inpatient care. Bringing a full-service facility to the first district is something that we have been looking at for a long time, and 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, in the center of my district.

In conclusion, I too want to say thank you to the witnesses for appearing today on such a blustery day outside, and I look forward to your testimony. I ask that my statement be included in the record, and yield back the balance of my time.

[The statement of Mr. Miller appears on pg. 32.]

Mr. MICHAUD. Thank you. Without objection. Dr. Snyder, do you have an opening statement?

Mr. SNYDER. No, I do not. Just a comment about whether it is truly blustery, or just plain cold.

[Laughter.]

Mr. MICHAUD. Thank you very much. So we will begin, Dr. Kussman.

STATEMENT OF MICHAEL J. KUSSMAN, M.D., M.S., MACP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOEL KUPERSMITH, M.D., CHIEF RESEARCH AND DEVELOPMENT OFFICER, VETERANS HEALTH ADMINISTRATION; IRA R. KATZ, M.D., PH.D., DEPUTY CHIEF PCS OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION; AND PAUL KEARNS, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION

Dr. KUSSMAN. Well, thank you, Mr. Chairman, and Ranking Member, and Dr. Snyder, good afternoon. I have submitted a written statement for the record. Sir, you did a very good job of introducing the panel so I won't go through that again.

Mr. Chairman, let me begin by telling you how proud I am to be leading the Veterans Health Administration today. I firmly believe that if you are a veteran, you have a much better chance to receive the care you need in an expeditious and thorough manner from the VHA than any other healthcare system in the nation, or perhaps the world.

I am not the only one who says that. In 2006, American Customer Satisfaction Index found that customer satisfaction with our system was higher than the private sector for the seventh consecutive year. Last year, Harvard University recognized the VHA's computerized patient records system by awarding us with their prestigious Innovations in American Government award. We recently received an award from the American Council for Technology, along with the Department of Defense, for our innovative ability to securely exchange real-time medical records between our two de-

partments. We are the best around, and we are working to be better.

My written testimony discusses the details of the President's budget for veterans healthcare. Our total budget is more than 83 percent higher than the funding available to VHA for healthcare at the beginning of the Bush Administration. There are some who have said that our Department is or will soon be overwhelmed by the number of returning veterans we are seeing from Operation Iraqi Freedom and Operation Enduring Freedom. That is not correct. In 2008, we expect to treat about 263,000 veterans of the Global War on Terror.

This is only a small fraction of the 5.8 million patients we expect to treat overall in 2008. With the resources we have requested for medical care in 2008, our Department will be able to continue to ensure that servicemembers transitioning from active duty status to civilian life is as smooth and seamless as possible, and to continue our exceptional performance in providing access for all veterans to VA healthcare. We expect to meet our goals at 96 percent of our primary care appointments, and 95 percent of our specialty care appointments will be scheduled in 30 days of the date our patients want them to be scheduled.

Another area in which VA's readiness has been questioned is in the area of mental health. The President's budget request includes nearly \$3 billion to improve access to VA mental health services throughout the nation. These funds will help ensure that we provide standardized and equitable access throughout the nation to a full continuum of care for veterans with mental health disorders. Much has been made recently of the incidence of PTSD among OIF-OEF veterans. Thus far, approximately 39,000 veterans have received provisional diagnoses of PTSD in our hospitals and vet centers.

But most veterans with mental health issues do not have PTSD. They have easily treatable problems related to their readjustment to civilian society after serving in combat. Mislabeling readjustment issues as PTSD may keep some veterans from seeking care, and paints a misleading picture of the likely effects of combat service. VA has the capacity to treat those veterans with PTSD, and those with readjustment disorders, and we will augment that capacity if needed.

Suicide among veterans is another issue that has recently been in the news. VA recognizes that any veteran suicide is a tragedy, and we are committed to address the needs of veterans who may be at risk of taking their own lives. VA mental health professionals work with community providers and agencies to ensure that veterans in need are referred for care.

Our vet centers, open to combat veterans from all wars, provide outreach to returning veterans, and encourage them to seek help if they are having difficulties in readjusting to society. By April, every VA hospital will be funded for a designated suicide prevention coordinator. They will work to identify veterans who have previously attempted suicide, and enhance their care. We are increasing the availability of 24-hour mental healthcare, and we will soon hold a Suicide Prevention Awareness Day, to remind all VA employees of their responsibility to help prevent veteran suicide, and

to increase their awareness of possible warning signs that might indicate a veteran is considering taking his or her own life.

Our budget includes funding for the expansion of our services to severely injured servicemembers from Iraq and Afghanistan. Our four polytrauma centers have already been expanded to encompass additional specialties to treat patients with multiple complex injuries. Their efforts in turn are augmented by 21 polytrauma network sites and clinic support teams around the country, bringing state-of-the-art treatment closer to the injured veterans' homes.

The budget also includes funding to continue construction of a new medical center in Orlando and completes funding for our Las Vegas hospital, provides funds to build new facilities in Pittsburgh, in Denver, and a spinal cord injury center in Syracuse, and an outpatient clinic in Lee County, Florida.

Altogether, our fiscal year 2000 construction request will bring the nation's investment in improving our infrastructure, since the CARES report was issued, to \$3.7 billion.

Mr. Chairman, the President's requested funding level will allow VHA to continue to improve the world-class care we provide to veterans, especially those who need us the most; the OIF-OEF veterans, those with service-connected disabilities, those with lower incomes, and those with special care needs. I am proud to present it to you today.

This concludes my presentation. Thank you.

[The statement of Dr. Kussman appears on pg. 34.]

Mr. MICHAUD. Thank you very much, Dr. Kussman.

In your budget, again this year, you have requested increased pharmaceutical copayments from \$8 to \$15 for certain veterans. In comparison to previous years, when you have advocated an increase in pharmaceutical copayments, the revenues received would be treated as mandatory dollars instead of discretionary dollars. How many veterans do you estimate would leave the VA in fiscal year 2008 as a result of the enactment of the copayments? Second, is what discussion led you to decide in this budget cycle submission to deem these fees mandatory revenues instead of discretionary revenues? And last—and you can submit to the Subcommittee—if you could detail for the Subcommittee, categories built upon earnings; the enrollment fees and co-pays. Could you break out how many veterans are affected in those different categories?

Dr. KUSSMAN. Yes, Mr. Chairman, thank you for the question. There are three policy issues in this budget. One is co-pays, as you had mentioned, and those are tiered. That is a new thing, that has never been done before. And then the second is the pharmacy copay, and there is a third one that we can discuss as well.

It is important to remember that these policies only affect people who don't have any service-connected disabilities. It wouldn't affect anybody who is one through six. It just focuses on the sevens and eights. And obviously, the difference between seven and eight is how much money you make. So, it starts at \$50,000, and goes up to \$100,000, I believe. And so, the issue was one of an equity issue that we have discussed in the past. As you know, people like myself and others who spent 25 or 30 years in service to our country, when we retire, if we tend to use TRICARE, have to pay enrollment fees that are in the same ballpark of figures that we are talk-

ing about. And so the feeling was that somebody who didn't have any service connection and was using our system, it would not be unreasonable to expect some nominal co-pay of \$250 a year, \$21 a month, I think it is, if you make \$50,000 and tier it up to \$100,000.

So that was the thought processes behind it. But in the past, as you know, those initiatives are part and parcel of our budget. And we know that this is not a popular thing, and we know that when we have come to Congress, each time it has been not approved with that, and then that we were confronted with a deficit in the budget that had to be made up. In this case, our budget as requested is separate from this, and we believe that this was a fair way to look at it so veterans in general, and the budget, didn't get deficit.

Mr. MICHAUD. And would you provide for the Subcommittee how many veterans are affected in each of the tiers? Because you came up with a dollar figure, so if you can provide that to the Subcommittee? How many veterans will be affected by this proposal, do you think, be dropped in all this?

Dr. KUSSMAN. Totally, if you look at uniques, not enrollees, but the people who are actually using our system—as you know, a lot of people enroll with us and then don't actually use the system, effectively at all. They keep it as a hip pocket, because obviously they are using some other healthcare system for their needs.

Of the 5.5 million or 5.8 million that we expect to see in 2008, I believe that the total number would be 111,000, of people who might choose to not use the system.

Now, we have done some review of the types of patients who are sevens and eights, and particularly eights, who might not use the system. And 89 percent of them have another type of insurance. So those are the numbers that we looked at.

Mr. MICHAUD. The enrollment fees do not start until 2009?

Dr. KUSSMAN. Yes. We don't think we could have the infrastructure ready and everything to start collecting that until October of 2009.

Mr. MICHAUD. Okay, so this number is predicated on 2009?

Dr. KUSSMAN. Yes.

Mr. MICHAUD. The long-term care issue; the average daily census level in nursing home care is 11,000. As you know, Congress passed legislation back in the 106th Congress, that would mandate it be maintained at 13,391. Does the VA plan on submitting another budget? How are you going to meet that obligation of the 13,391? Do you plan on not meeting it?

Dr. KUSSMAN. Sir, as you know, we have gone back and said that that was related to the Millennium Bill, that was established in 1998, I believe, that set where we were in 1998. And we believe that the types of care for long-term care have dramatically changed, emphasizing noninstitutional care. And for us to try to maintain 13,391 would not be effective use of our resources. More and more of our veterans want to be treated near where they live.

And as you know, we have basically four ways of delivering care. One is in our bricks and mortar. One is in community-based nursing homes. And the third is in State homes. And the fourth one, which is really the most rapidly growing one, at really 124-percent increase from 1998 to 2008, is noninstitutional care, to assist peo-

ple in staying home and things like that, where they really want to be.

And so we believe that we are increasing the total census of patients that are being provided for us. It is up 30 percent from 1998. But we also believe that we are putting them in the right place.

Mr. MICHAUD. And if you had all the slots available? If you had the over 13,000 slots, would you be able to fill them today?

Dr. KUSSMAN. With the types of patients that we are emphasizing, people who have priority one, special needs, indigent, and others; we believe that we are providing that service for the people in the full spectrum of the beds that are in those four categories.

Mr. MICHAUD. So if the beds were available, would you be able to fill them?

Dr. KUSSMAN. If we put those beds open in our own facilities, they would be adequately utilized, and that is what you are asking me, to go from 11,000 to 13,391? We don't believe that those beds would be appropriately utilized for the needs of our veterans.

Mr. MICHAUD. Congressman Miller?

Mr. MILLER. Back to the co-pay, do you anticipate any increase in co-pays for fiscal year 2008 based on the medical consumer price index? I know we had one last year, do we anticipate one this year?

Dr. KUSSMAN. I think it would be overcome. I mean, we are going from eight to 15.

Mr. MILLER. You can strike that, that is not going to happen. I am talking about your annual review—it was seven dollars and then went to eight. Do you anticipate it going up?

Dr. KUSSMAN. I understand the question. No, because it is not part of the budget. We are not counting on any change from any of this, eight to 15, or anything else, because the budget stands for itself. We believe we will be able to provide the services with the budget as submitted.

Mr. MILLER. The 2006 GAO report on VA's budget formulation revealed that VA had underestimated the cost of serving veterans returning from Iraq and Afghanistan in fiscal year 2006 in part because VA was not able to obtain sufficient data needed to identify these veterans from DoD. I have three questions, if I can give you all three of those, or I can give them to you one at a time.

To what extent has VA improved the projections on demand for care for returning OIF and OEF veterans?

The second question is, what challenges does VA continue to face in getting the data from DoD to identify these veterans? Is there a continued problem there?

Lastly, does your budgeting process include the projection of the future long-term cost for treating OIF and OEF veterans? Example, mental health and rehabilitation?

Dr. KUSSMAN. We believe that, as you mentioned, our original projection was lower than it turned out to be. In 2006, there were actually 155,000 OIF–OEF veterans who came in. We have learned from that. Our actuarial model is being perfected. The OIF–OEF people are new to the actuarial model, and so we have learned. We project that in this year, in fiscal year 2007, the total number of OIF patients will be 209,000, 54,000 more than we saw in 2006.

I can tell you that we monitor this on a monthly basis now, and that it is tracking quite closely, so we won't be surprised at the end

of the year with a sudden influx or number that we weren't aware of. We have projected another 54,000 for 2008. A lot of this, as you know, will be driven by what happens in the war itself, and how many people are deployed, or not deployed.

We put money against these types of veterans. In 2006, there were \$405 million directed directly to the 155,000. In 2008, it is \$752 million against the 263. That is an increase of dollars at 86 percent, with what we project a 70 percent increase in individuals. So we are watching that very carefully, to be sure that we have an accurate assessment of the total number of new OIF-OEF that are coming in.

As far as the second question, about getting info, we work very closely, and these numbers are coming readily to us, and we have a very good working relationship with DoD.

As far as long-term care, as I mentioned, as far as mental health and things, there is still a small number of patients in the 5.8 million that we expect to see that most of the patients with mental health issues are what we hope will be short-term, not long-term issues, related to severe mental illness. Most of the people have readjustment reactions related to normal reactions to abnormal situations. But we will continue to monitor that, and put money against it as we need, for both that and any other kind of rehabilitation services.

Mr. MILLER. I will hold my questions, and let some of the other Members ask.

Mr. MICHAUD. Dr. Snyder?

Mr. SNYDER. Thank you, Mr. Chairman.

I have two lines of questions I wanted to ask about, and I'm sure, Dr. Kussman, you can predict the first one, that is this research issue that I get discouraged about. With this Administration, it seems like this issue never goes away. Secretary Gates was unaware, and said he was going to personally look into it, because it concerned him after we called it to his attention. But in the defense budget, the President's budget has a basic research cut of 9 percent, and an applied research cut of 18 percent. And that is, when you look at what the inflation rate may be for that kind of technological inflation rate, which I expect is a point or two higher than normal inflation rate would be in real dollars, even more than that. It just makes no sense as we are looking ahead to the military of the future, what our edge is, that we would be doing that.

And we had this discussion when you were sitting at the table the other day with Secretary Nicholson. I just want to reiterate, I do not understand why at this time in our Nation's history, when you are dealing with an influx of injured veterans and veterans with a variety of different diagnoses in great numbers, we are not looking to perhaps dramatically increasing the amount of dollars coming out of your budget for medical research.

I understand everything that you all say about, "we are going to leverage those dollars." Well, I will accept the argument, okay? You put in more of your dollars, you can leverage even more dollars. The American people expect us to do this kind of research, to help our veterans, particularly our new veterans, but also our older veterans, with the kinds of illnesses they face, and the kinds of injuries they face, and rehabilitation they face.

Are you all intending to revisit this number, which has essentially been flatlined for the past 4 years, in terms of the contribution coming from veterans' healthcare budget to medical research?

Dr. KUSSMAN. As you know, sir, we believe that there is a 3.7 percent increase in the research budget this year, that includes both money from appropriated dollars, other government agencies, and the industry. With that, we have readjustment on how we spent that money, and projected that we are moving from a 48 percent to 59 percent of that total amount of money is geared toward issues related to OIF-OEF, such as TBI, PTSD, other mental health things, amputations, and things of that sort.

Mr. SNYDER. But my question was, why would you not want to increase your Federal dollar share, your VA Federal dollar share of research, so that you could leverage even more dollars at this point in our nation's history?

I mean, the answer is you don't have a good answer. I mean, if I was sitting there I wouldn't have a good answer either. My guess is that you all probably advocated to do that and you got shot down, so maybe we will just leave it at that. But I think it is really hard to understand. But it is also consistent with what either the Administration or OMB has done to research budgets for the last several years. And I don't understand. I think it is very short-sighted. So maybe I will just leave it at that.

I wanted to ask about the interface between DoD and VA. And I want to ask you the same question I asked Dr. Winkenwerder yesterday, but I won't tell you his answers until I hear your answers. And it is not like it is a trick question—

Dr. KUSSMAN. Thank you.

Mr. SNYDER. Yeah, that is right. My question was, you know, he was bragging on you all, and feeling like the two of you, between DoD and between military healthcare and the VA, that there has been progress in terms of seamlessness and some other joint—for want of a better word, “joint-ness.”

I asked him yesterday at our hearing, before the Military Personnel Subcommittee, what were the things on his list of things that he would like to see better between DoD and VA, or things that he is working on, or would like to work on? Tick off four or five things on your list of things that you think that you all ought to be working on, or that you want to see progress made on.

Dr. KUSSMAN. Thank you for the question. It is a very interesting one, and I hope I don't give an answer that is a diametrically different one than—

Mr. SNYDER. Well, if you do it just means instead of four items to work on, we will have eight items to work on, which is okay, too.

Dr. KUSSMAN. You know, I am retired military, and both on a personal and professional level, we have unprecedented cooperation with DoD and VA. We have put VA benefits counselors and social workers in 10 major transition points in the military health system. We have military active-duty people in our four major level one trauma centers. So we are working very closely.

As far as the things that we need to improve on, as you know, we just announced recently the initiative to work together to get a single inpatient electronic health record, and I am very excited

about that. And we will see hopefully some dramatic results of that in the not-too-distant future.

One of the other things that we have been challenged with, and really in an unprecedented way, is working together to case-manage people who have multiple venues of care. The people who are leaving DoD, I am talking about the segment that have been significantly injured getting medically retired. They have options to use their TRICARE benefit, they can use the military health system, or they can come to the VA. And sometimes they use all three of them. And that has been a challenge, to be able to keep track of what is going on, as well as, you know, in an unprecedented way, the active-duty people, many of them are staying on active duty.

But also, when they come to us, frequently they are still on active duty. We are not waiting for them to go through their PEB process. And so they frequently go back and forth; to VA facility, then they go back to a military facility, and come to us. And working together to make sure that nothing falls through the cracks, from a clinical perspective, on what we are doing.

So those are the things that I would really want to emphasize in our partnering.

Mr. SNYDER. I will give you my summary of what Dr. Winkenwerder had as his four things, and you may want to pull the transcript, or you all have ongoing discussions with him anyway, and maybe just have you respond to them.

Number one on his list was the electronic health record, that the work needs to be done. He specifically mentioned the inpatient, and the challenges that will be there. This second one, he thought there needed to be improved screening in followup on traumatic brain injury, in terms of following people after they get back, and have been around trauma, but maybe not in such a way that they realize that they have been hurt.

And his third one was mental health issues. Again, transition. He said his experience is that people, when they get back, they may be so eager to get home they are just not as candid as maybe they think they ought to be, or want to be, and the transition following those folks. They may get a clean bill of health from them, but by the time they get to you, they have some issues. And he thought that there could be work done there.

And his fourth one was joint procurement issues, joint market access. He thought you all could work together closely in terms of buying stuff.

That is my amateurish summary of the four things he said. Do you have any response to or thoughts on any of those?

Dr. KUSSMAN. Yes, I would agree with those. I was looking at the things that are going on on a daily basis.

TBI is obviously an important thing. Every war has its sentinel things that you look at. TBI is one of those. I think what we are learning is that it is more complicated than anybody thought, in a way that we all know what to do, and the VA has been a world leader in taking care of TBI. We all know what happens when somebody has a gunshot wound to the head, or significant TBI. The challenge is undiagnosed or minor TBI. And we are working par-

ticularly with the Army and the Navy, to look at ways of screening people for minor TBI.

I mean, no one really knows what happens if you—whatever your full capability was, if—and it is related to boxing and playing football. You know, football players, they get concussions repeatedly, really are in the same category of things. And together, we are developing a screen that we will provide for everybody when they come back. We have a screen now, when somebody comes to us, who was in OIF–OEF, when they come—it could be for anything. When they go see their primary care provider, a drop-down menu alerts them and they have to ask certain questions related to PTSD. We are going to provide that same drop-down menu for TBI to ask the questions.

As you know, there is no single test to determine about—there is no x-ray or one blood test that you can do. The issue is to be sure that we do what we can, and help people maximize whatever capacity they have. So we are working together very aggressively on that.

Joint procurement are things that we have always been working—we need to more aggressively do that, have joint purchases, leverage our buying capacity.

Mental health is one that we have talked about a great deal. As you know, along that spectrum, whether it is a readjustment or PTSD, there are a lot of resources in-country, to try to talk with people as they develop it.

But when they come back, as you know, particularly with the National Guard and Reserve, the American soldier is very smart. They know what to answer and what not to answer, and that if, you know, if you say “yes” to anything that is said to you, you are going to have to stay around for a couple more days versus being able to go home, they say “no.” And it is not only that they want to go home but, you know, as you alluded to, is that sometimes people with adjustment reactions or PTSD don’t know they have a problem that early on, and they transition back because they are euphoric about coming back, and many of us have experienced that same thing; you come back and you just want to go home.

And that is why we have initiated, with DoD, the Post-deployment Health Risk Assessment, that is focused on the National Guard and Reserve—and they do it on active duty, but that is not a group that we are involved in—that takes place 90 to 180 days later, to ask those questions again. We have been quite successful in that outreach. For the VA, we have hired 100 Global War on Terrorism counselors. Almost all of them are OIF–OEF veterans that worked with our vet centers. They go out to all the armories and things, going out and making sure that—asking questions. We work very closely with the State.

So the outreach program to try to get people to understand, and make it easy for them to come in and get help—as you know, in our country there is a stigma related to that, and people generally don’t want to come. And what we need to do is make it easy for them and nonthreatening to come in, so we can assess.

It is clear that if you have symptoms related to PTSD, if you can get at it early and treat it, you can attenuate, if not eliminate, the

long-term complications. So we are very aggressive about outreach. Sorry to be so long-winded.

Mr. SNYDER. One final question, and I guess no answer is fine with me if that is what you would like to do. Secretary Nicholson was talking prospectively about the electronic health record that you have—now, I go back to my VA training days, when we would have two-volume charts of handwritten notes, and they would be literally several inches thick, and how are you going to make a conversion over to an electronic health record?

My question is, is there anything inherently different in the VA system in the transfer over to the electronic health record for inpatients, from the private sector? You know, a community hospital would also have a thick written record. Is there anything inherently different in making that transition to an electronic health record for inpatients?

Dr. KUSSMAN. Sir, do you mean nationally?

Mr. SNYDER. [Nods head affirmatively.]

Dr. KUSSMAN. We believe it is a state-of-the-art system. It has one weakness with it; it is MUMPS-based rather than Java-based, Web-based, and we are in the process of re-engineering that. That will make it more easily compatible with what I believe Secretary Leavitt and the country is moving to, to make them be able to communicate more easily.

Mr. MICHAUD. Thank you, and we will be having a separate hearing on TBI and mental health issues.

Congressman Brown?

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, and thank you, Mr. Under Secretary, for being here today. I know we had the Secretary come the other day, and brief us on some items; I want to commend you for your cooperation between the DoD and the VA on trying to make some things happen. In my district, we have an outpatient clinic which is a combination DoD and VA. And we also are trying to do some things to even further that combination of sharing of research, and sharing cost, and sharing patient load.

And we have been working with the Medical University of South Carolina to try to get some joint efforts moving toward, you know, better service for our veterans. And I noticed, as we passed the construction bill last year we added some \$36.8 million in there for planning at Charleston. And I noticed in this budget that you have before us today, that nothing was included to continue that planning. And I was just curious, exactly where we are on that particular issue?

Dr. KUSSMAN. Thank you. As you know, it was an authorization. There was no appropriation with the dollars, and we are certainly still—we hope not too much longer—in our Continuing Resolution.

But as you know, we are aggressively working with the University of South Carolina in Charleston. We have always had a great relationship with them and, as you know, with partnering and staffs interchange.

The director of the veterans hospital is working with the medical school now, finishing up a very elaborate memorandum of agreement. What we intend to do is buy equipment, sophisticated—particularly radiologic equipment, that we don't believe that either one

should alone as neither one would have the number of patients to fully utilize it. It will be on the campus of the University because of space issues with the VA. But we will pay for the equipment, and we will get the services of the specialists that are at the University, and they will be able to keep track of quid pro quo, get free services, if you will, from the University, at the same time as buying in a partnership.

So we believe there is a lot of movement to that. The specific relationship, building a new hospital, is still under negotiation, as you know.

Mr. BROWN OF SOUTH CAROLINA. And I appreciate you bringing that to our attention. I know that 95 percent of those doctors actually come from the Medical University, and I am grateful for that cancer research equipment, treatment equipment that is going to be shared. But the Medical University, of course, is under a construction program now. It would seem like to me that the ideal time to continue further cooperation would be for the VA to explore the possibility of replacing the old VA with more current facilities. And if we don't move, I guess, within the construction timeframe, then this could be difficult to utilize the space available at that site. And as we speak, the VA hospital is in a flood zone, and we would be at certainly the same risk as New Orleans was back when Katrina hit if, in fact, we had a class three or four hurricane come into Charleston.

Dr. KUSSMAN. Yes, sir, I understand.

Mr. BROWN OF SOUTH CAROLINA. And one further question if I might, Mr. Chairman.

We have had some of our returning veterans develop ALS. And I was just trying to find out in the budget how much dollars were going to be directed toward ALS research?

Dr. KUSSMAN. I will have to ask Dr. Kupersmith, but as you know, we have made ALS a service-connected issue. The number is 6.8 million.

Mr. BROWN OF SOUTH CAROLINA. Six point eight million.

Mr. Chairman, if I might, if you could maybe arrange to have, like, a public hearing on ALS, to give our veterans an opportunity to be heard? Because they tell me, and I will just read this for further clarification.

It says that, "I recently learned of a number of cases in my district of veterans who have developed ALS, where VA has denied their claims because their service was not within the presumptive timeframe of August the second, 1990 through August the 31st, 1991."

Is that correct?

Dr. KUSSMAN. I am sorry, I cannot answer that. We have to ask the Veterans Benefits Administration, so we can be happy to take that question for the record, and get back to you.

Mr. BROWN OF SOUTH CAROLINA. Okay, I appreciate it. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Mr. Brown. We definitely will work with you on that, as well.

Congressman Salazar?

Mr. SALAZAR. Well, thank you, Mr. Chairman, and thank you, Mr. Secretary, for coming and joining us today.

I have great concerns about the President's budget and his proposal to cut dollars for prosthetic research. Could you address that a little bit? I know that there are great new, exciting advances that have been made in myoelectric prosthetic limbs. And you know, I was at Walter Reed Hospital a couple weeks, Monday, and the greatest concern I have is that we have a brand new generation of veterans that are basically left without arms and legs. I had the opportunity to meet with several from Colorado. I think it is critically important that we continue to develop that research, and to provide better prosthetics for returning men and women from Iraq and Afghanistan.

And secondly, I would also like to ask you about the CBOC facilities. I know that there are certain requirements that you have to meet before a CBOC can be constructed. I know that out in Craig, Colorado, we have been working on trying to put one together there because veterans have to travel over 5 hours of mountainous terrain to get to any kind of primary healthcare physician.

Is there any way that we could waive some of those provisions, or some of those requirements, to be able to do that? Or is there a way that we would be able to contract with private industry, or private healthcare to address the needs of these veterans?

Dr. KUSSMAN. If I could, sir, I will try to answer the second one first.

Mr. SALAZAR. Okay.

Dr. KUSSMAN. And then if I can remember what the first one was—no, I can remember it.

[Laughter.]

Rural health is a very important issue to us, as you know. And we are going to establish an office of rural health, to look at some of the questions that you ask. There are challenges, obviously, with people who live in—I want to say “inaccessible,” but I mean rural areas. It is not just with healthcare and the VA. It is healthcare in general that they have challenges with. And they also have trouble getting phone service, and cable TV, and all kinds of things that are challenges with living there.

You are right. We do have criteria that are established under the CARES process, to look at CBOCs, the number of veterans that are living in a place, the type of veterans in there, the needs of the veterans. We try to adhere to that as much as possible, obviously, so that we can be consistent with what we are doing. We are always willing to look at unique issues and see what we can do. This particular issue, because we are going to set up this office, that would be something that the office could certainly look at.

As far as the rehabilitation and prosthetics research, as I mentioned, we are redirecting a sizable amount of our research, 48 percent to 59 percent, related to OIF–OEF and prosthetics research. Prosthetics and rehabilitation research has gone from 55 to 63 and a half million, from 2006 to 2008; that our prosthetic budget, totally, is \$1.3 billion. Now, that prosthetic budget encompasses a lot more than limb prosthetics; it is the whole gamut of things. But as you may or may not know, the number of amputees that have been suffered in this conflict—now, we are not talking about toes

and fingers. It is a limb loss, the number of servicemembers that have suffered an amputation is under 600. And not that that is not 600 more than I would like, but it is not an overwhelming number that both together DoD and VA can approach. So we believe that we are monitoring these people very closely, providing them all services they need. Cost is not an issue with them. We will provide them anything they need.

Mr. SALAZAR. Thank you, sir. I yield back.

Mr. MICHAUD. Thank you, Congressman Salazar.

To follow up on the CBOC question that Congressman Salazar posed, and Congressman Miller; how many CBOCs will be open in fiscal year 2007? And how many will be open in fiscal year 2008?

Dr. KUSSMAN. Twenty-four have been announced for 2007. Did you ask about 2008?

Mr. MICHAUD. Yes.

Dr. KUSSMAN. Yes. There is a projection of up to 29 for 2008. That hasn't been totally decided on, but that is a fair guesstimate of where we are.

Mr. MICHAUD. Okay. And out of which appropriation account are these new CBOCs located?

Dr. KUSSMAN. That question came up, as you know, and it comes out of the VISN VERA dollars. The VISNs started, locally determined where they think a CBOC should be, meeting all the criteria. It does come up to the central office for review, not for distribution of dollars, but for review to make sure that everybody is following the same rules that we have standardization and consistency about what we are doing.

Mr. MICHAUD. Okay. And where does the VISN get their money?

Dr. KUSSMAN. It comes out of the VERA distribution of medical dollars, that we take our \$36 billion in budget, and we distribute it through the VISNs, and they are tasked to initiate CBOCs if they think it is appropriate, at the local level.

Mr. MICHAUD. So it comes out of medical care dollars?

Dr. KUSSMAN. Yes, sir.

Mr. MICHAUD. You know, the concern I have with that is if you actually require the VISN to request a CBOC in order for them to move forward, even though the CARES process says that there is a need there, unless the VISN asks for a business plan, then it doesn't move forward, and it is like a catch-22. If you don't have the money, you are not going to ask for a business plan, and therefore you are not going to get it, and therefore there is a lack of service, particularly in the rural areas. And it goes right back to some of the issues that we have talked about before on mental health issues, and a lot of other issues. I know the VA is doing all it can with PTSD and other issues, but the need is not being taken care of.

I was reading an article this morning, and I will quote. It says, "I am not going to take shots at the Administration or the Democrats. It is just a problem that needs to be fixed. It is an American problem." End of quote. That was from Larry Provost, an Army reservist who was given two months' wait for an appointment to address his PTSD problem.

And you know, Larry is not the only one. I am reading the articles where suicide has occurred because the service is not there.

My concern, particularly when you look at the CARES process, in rural areas is to make sure that we have adequate service for our veterans. And we look at the mental health area, former Congressman Lane Evans and myself, when we asked the GAO to look at the mental health dollars, to help initiate the mental health initiative; when it came back, it pretty much showed that the VA did not use all the money that it was allocated. Some of the money they did use they couldn't figure out where it was used. So I guess my next question is, does the Department plan on using all the money in the mental health area that has been allocated for fiscal year 2008? As well as the \$306 million in 2007? Are you going to be utilizing all that money?

Dr. KUSSMAN. Yes, sir. The intent is obviously to use that money. Let me address the GAO's report. And we are not refuting that. The problem was that between a Continuing Resolution and our challenge to hire people, we did not spend all the money. We didn't lose the money, it was carried over to the next year. We are working very hard to track, and be sure that we put a performance measure in place to monitor that on a monthly basis of how that mental health money is being used. So we are very aggressive on trying to—but we don't want to waste it either. We want to be sure that it is appropriately spent to increase services for the veterans.

As far as waiting times go, obviously there can be all kinds of anecdotal situations. We provide 39 million appointments a year. Thirty-seven million of them are done within 30 days of the request of the patient, 95 percent. So we want to make it 100 percent. We are going to work hard to do that. But all told, I think we are providing pretty good service for people when they need it.

Mr. MICHAUD. But do you agree that that service could be improved?

Dr. KUSSMAN. It can always be improved, sir.

Mr. MICHAUD. Good answer. Just a couple more quick questions.

Dealing with priority eight veterans. When the Secretary was here the other day, in order to include the remainder of priority eight veterans, he said it would cost \$1.7 billion. The Independent Budget came up with a much lower number, \$366 million. Out of that \$1.7 billion, did the Secretary forget or not calculate the effect of the fees and the copayments? Is that the difference between the Independent Budget's numbers versus the Secretary's?

Dr. KUSSMAN. The Secretary never forgets anything, sir. I believe that it is in there, in the \$1.7 billion, but we will get back to you on that. Over 10 years, it is \$33 billion projected that it would cost if we open back up to priority eights.

Mr. MICHAUD. What?

Dr. KUSSMAN. Over 10 years, and we opened it to—the cost would be \$33.3 billion.

Mr. MICHAUD. But for the priority eights that will be utilizing the system, they will also have to pay copayments.

Dr. KUSSMAN. Right.

Mr. MICHAUD. Now, out of that number, the \$1.7 billion, have you backed out all of the copayments?

Dr. KUSSMAN. I think that they have, but we will need to get back to you on that, because I don't want to give you the wrong answer.

Mr. MICHAUD. Okay, great. Congressman Miller?

Mr. MILLER. I will go ahead and pass, I know we have another panel.

Mr. MICHAUD. Congressman Brown?

Mr. BROWN OF SOUTH CAROLINA. [Inaudible.]

Mr. MICHAUD. Once again, I want to thank the panel for coming over this afternoon. I really appreciate it and look forward to working with you, and look forward to doing whatever we can to improve how we give services to our veterans. So thank you very much.

Dr. KUSSMAN. Thank you, Mr. Chairman.

Mr. MICHAUD. I would ask the next panel if they would come up, please.

I would like to welcome the second panel. The second panel includes Dr. Joseph English, who is a Board of Trustee Member of the American Psychiatric Association; Gary Ewart, who is the Director of Government Relations for the American Thoracic Society, on behalf of the Friends of the VA Medical Care and Health Research; and we have Patrick Campbell, who is Legislative Director of the Iraq and Afghanistan Veterans of America. So I would like to welcome all three of you gentlemen, and we will start off with Dr. English.

STATEMENTS OF JOSEPH T. ENGLISH, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN PSYCHIATRIC ASSOCIATION, CHAIRMAN OF PSYCHIATRY, ST. VINCENT'S CATHOLIC MEDICAL CENTERS OF NEW YORK, PROFESSOR AND CHAIRMAN OF PSYCHIATRY, NEW YORK MEDICAL COLLEGE, AND COMMISSIONER, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS; GARY EWART, DIRECTOR, GOVERNMENT RELATIONS, AMERICAN THORACIC SOCIETY, ON BEHALF OF THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH (FOVA); AND PATRICK CAMPBELL, LEGISLATIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF JOSEPH T. ENGLISH

Dr. ENGLISH. Mr. Chairman, I appreciate that, and it is a pleasure to address you and Members of the Committee. I also serve as Chairman of Psychiatry at St. Vincent's Catholic Medical Centers of New York, and Professor and Chairman of Psychiatry at New York Medical College.

My department is affiliated with two VA medical centers; Montrose and Castle Point, in the Hudson Valley. And I currently serve as a Commissioner of the Joint Commission on Accreditation of Healthcare Organizations which, as you know, surveys and accredits healthcare facilities.

I am especially proud, Mr. Chairman, that my oldest son Patrick has recently completed service as a captain of infantry in the United States Marine Corps, with service in Afghanistan and Iraq. His last assignment was to serve as the aide de camp of the commanding general of the Fourth Marine Division, whom he assisted with the problems of wounded Marines and their families cared for

by the VA. So it is a pleasure to be able to talk to you about some of this this afternoon.

Today I am principally representing the American Psychiatric Association, as you mentioned, with 37,000 practicing psychiatric physicians as members. And I also want to thank the Members of the Committee, and your colleagues in the House, for your continuing commitment to the welfare of our veterans, and would specifically like to mention Dr. Katz and Dr. Cross, who you know well, who are of great help to us in assisting with that. And I must say, Dr. Kussman's testimony, having to do with some of our concerns, was great to hear before this Committee.

We are very encouraged by VA Secretary Nicholson's testimony emphasizing the importance of providing mental healthcare to returning National Guard members, as well as other veterans. And we are encouraged by the President's request for additional funds for the VA Department of Mental Health Strategic Planning. All of that is good news for us.

But we are concerned that there is increasing need both in the number of servicemembers returning from combat, and the severity of their mental health diagnoses, that continues to warrant the attention of this Committee. Colonel Hoge reported a 2006 "JAMA" article, that approximately 15 to 17 percent of our recent vets have such conditions as posttraumatic stress disorder, major depression, other mental health problems, as you well know.

According to a GAO report issued less than 2 years ago, and I quote, "the reliability of the VA's estimate for the total number of veterans it currently treats for PTSD is uncertain, and the VA lacks the information it needs to determine whether it can meet an increased expected demand for PTSD services," as you have already manifested concern about.

The APA is concerned that the VA's PTSD service expansion, improvement, and coordination, may be inefficient and slow to respond due to VA data problems. The APA, along with Friends of the VA, remain extremely concerned that data collection in the VA and the DoD is hampered by non-congruity of data measurement classifications from year to year, due in part to realignment initiatives and quality of care initiatives.

And while the homelessness and posttraumatic stress disorder programs have received attention, problems remain. There is a disparity among the VISNs regarding physician staffing, waiting lists for treatment programs, as well as lack of resources. The VA should continue to invest resources in these programs and develop all the elements which provide a continuum of care.

We also commend the efforts of the VA to improve access to mental health services by locating them in a primary care facility, and encourage expansion of these co-locations. We have seen this in our own VA facilities. It makes a tremendous difference for access to veterans.

The APA is hopeful that with continued education in organic brain changes that occur with combat stress, the stigma against mental illness will be greatly diminished. Tens of thousands of soldiers which are deployed to combat zones are members of National Guard and Reserve units. These troops do not receive their health-care from the VA, as you know, but most often from private em-

ployer-sponsored health insurance plans when they return to civilian life. It is therefore important that data on the DoD's TRICARE program's accessibility to Guard and Reserve troops continue to be collected, to monitor the need for expansion and increased funding for this program.

And the APA urges the adoption of insurance parity laws for private employer health insurance, to improve access to care.

We are very concerned about the ancillary mental healthcare available from TRICARE to family members of the soldier who is deployed. The same holds true for families of veterans who have returned and are experiencing readjustment problems.

We would also like to encourage the DoD and the VA to continue to work together for a seamless transition of soldier family to veteran's family, and that family resilience be an important factor in the comprehensive care of veterans.

In summary, we are pleased to note some of the achievements of VA mental health and substance abuse programs in the areas of clinical care, research, and education. However, we continue to have concerns about the disparities among some of the VISNs, the remaining stigma toward mental illness by VA administrators, as well as the quality of psychiatric care and patient safety. We support the Administration's fiscal year 2008 budget proposal, and request additional funding of \$500 million every year until fiscal year 2012, to ensure the success of the VA's healthcare mission.

And Mr. Chairman, I would also like to say a word if I have a few minutes, because my son I mentioned worked for the general who commands the fourth Marine division, who has a lot of contact with families. As a matter of fact, when he visits families and Marines at Walter Reed and other facilities for the country, he gives them his card and encourages them to call if they have a problem. And they do, and oftentimes my son would be called upon to help with those problems.

And I reached him on the phone yesterday. My son arranged a call, and we had a wonderful conversation. I would like just to share a little bit of what he had to say. First of all, he is the first to say that great things are being done for our soldiers in the VA. But there are problems. For example, you can have a soldier that is given excellent care at Walter Reed. And then he is returned to a facility close to his home, and that facility may not have a fraction of the resources for the continuing care that soldier needs. My son has called me about that a couple of times, and I have called the VA, and they have quickly made adjustments for that. But it happens more often than—the reasons why would be obvious, but it is something I think we need to pay attention to with these very seriously wounded soldiers.

Secondly, there are administrative complexities in dealing with the VA, at the administrative level. He says that the differences in the understanding of what the benefits are and who qualifies for them in different regions of the country can sometimes be a nightmare that takes a Marine general to deal with. And this also affects financial aid to the families. He cited one example of a father who was caring for his severely wounded son living there with him, supposed to get family assistance, away from his job for months. But no subsistence, and the maze that he had to go through to get

that problem corrected, which he did, is an example of another thing that under the surface is a problem that he is certainly concerned about.

And finally, he would be gratified to hear the discussion at this Committee this morning of concern about TBI, these traumatic brain injuries. His concern, as a general, concern about his men, is that a lot of these men with closed-head injuries, which don't appear to be causing difficulty at the moment, are going to end up with delayed illnesses, and somebody 10 years from now is going to wonder whether or not they are service-connected. And that is why he is urging, together with the physicians that he speaks to at these centers, that research funds be provided for the study of this kind of problem, so that we are able to take care of the young men and women when the problems may arise later on.

And then finally, sir, this may not be within the province of this Committee, but I just feel impelled to tell you about it because listening, here, to the cooperation that is going on between the VA and the DoD, perhaps it can help with this. We have Reserve physicians who have retired who allow themselves to be reactivated, to go back into the military to help with the current situation. One of these very distinguished surgeons from my area of New York, Bronxville, New York, went to the major DoD facility in Germany, where some of the very seriously wounded soldiers are being brought.

Sir, for significant portions of time, there was no neurosurgeon in that facility, and that is almost unbelievable. I am sure it is not because the DoD didn't want one there, but it is because they can't get them. My question to you, sir, is whether or not it might be possible for the VA to help with this, in the spirit of collaboration that is going on.

Well, sir, I could go on and on, but I very much appreciate this opportunity and the help that all of you give to this great cause.

[The statement of Dr. English appears on pg. 40.]

Mr. MICHAUD. Thank you very much for your enlightening testimony. Mr. Ewart?

STATEMENT OF GARY EWART

Mr. EWART. Thank you. I am Gary Ewart, Director of Government Relations for the American Thoracic Society, and I am here today speaking on behalf of FOVA, Friends of VA Medical Care and Health Research, a coalition of over 80 organizations, veterans service organizations, physician organizations, and patient organizations, that support the mission of the VA health system.

I am here today to speak in particular emphasis on the VA research program, and to present our request for \$480 million for fiscal year 2008, for the VA research program.

I must say, FOVA recognizes the significant budgetary constraints that this Committee is under, and thanks both the House Veterans' Affairs Committee and your Senate colleagues for the consistent support you provided for the VA research program in your views and estimates budget. I would like to remind this Committee that in last year's views and estimates budget for 2007, there was a recommendation between \$28 million to \$51 million increased for the VA research program. I think the views and esti-

mates of 2007 demonstrate the strong support this Committee has provided in the past for the VA research program, and we hope to continue to build on that support for the views and estimates for 2008.

Lest I assume you will continue to support the VA research program, let me give you three good reasons why I think you should continue your support of the VA research program.

First, the VA research program is a successful program for attracting and retaining physicians in the VA healthcare system. I think it is fair to say when physicians graduate from their fellowship programs, they have a menu of options available to them. And one of the things that attracts physicians to serve in the VA is the ability to do clinical care, and seeing and treating patients in the veteran system, as well as compete for the intramural research budget that the VA offers. And by "intramural" I mean you have to be at least a five eighths physician to compete for the intramural research program that VA offers.

What this allows is the VA to entice young physicians who want to see patients and develop their scientific career, to join the VA. It is a successful program for bringing these kind of doctors in.

Equally important, it is a successful program for retaining these physicians over time. And I am sorry that Dr. Snyder isn't here because I would tell him about his good friend Dr. Joe Bates from Little Rock, Arkansas, who, for 25 years, served in Little Rock, Arkansas. And he would consistently say to me, "Gary, the program works, it got me in, it is why I stay. It is what birthed my career, both as an investigator, and allowed me to get NIH funds over time, to contribute to the science and care, treating veterans."

The VA research program also produces good science, and particularly good clinical science. The colleagues at NIH do a great job of doing basic research, and generating a wealth of ideas. Somebody needs to take these ideas, and apply them to good medical care, and that is something that the VA research program does an excellent job; taking basic research findings and using them to improve the care for veterans and ultimately all Americans.

Examples of some of these findings are in my written examples, and these have been published in prestigious journals like the "New England Journal of Medicine," and the "Journal of the American Medical Association."

In preparing for this testimony I was trying to think of another metric to demonstrate for you the value of science that the VA research program supports. And I thought Nobel laureates might be an interesting way of looking at things. The VA research program can claim three Nobel laureates in medicine as part of their family. And that is on a budget of about \$412 million. As a point of comparison, NIH, which has an intramural research budget of about \$2.6 billion, has four Nobel laureates. So I think this compares very favorably between VA and NIH, and it shows the quality of science that is being conducted at the VA research program.

And lastly, the VA research program is good for veterans. And let me say it again for emphasis: it is good for veterans. It gets these high-quality, thought-leading doctors in the VA system. It gives veterans access to cutting-edge treatment. And because the VA system is a system, unlike our dyslexic healthcare system out-

side of the VA, it allows an entire system to apply these findings across the board, so not just those in the research lab can enjoy these increased treatments for veterans; that they can be applied across system-wide.

While I am very enthusiastic about the VA research program, there is one problem I need to bring to this Committee's attention once again, and that is the deteriorating lab space in the VA system. It is fair to say that the VA research lab space is woefully out of date. If the VA wants to continue to maintain a state-of-the-art VA research system, we need to have state-of-the-art VA research facilities. FOVA greatly appreciates the Subcommittee's effort in the past, both in holding hearings and report language addressing the problem. However, the problem still persists. We strongly recommend that the views and estimates for 2008 specifically recommend \$45 million for rehabilitating existing lab space within the VA research system.

Mr. Chairman, I think it is clear that the VA research program does a lot of good for a lot of people, for very little money. We strongly encourage this Committee in developing your views and estimates to support both the need for the VA research program, and \$45 million for the VA lab space infrastructure. Thank you.

[The statement of Mr. Ewart appears on pg. 45.]

Mr. MICHAUD. Thank you very much. Mr. Campbell?

STATEMENT OF PATRICK CAMPBELL

Mr. CAMPBELL. Mr. Chairman, it is a pleasure to be here. This is a far cry from the basement, the last time I testified in front of you.

My name is Sergeant Patrick Campbell. I am a medic with the D.C. National Guard, and the Legislative Director for the Iraq and Afghanistan Veterans of America. I have submitted a written testimony so I am not going to just read it. I figured I would take my couple of minutes and tell you a short story.

A little bit of background on me. When I was in Iraq, I witnessed over 16 IED, mortar, gunfire attacks. As a medic, I frantically tried to save many lives. I saved most, but lost too many. Mr. Chairman, I have told you some of my war stories before, and to be quite frank I am not ready to relive some of them today. I figured I would tell you a different type of story.

When I got home off that plane, it was 2 days before Hurricane Rita hit, made landfall in Louisiana. I kissed the tarmac. The first meal I had was Taco Bell and a beer. I was home, I was safe, and I was wrong. In my mind, when I turned in my weapon that day, the war was over for me. It took me less than one month of being back to alienate, anger, and scare off some of my closest friends. I did things, I said things that were supremely insensitive. I drank too much, I caroused, I was mean. All the while, I was vehemently arguing that I was the same warm, fuzzy person that everyone remembered before I left.

Now today, a year and a half later, I am sitting in front of you as a medic, a graduate of UC Berkeley, a law student, an advocate for veterans service organizations, and someone who is thoroughly aware of the medical services that are available to veterans for mental health counseling.

When it came time for me to ask for help, I wouldn't. I mean, I couldn't. It took an intervention of some of my closest friends threatening that they would never talk to me again unless I sought medical services. I am proud to say a couple of months ago I went into the vet center, sat down with my vet counselor and he said, "No one who goes to war ever comes home the same person." Unfortunately for many soldiers, the real battle begins the day that they get home.

As you well know, we people in the military are a proud bunch. We are trained to overcome and defeat any obstacle. For most of my buddies, the thought of attending counseling is admitting defeat in a mental war that rages well beyond the days we turned in our weapons.

I have been diagnosed with posttraumatic stress disorder. I would prefer to call it readjustment problems, but it has been officially diagnosed. Every time I say it gets a little easier, but I keep thinking there is someone in the back of the room, or someone watching at home, staring at my bald spot, laughing at me, thinking, "That guy is not a real soldier. He needs to get back in the fight."

I can say from personal experience that to think that even a majority of the veterans who need mental health counseling will ask for help is just plain naive. The VA's passive approach of waiting for veterans to come to them isn't working. Right now, the budget that you have submitted before you is predicated on the idea that the people who ask for help are the people we are going to serve.

We are not going to get to the people who need the most help. The people who check a box on their post-deployment health reassessment form, or the people who make that phone call, or the people who have the support network where a spouse or a friend stops them and says, "You need to go get counseling," they are not the people we need to worry about. We are worried about the person whose wife, whose husband, whose friends say, "I can't deal with you anymore," and just leave, and watch that person spiral out of control.

This budget is predicated on the VA sitting around and waiting, waiting for those soldiers to call. Soldiers need and deserve mandatory health screening. Every soldier who comes home from combat needs to see a counselor. You ask any police department around the country, the moment a bullet is fired, by the police officers, by anyone else, every person in that area immediately sees a counselor. If they don't, they will not be paid for the next paycheck.

We have hundreds of thousands of troops who have seen things that they will never want to tell anyone. I mean, watching someone die in my hands because of a mistake that I made is something I will have to live with for the rest of my life. And as I sit here before you, I don't want to talk about it. I don't want to tell the world about it, but I definitely don't want to tell my friends. I don't want to tell anyone who is going to look at me with those eyes and say, "I'm really sorry," but I know they don't understand.

The only way we are going to remove the stigma of mental health counseling is to require everyone to attend. They say an ounce of prevention is worth a pound of intervention. By requiring

all soldiers to submit to mental health screening today, we would be saving billions of dollars 10 years down the road.

There is a wooden sign that hangs over the door of the D.C. vet center that says, "Welcome home." I will never be the same man I was before I left for Iraq. But I know whoever I become, I will always have a home at the vet center. I just pray that every one of my battle buddies find the courage to find their way home. We need to lead that fight. When you look over this budget we need to reject the assumption that soldiers who need help the most will ask for it, and we need to go to every soldier. If money is no object for people who are missing a limb, money should be no object for treating those people who have borne the burden of this war.

Less than 1 percent of this country has fought in Iraq or Afghanistan, and they are going to keep going. I am scheduled to redeploy in a year, year and a half, for my second tour. And you know, I am not trying to shirk that responsibility. I just want to make sure that I am as fixed as it can be so that when I go back again, it is not just compounded.

I really appreciate the opportunity to speak here. I am glad that we were invited and we are ready for your questions.

[The statement of Mr. Campbell appears on pg. 49.]

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

I know Mr. Brown has to run off to another meeting, so I recognize you for your question, Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, and it is a pleasure sitting on this side, you know. I want to congratulate you on the Chairmanship, and for conducting such a great hearing.

And thank you, gentlemen, for coming and sharing with us your insight. Dr. English, I was particularly refreshed to hear your willingness to offer volunteers to help fill in the gap. That is what makes America great, is those people that are willing to come forward and to meet a need.

And Sergeant, we are glad to have you, and grateful for your service to this country. War is never easy. We want to be absolutely sure that those needs are going to be met, and I think you made a good point. Sometimes PTSD can't be recognized like a missing arm or a leg, but yet the pain is still there, and I am grateful for you bringing that insight to us.

Sir, we are grateful for your testimony, and we recognize that there are never enough research dollars. And we are trying to do some things in Charleston where we are trying to broker between the Medical University and the VA, a research facility. It is basically concentrated on heart disease, but it is the right way. There are never enough dollars, so we have got to find smarter ways to be able to work within those programs. But I wanted to just particularly thank you for coming.

And Mr. Chairman, I apologize for having to leave, but thank you for your leadership.

Mr. MICHAUD. Thank you very much, Mr. Brown. It is always a pleasure working with you. I know you care deeply about the veterans, and I really look forward to continuing working with you over the next couple years on this Subcommittee.

It took me a while to get used to that accent, to figure out what you were trying to say. But after I learned that, we got along very well. So thank you very much.

[Laughter.]

I have got a couple questions. The first one is for Dr. English. If you look at the higher percentage of women that are now serving in Iraq and Afghanistan, combat veterans, do you think that the VA PTSD treatment programs and research initiatives are keeping pace with the unique needs of women veterans? And if not, do you have any recommendations for that?

Dr. ENGLISH. Well, I think that is an important question, Mr. Chairman. I have a woman chair at our own facility. She is very interested in that question, too. And what I hear from her—needless to say I touch base with our own VA facilities before coming down here—is very encouraging in that regard. There is a growing awareness that women need these services as well as everyone else. They have their own problems of stigma in approaching these services. But I think the VA is doing good things to try to help solve that problem.

Mr. MICHAUD. Do you think that the VA should mandate that all CBOCs provide some type of mental health services?

Dr. ENGLISH. Well, I listened to my colleague's very moving testimony here, and I must say it is hard to argue with anybody that comes here with his credentials. I think the other side of it, though, that we have got to be careful of is that some people would really resent the program if it were mandated. You know, they get that Orwellian feel. We have had that problem with the police in New York, where there is a mandatory program, sometimes. So I think there is a middle ground there somewhere that, working with folks who have had this experience, we can achieve.

I think right now what he is saying is correct; that maybe the bulk of the people that need the help that we ought to be able to provide do not come to it without something that provides them an incentive. Whether that goes all the way to mandation or not I am not so sure, but it is certainly an important issue for us to continue looking at.

Mr. MICHAUD. Thank you. And you also, Doctor, expressed concerns in your testimony over the lack of a system-wide approach for proper identification, management, and surveillance of those who sustained mild to moderate TBI, concussions. What would you recommend to the VA to address this problem, or to Congress, of how we should address this problem?

Dr. ENGLISH. Well, I think some of the Secretary's comments to you here this morning were encouraging in that regard, Mr. Chairman, because it looks like they are very much aware of this problem, and they are looking at better ways to detect and discover problems that the soldier, or the Marine, or the sailor, is not going to volunteer themselves. I think we feel that there is attention being given to that.

I think the concern we have is that there may not be adequate research being done into the long-term effects of some of these TBIs that appear on first—you know, it could be—these explosions, as you know, can cause tremendous damage to the brain, that is invisible or undetectable. And yet, there is evidence that there is

going to be long-term impact from that, that may develop only years later.

And I was particularly interested in what the general had to say about this. He talks to a lot of the docs in these facilities about this kind of thing, and that was the major thing that he asked to be represented here this morning; that there be research into the long-term impact of some of these head injuries that are really not as evident when they are being examined acutely.

Mr. MICHAUD. Thank you.

Mr. Ewart, you had mentioned more money in the VA for research, \$480 million for research. That is just to meet the cost of inflation. Do you think that much more money has to be provided to the VA, to address polytrauma and genomic medicine?

Dr. ENGLISH. I sure do, Mr. Chairman. You summed it up beautifully.

Mr. EWART. I agree with his comments.

[Laughter.]

First, if I could caution, there is a little bit of disingenuousness in the President's budget. If you read the budget documents, it mentions a 2.7 percent projected increase in total VA research enterprise. That is including all the NIH money VA investigators may get, and private money VA investigators might get.

Unfortunately, NIH's budget is also being flatlined, and I think the assumption that the VA investigators are going to aggregately pull in an additional 2.7 percent more money this year as opposed to last year, particularly when NIH's budget is flat, and VA budget, as in the President's proposal, is being cut. I think that is an unrealistic budget assumption.

To answer your question regarding current services, if you assume that the biomedical research inflation is 3.7 percent, it would require \$427 million in fiscal year 2008 just to maintain current service, or current buying power, in the VA research program.

There are a number of needs. We have spent a lot of time talking about the returning veterans from Iraq and Afghanistan, and traumatic brain injury, and multiple injuries that they are facing. That requires a great deal of additional research on both the obvious wounds, and the less obvious wounds, and how best to track and treat those individuals over time.

But we also have commitments to veterans of previous wars; World War II, Vietnam, Korea, they still have pressing health needs that require additional research. So I think there is a compelling case to be made for an increase in the research budget for the new problems that face the veterans population, as well as the less new problems that are facing the veterans population.

Mr. MICHAUD. Okay. Dealing with the research issue further, research done at VA facilities incur direct and indirect costs associated with a particular research project. Direct costs for research are usually covered by the grant, or contract provisions. The indirect costs associated with research, which in VA's case, in facilities, and administration costs, are paid by the medical account from the VA. Do you believe that the VA should be able to get reimbursed for those indirect costs from NIH?

Mr. EWART. You are asking, Mr. Chairman, a very challenging question. The indirect cost issue has been a sore point between the

VA research program and NIH research program for quite some time. NIH has taken the position that they are barred from essentially using Federal dollars to pay for another Federal program, and that has been their position over time.

The VA has taken the position that much like any other grant program, they are entitled to indirect costs. I think there needs to be some middle ground established that will allow for recognition of the indirect costs associated with VA-funded grants, and particularly with NIH-funded grants that are being done at VA facilities. What that magic middle ground is I cannot tell you today. But I do think that is an area that needs to be solved soon, and solving that will provide additional resources for the VA research program, I hope and expect.

Mr. MICHAUD. Thank you.

Mr. Campbell, you had mentioned in your testimony that it was because your friends were very persistent, that you went to seek help for PTSD. What are you recommending for those—and you mentioned also that, you know, it should be mandatory. But what would you recommend for those who might not have the supportive circle that you had around you to encourage you to seek PTSD help?

Mr. CAMPBELL. Well, I had my most recent counseling session on Monday, and I asked my counselor, you know, “if you could be testifying here today, what would you say?”

And he said, “I think that every returning veteran should check in the local vet center when they get home.”

And I agree with you that when you talk about mandatory, when you have someone who is out of the military, they are not being told what to do anymore. You know, you almost have to bribe them to get there. You have to give them an incentive.

Right now, we pay \$50 to every U.S. soldier to enroll in a recruitment program. And for every person they bring in, we get \$2,000. So right now, to get people into the military, we are literally bribing people, “Just enroll in the program and we are going to give you a \$50 credit card.”

I am not saying it needs to be \$50, I am not saying it needs to be, you know, whatever. But you need to incentivize; when someone leaves the military, that they go and the first thing they do, or within a short period of time, go in and check in with a vet center. It only takes one time for these trained counselors to see if there is going to be a problem. And you know, like I said, the more people who go, the less of a stigma it has. You know, if you cannot make it mandatory for someone who is out of the military, give them a reason to go.

And it has got to be a major campaign, just like the—you know, hire a PR firm. You know, we are spending it on, I don't know, billions of dollars, it feels like, on recruitment programs. We also need to worry about it on the back end.

Mr. MICHAUD. When you returned from Iraq, what type of screening or help did you get from your unit? And what type of outreach did you encounter from the VA?

Mr. CAMPBELL. I remember this very distinctly. We were sitting in a very large auditorium, and they hand out a bunch of sheets of paper, and my captain gets up and says, “I want you all to an-

swer this questionnaire honestly.” Everyone gets it, “But if you answer yes to any of these questions, you are going to stay and everyone else gets to go home.” And that questionnaire was asking about symptoms for posttraumatic stress disorder.

Now, the first thing I did when I got home, because I used to work on the Senate side, was go to my old boss and say, “This needs to be fixed.” So we took the post deployment-health assessment form, and we created the post deployment re-health assessment form.

Problem is, anyone who got home before January 2006, if they were triaged, they never got followup counseling. As I said to you before, the last time I testified, down in the basement, I had just got a phone call from one of my buddies who said that my next door neighbor when I was in Iraq committed suicide on the same day the VA decided that they were going to do a sample of 40 troops from my brigade out of 4,000. So they took and had a mandatory face-to-face counseling with 40 of them, and one of my buddies wasn’t on that list, and he committed suicide that same day.

The problem is that we fill out tons of forms. I mean, I have not filled out the post to post deployment health reassessment form. The only thing that has happened to me because of that is I can’t be deployed until I re-fill out that form. I was talking to one of my buddies, Sergeant Todd Bowers downstairs before I came up here. He has filled out the form six times. He got called yesterday by the Marines asking him the same question he has filled out. He has answered the questions the same way each time, and he has never been reached out to by a mental health physician.

These tools, these post-deployment health reassessment forms are very powerful tools only if there is the followup; meaning, getting these people to counseling. People who were in a war zone have seen things—like my counselor said, no one goes to a war zone and comes home the same person. You know, these questions say, “Have you ever seen anything—did you ever feel that your life was in danger?” Yes.

You know, talk about traumatic brain injury, I had an IED go off right next to my ear, to the point where I started bleeding from my eardrum. You know, I have never been screened for a traumatic brain injury. You know, that was probably one of three or four that I can say were within five to 10 feet of me.

You know, we know what has happened to these people now. We are just not actually doing anything about it. And my unit, out of 4,000 people, I would say—I can say about my 22 guys, I had 22 guys there. Three of them have gone and gotten counseling, including myself.

The last thing I am going to say is in terms of making it mandatory. In Fort Bragg, if you go to the TMC, the troop medical clinic, for a hangnail, you will get mental health counseling. You know, the moment you walk into a healthcare center, you get mandatory mental health—and the number of soldiers that they have been able to treat for mental health issues has gone up greatly. Because Fort Bragg, of all the places, has some of the people who have seen the worst fighting.

Mr. MICHAUD. Doctor?

Dr. ENGLISH. I would like to say a word just reflecting on this testimony, Mr. Chairman. This is going to be an analogy that is maybe stretched a bit, but I happened to serve as the First Chief of Psychiatry for the United States Peace Corps. And Sergeant Shriver was rather concerned when "Life" magazine did a front page story on the reverse culture shock that Peace Corps volunteers would experience after service, coming back into the United States. I don't mean to compare this to posttraumatic stress disorder, but they left one way, lived in radically different circumstances, had experiences that nobody their age would ever have, and then they are coming back.

So he felt that something had to be done about that. And we also were worried about forms, all the usual things. What he allowed us to do was to start something called "completion of service conferences." All over the world. Every single group of Peace Corps volunteers, or the first 5 years that I can speak to, about 2 months before they left the country, were brought together in the group that left the states, under the auspices—well, originally it was a couple of us in our field. It was to debrief them, it was to get a sense of what their experiences had been. But in the course of that, we were able to ask, and actually inventory, through a questionnaire, what their psychological difficulties had been while they were there, what they had done to get over it, and then to begin to make the transfer into what they were going to be encountering when they came back home.

And let me tell you something. I think they would have reacted exactly the same way that you are hearing here, as soldiers do when it is done through, you know—but when you get them together in a group, when you get them talking about experiences they have had that might relate to something that is going to occur back home, when you normalize it, and then most importantly, when—first of all, those sessions themselves were tremendously helpful in making the adjustment. They went on for 2½ days, all over the world.

But then, we had touch with them when they came back home. We had 400 psychiatrists identified. If we got a call from one of those Peace Corps volunteers, they would immediately be seen by one of the best people in that region in the country.

What that resulted in was a complaint from the General Accounting Office that we might not be adequately explaining to Peace Corps volunteers their benefits, because there was so little required in the way of long-term illness benefit associated with such a population that had been overseas, they didn't understand it, and they thought we weren't educating the volunteers.

So there may be some experience there that would be relevant for trying to tackle this very important problem.

Mr. MICHAUD. Thank you.

What are the three recommendations you would list as the highest priority for this Subcommittee to deal with? And we will start with Mr. Campbell.

Mr. CAMPBELL. I can give you two, because I am first. I think traumatic brain injury research. And I know the fight we had last year about funding just the small program, the Defense Veterans Brain Injury Center. That shouldn't even be a fight. You know, any

program that is doing research for veterans, the Department of Defense, TBI just needs to be fully funded.

And number two, I am going to harp on this again. Any way we can get soldiers to mental health counseling; requiring, incentivizing it, but it cannot be a passive system. It has to be an aggressive system. The budget we have now is predicated on the idea that people are going to ask for help when they need it. If we go out to these soldiers and we ask them, "Do you need help?" We are going to find a lot more people coming into the system. It is going to cost more now, but save down the line.

Dr. ENGLISH. I could just say "ditto," Mr. Chairman, let me just phrase it this way. I think the research is enormously important. What I would simply suggest is that we also have specific research dealing with a long-term effect of these injuries, like my friend here may have, the effects of which may not be felt for 10 years, and there is evidence from other illnesses that that is what can occur.

Secondly, I think the question of access. I think there could be some very creative work. I was assigned to the Peace Corps as its First Chief of Psychiatry from the NIMH, from the National Institute of Mental Health. I was there to help us learn, for NIMH, what might be relevant to other things other than overseas service. Would it be useful to bring some of that kind of research to bear on this problem of access. It is not the first time analogous situations have been faced.

And thirdly, sir, continued support and surveillance of this Committee of the terrific efforts that are going on to meet the mental health needs of veterans, and the Reserve and so forth, that we just keep it going, that when the resources are committed, it is spent. If it is not spent, why isn't it being spent? It isn't certainly because of need. It may be because of some of the same bureaucratic problems that were suggested by the Secretary in his testimony.

But those three things we would most appreciate.

Mr. MICHAUD. Great, thank you.

Mr. EWART. Thank you, Mr. Chairman. And you are tempting me sorely, because I lobbied for the American Thoracic Society, and part of me wants to speak about the unique needs in the pulmonary community, but I will speak more broadly. And I think there are three things that we, FOVA, would like to see additional resources to fund in the VA research program.

First is deployment health. As has been so well articulated today, soldiers are going to war and coming back differently, and we need to understand what those health needs are. We need to survey what their health is before they are deployed, and what their health profile is upon returning. And if the VA research program has a vigorous proposal out there, that is only being applied in limited ways because of lack of funding, I think additional funding for the research aspects of deployment health is essential.

I think genetics is a field of just wonderful potential, beyond the VA, but particularly for the VA. With the power we can get from actually understanding genetic makeup of each individual, it will allow the VA system—which is a system unlike our dyslexic U.S. healthcare system—to really track what are your genetic predis-

positions to diseases, and to focus your early detection efforts, and hopefully early intervention efforts, to make sure that medicine is being provided by the VA health system, as uniquely tailored to the individual.

What is an additional beauty to this is not only does it improve care for the veterans, it also allows the VA healthcare system to enjoy the benefits of earlier targeted interventions, and earlier treatments that hopefully will lead to reduced medical outlays in the VA system.

And because the VA is a system, it should not only be able to coordinate care of providing genetically tailored medicine, but also capture the cost savings system-wide, that I don't think other actors in the U.S. healthcare system are capable of doing.

And the third one is chronic disease management. Whether it is chronic disease of chronic obstructive pulmonary disease, or HIV/AIDS, the burden of chronic illness in the veteran population is significant. How to appropriately develop programs to manage chronic disease over time I think is something the VA population is uniquely in need of in the VA healthcare system, and the VA research program is uniquely suited to doing some scientific investigation on the best way to manage chronic diseases.

Majority COUNSEL. Maybe we should include pulmonary care as a recommendation. Count it as one-half of three and a half.

Mr. EWART. That would be appreciated.

Mr. MICHAUD. Well, once again I would like to thank the three panelists for your heartfelt testimony. It definitely has been insightful, and really appreciated. I also want to thank the staff on the Democratic and Republican side for being here today, and I want to wish everyone a happy Valentine's Day.

So once again, thank you very much. The hearing is adjourned. [Whereupon, at 3:42 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud Chairman, Subcommittee on Health

I would like to thank everyone for braving the weather today.

This will be the first of many hearings in the 110th Congress for the Veterans Affairs Health Subcommittee.

I would like to welcome my Ranking Member, Congressman Jeff Miller of Florida and say that I look forward to working with you.

We have a lot on our plates and I know that by working together, we will be able to accomplish a great deal this year.

I would like to welcome our first panel of witnesses, Dr. Kussman, Dr. Kuper-smith, Dr. Katz, and Mr. Kearns from the VA.

The Veterans Health Administration is responsible for the health and well-being of our nation's veterans.

There are few in any more important responsibilities of our government.

We have an aging veterans' population. We also have a new generation entering the system with unique needs like mental health, traumatic brain injury and other wounds from service in Afghanistan and Iraq.

We are here today to learn if this budget request can meet all of these needs.

The request is an increase of 6 percent over last year's funding. We have heard from the Independent Budget and from other veterans service organizations that more money is needed.

This request includes increases to fees and copays that this Committee and this Congress have rejected in the past.

It also includes a cut in medical and prosthetics research that we will address.

That being said, I believe this request is a good starting point for us, and I think we can move forward to create a budget that we can all consider a success.

And let me be clear, I don't measure success by the dollars spent or the dollars saved.

I measure success by the number of veterans receiving the highest possible quality of care in a timely manner.

We look forward to hearing your testimony and to having a frank discussion about meeting the needs of our veterans.

Prepared Statement of Hon. Jeff Miller Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman. I want to congratulate you, Mike, as you assume your new role as Chairman of the Subcommittee on Health.

I, myself, am honored to have been selected by my colleagues to serve as the Ranking Member. With the return of thousands of new veterans from the Global War on Terror in need of medical services, this Subcommittee faces additional responsibilities and challenges. I look forward to working with you and all of the Members of the Subcommittee to see that the highest quality medical care is provided to our new generation of younger veterans and our older veterans from past conflicts.

In recognition of today being Valentine's Day, I want to express my heartfelt gratitude to the brave men and women serving in our Armed Forces. I also want to take this opportunity to thank all the dedicated VA healthcare personnel throughout the country that work hard to make sure that servicemembers returning from Iraq and Afghanistan and all of our honorable veterans receive the best care.

Over the past decade, we have watched VA transform its healthcare system from one with a lackluster reputation to one that is highly rated and highly regarded. Research study after study continues to distinguish the VA healthcare system for

its outstanding performance, recognizing the significant benefit of VA's use of electronic medical records, focus on preventative care and measurable accountability.

The Department proposes a record \$36.6 billion for VA healthcare for fiscal year 2008—the largest amount ever requested by any Administration, and a 6-percent increase over the fiscal year 2007 request.

It is satisfying to see that after this Committee uncovered weaknesses in the process VA used to develop its healthcare budget last Congress, the budget request for fiscal year 2008 is more transparent. For example, this year's budget submission does not assume savings from "management efficiencies," that the Government Accountability Office (GAO) recently reported, did not materialize in years past.

I am concerned, however, that the Administration again requests legislation to establish enrollment fees and increase pharmacy copayments for certain Priority Group 8 veterans. These proposals do differ from last year in that they are not assumed as reductions to the Administration's request for appropriations. Still, Congress has emphatically rejected similar legislative proposals the last 4 years running and I am certain that the political will of this Congress will not support these proposals.

The Administration requests nearly \$3 billion for mental health services, including \$360 million to continue implementation of mental health initiatives begun in 2005 to address deficiencies and gaps in services. While this amount is substantial, last September, the Government Accountability Office (GAO) reported that VA had not used all of the mental health funds Congress allocated in 2005. We must have a better handle on how much and in what way VA is spending its resources to meet the emerging demand for mental health services, especially Post Traumatic Stress Disorder (PTSD). VA must plan for and fund those programs that have been identified as particularly relevant to the needs and requirements of our soldiers.

The Department of Defense is reporting that more than 12,000 returning wounded servicemembers suffer with Traumatic Brain Injury (TBI). Because of the frequency and unique nature of TBI, it is vital that VA continues to embrace and enhance an interdisciplinary program to handle the medical, psychological, rehabilitation, and prosthetic needs of these injured servicemembers. It is a high priority of mine to ensure that appropriate funds are available to support important research into TBI causes and prevention and efforts for early identification and better clinical diagnosis to separate TBI from PTSD.

The Administration's budget request includes \$740 million for major and minor medical facility construction, more than a 60-percent increase over the FY 2007 request.

Three years ago, the Capital Asset Realignment for Enhanced Services (CARES) Commission identified the 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 the more than 100,000 veterans who live in my Congressional District. Currently, many of these veterans have to drive to Mississippi to receive inpatient care.

The VA patient workload in the State of Florida 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.

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.

In conclusion, I thank our witnesses for appearing today, and look forward to your testimony.

Thank you, Mr. Chairman, I ask that my statement be included in the record, and yield back the balance of my time.

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

Chairman Michaud and Ranking Member Miller, thank you for calling this important hearing to discuss the Department's Fiscal Year 2008 Budget for Veterans' Healthcare. I look forward to the testimony from our witnesses and discussing what has been such an important issue for me during my time in Congress.

As Chairman of this Subcommittee during the 109th Congress, I was proud to share an equal commitment with Mr. Michaud to the well-being of our veterans, and I am glad to see that the Subcommittee is in your very able hands. The same senti-

ments go to Ranking Member Miller, who I know is committed to working for the good of our nation's veterans.

This budget, overall, represents just how far we have come since 2001 in meeting the needs of our nation's veterans. Funding for the VA has increased every single year, with medical care dollars a special priority of Congress. And during that time, we have seen the VA, Congress, and the VSOs come together and work on a number of priority issues: the process VA uses to estimate its budgetary needs, the centralization of VA's IT, and the move by the VA and DoD to a common electronic medical record. These moves, which are at varying stages of completion, will ensure the VA truly requests what it needs, protects the security of private records, and provides a seamless transition for our uniformed men and women into the VA system.

During this hearing, I want to focus on a few areas, especially advanced planning for a joint use facility at the Charleston VAMC, and how the VA manages treatment and research related to ALS, a terrible disease that has affected a high percentage of veterans. ALS has touched one of my friends, former Air Force General Tom Mikolajcik. A 27-year Air Force veteran, Tom commanded a C-130 Wing during the Gulf War and lead Charleston Air Force Base as the C-17 was deployed. General Mikolajcik commanded all air operations during the first U.S. operations in Somalia. And General Mikolajcik suffers from ALS.

Even with this debilitating disease, Tom is an extremely active member of the Charleston community, especially as it continues to move past the closure of the Naval Base. We owe it to veterans like Tom to provide the best possible care to veterans with service-connected ALS, and to use the resources available for researching new treatments.

I look forward to hearing from our witnesses on these and other important issues. Mr. Chairman, I yield back my time.

Prepared Statement of Hon. John T. Salazar

Thank you, Mr. Chairman.

While many areas of this budget have proposed increases, I'm concerned to see that the Administration would like to cut funding for Medical and Prosthetic Research.

Because of advances in medicine, soldiers are returning from Iraq and Afghanistan that may not have survived in past wars.

We have had over 50,000 soldiers injured in Iraq and Afghanistan, a large number who are amputees.

The twentieth century has seen advances never before imagined in prosthetic research.

The most exciting advances have been in myoelectric prosthetic limbs.

Myoelectricity involves using electrical signals from the patients arm or leg muscles to move the limb.

Just last week I had an opportunity to see this technology in action at Walter Reed Medical Center.

Mr. Chairman, I urge this Committee and its Members to oppose any cuts to Medical and Prosthetic Research that could damage the quality of life for our American heroes.

Prepared Statement of Michael J. Kussman, M.D., M.S., MACP, Acting Under Secretary for Health, 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 Veterans Health Administration (VHA). 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).

The President's requested funding level will allow the Veterans Health Administration (VHA) to continue 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 health-care needs.

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.

Last week, Secretary Nicholson 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, survivors, and parents of the latest generation of combat veterans, will report directly to the Secretary. 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.

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 servicemembers 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 has a designated point of contact to coordinate activities locally and to ensure the healthcare needs of returning servicemembers 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 servicemembers from Iraq and Afghanistan are frequently sent for care. These include benefit counselors who help servicemembers obtain VA services as well as social workers who facilitate healthcare coordination and discharge planning as servicemembers transition from military to VA healthcare. Under this program, VA staff provides 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 servicemembers. 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 servicemembers regarding military-related readjustment needs.

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 copayment 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 copayment 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.

Capital Programs (Construction and Grants to States)

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.

Information Technology

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

Summary

Our 2008 budget request of \$36.6 billion for medical care 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.

Mr. Chairman, I am very proud to be leading the Veterans Health Administration at this time. I am proud of our system and its accomplishments, and I look forward to working with the Members of this Committee to continue the Department's tradition of providing timely, high-quality healthcare to those who have helped defend and preserve freedom around the world.

Prepared Statement of Joseph T. English, M.D., Member, Board of Trustees, American Psychiatric Association

Mr. Chairman and Members of the Subcommittee, I am Joseph T. English, M.D., the Chairman of St. Vincent's Catholic Medical Centers of New York City and Professor and Chairman of Psychiatry at New Medical College. New Medical College is affiliated with two VA hospital centers: Montrose and Castle Point. I thank you

for the opportunity to present the American Psychiatric Association's (APA) recommendations for appropriations for the Department of Veterans Affairs (VA) health-care and medical research programs for fiscal year (FY) 2008. The APA consists of over 37,000 psychiatric physicians nationwide who specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

First, I would like to thank the Members of the Subcommittee and your House colleagues for your commitment to providing the highest quality medical care for our nation's veterans and for supporting necessary research to advance the quality of that care.

The APA is grateful for the \$786 million the President requested for Outpatient Mental Health Care, Readjustment Counseling and VA Mental Health Initiative.¹ Sadly, it may not be adequate to meet the growing needs of veterans with mental illnesses.

Current and Emerging Needs of OEF/OIF Vets

VA and the Department of Defense (DoD) are well aware that a significant percentage of combat veterans of Operations Enduring and Iraqi Freedom (OEF/OIF) are at risk for PTSD and other mental health problems. In a 2006 study published in the *Journal of the American Medical Association*, Col. Charles Hoge, M.D., of the Walter Reed Military Research Institute, evaluated relationships between combat deployment and mental healthcare use in the first year following return from the war.

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. Col. Hoge reported that mental health problems recorded on the post-deployment self-assessments by military servicemembers were significantly associated with combat experiences and mental healthcare 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 post-deployment among soldiers preparing to return to Iraq for a second deployment. Col. 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, Col. 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 healthcare system is also seeing increasing trends of healthcare 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 healthcare since fiscal year 2002, a total of 73,157 unique patients have received a diagnosis of a possible mental health disorder. Nearly 34,000 of the enrolled OEF/OIF veterans had a probable diagnosis of PTSD.²

VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of healthcare utilization among this group reflect the fact that these veterans have ready access to VA healthcare, which is free of charge for 2 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 underway, and expanded access to healthcare 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.

VA's PTSD Programs

According to VA, it operates a network of more than 190 specialized PTSD outpatient treatment programs throughout the country, including specialized PTSD

¹Combination of: Outpatient Mental Health Care \$311m, Readjustment Counseling \$115m and Mental Health Initiative \$360m from the President's Fiscal Year 2008 Budget Proposal.

²Independent Budget, Critical Issues Report on Fiscal Year 2008.

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.

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 of 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 consequently rationed access to, these specialized services.

Mental Health and Traumatic Brain Injury

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. Research from Charles Marmar, M.D., at the San Francisco VA Clinic indicates that many OEF/OIF veterans have suffered mild brain injuries or concussions that have gone undiagnosed and that injury symptoms will only be detected later when these veterans return home.

We are concerned about emerging literature³ that strongly suggests that even “mild” TBI patients may have long-term mental and medical health consequences. The DoD admits that it lacks a system-wide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI/concussion, in particular mild TBI/concussion. Therefore, the VA should coordinate with the DoD to better address mild TBI/concussion injuries and develop a standardized followup protocol utilizing appropriate clinical assessment techniques to recognize neurological and behavioral consequences of TBI as recommended by the Armed Forces Epidemiological Board.

The 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 collocated 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 support families and caregivers of these seriously brain injured veterans.

Long-Term Mental Health Services for Veterans

Over the past 15 years, there has been an increase in the number of veterans with serious mental illnesses being treated by the VA. This is partially attributable to other avenues of care becoming closed (e.g., when private insurance coverage for mental illness becomes exhausted or Medicaid systems are stretched to the breaking point). Over 90% of the veterans being treated for psychosis are so ill that they cannot maintain a significant income and therefore become indigent and heavily reliant on the VA for their care.

Until recently, mental healthcare has not been a priority for VA. Virtually every entity with oversight of VA mental healthcare programs—including Congressional oversight committees, the GAO, VA’s Committee on Care of Veterans with Serious Mental Illness, and The Independent Budget—have documented both the extensive

³August 11, 2006, memorandum, issued by the Armed Forces Epidemiological Board regarding Traumatic Brain Injury in Military Servicemembers.

closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with accessible community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These gaps highlight VA's ongoing problems in meeting statutory requirements to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs and a comprehensive array of services.

Congress has directed the VA to substantially expand the number and scope of specialized mental health and substance abuse programs to improve veterans' access to needed specialized care and services (P.L. 107-135). The law details the VA's obligation to make systemic changes network-by-network to reverse the erosion of that specialized capacity. Congress has made clear that the criteria by which the "maintain capacity" obligation is to be met are hard, measurable indicators that are to be followed by all Veterans Integrated Service Networks (VISNs).

Substance Abuse Treatment

Veterans with substance use disorders are drastically underserved. It has been the experience of some of my colleagues in the VA that returning soldiers with PTSD often try to mask their anxiety and panic symptoms by using alcohol or drugs such as marijuana. The APA is concerned that veterans who may be waiting for specialized substance abuse care may in fact have co-occurring PTSD that has not been adequately identified, or that vets are forced onto a wait list for a substance abuse treatment bed. A delay in treatment can have serious consequences. The dramatic decline in VA substance use treatment beds has reduced physicians' ability to provide veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illnesses or co-occurring substance use problems does not now meet the demand for care in that population. Additionally, despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

Military Families

The APA remains deeply concerned about the ancillary mental healthcare available from TRICARE to family members of a soldier who is deployed. The same holds true for the families of veterans who have returned and are experiencing readjustment problems. The VA currently only has an informal network of support groups to help families develop the coping and support skills necessary when a loved one is experiencing PTSD. The TRICARE services available are largely dictated by a family's geographic accessibility to a military base. The APA would like to encourage the DoD and VA to continue to work together for a seamless transition of soldier family to veterans family and that family resilience be an important factor in the comprehensive care of veterans.

Care for Homeless Veterans

The APA applauds the inclusion of funds in the Administration's budget to enhance and expand services for homeless veterans through the Samaritan Initiative, which is co-administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Housing and Urban Development (HUD). Psychiatric and substance abuse disorders contribute significantly to homelessness among veterans. Studies show that about one-third, or approximately 250,000 homeless individuals have served their country in the armed services. Over 40% of homeless veterans suffer from persistent and disabling mental illnesses, and 69% have substance abuse disorders. The VA's healthcare system is a safety net and, within that context, providing treatment and support services for homeless veterans is one of the VA's important missions.

MIRECCs and Research

The APA wishes to compliment the VA for initiating the Mental Illnesses Research, Education and Clinical Centers (MIRECCs). The MIRECCs serve as infrastructure supports for psychiatric research into the most severe mental illnesses. Additionally, the APA would like to compliment the VA Research Office for initiating the Quality Enhancement Research Initiative (QUERI), which has funded two new field centers focused on putting into clinical application evidence-based treatment for schizophrenia, depressive disorders, and substance use disorders. However, the nominal increase in the President's research budget request is likely to limit the implementation of this farsighted plan.

The APA supports the Independent Budget's request for \$480 million for VA Medical and Prosthetic Research (an increase of \$69 million over the President's request; with an additional \$45 million for research facility improvements. Despite high pro-

ductivity 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 FY06 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.

Psychiatric research funding originates with the VA's medical and prosthetics budget. Regrettably, it is inadequate to support the full costs of the VA research portfolio and fails to provide the resources needed to maintain, upgrade and replace aging facilities. VA medical and prosthetics research is a national asset that helps to attract 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: Over 60% of VA researchers treat veterans. As a result, the Veterans Health Administration, the largest integrated medical care system in the world, has the unparalleled ability to translate progress in medical science to improvements in clinical care.

Fellowships, Psychiatric Education and Workforce Issues

Closely related to research efforts are the training needs of professional staff members. The VA should provide sufficient funding to the Office of Academic Affiliations for furthering fellowships in the field of severe mental illness (SMI) patient care and other areas. Fellowships should also emphasize the multidisciplinary needs of effective mental healthcare, addressing the elements of a recovery- and quality of life-based care system, as well as evidence-based best practices in psychosocial rehabilitation.

The APA applauds the VA for initiating the program for Psychiatric Primary Care Education (PsyPCE), which allows psychiatric residents to assume the duties of primary care physicians for mentally ill patients in mental health and primary care settings. We regard this as an opportunity to enhance the capabilities of psychiatric trainees to provide psychiatric care at primary care settings in order to reach a sector of veterans with psychiatric illness who normally would not have come to the attention of mental health professionals. It is, however, important for VA to maintain its core psychiatric residency and fellowship training capabilities. Rapid expansion of psychiatric knowledge and the challenges of providing quality care to veterans at different venues would require the availability of additional competent psychiatric physicians.

The shortage of physicians and other mental health professionals has compromised the services VA provides and has endangered patient safety. Many veterans with mental illnesses are medically fragile—with diabetes, liver or kidney failure, or cardiac disease, for example. Their care requires a specially trained physician. A revision of salary schedules, recognition of the contributions of International Medical Graduates and minority American Medical Graduates, and the availability of Continuing Medical Education (CME) courses and other professional opportunities for advancement need to be addressed. We understand that there is a significant shortage of nursing staff—especially psychiatric nurses—and we request that the VA address this shortage area.

Summary

Overall, the APA is 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 post-deployment 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 servicemembers 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 healthcare 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 healthcare 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.

Recommendations

The APA is deeply concerned about veterans with mental illness and substance abuse disorders. We believe it is important to secure:

- additional and specifically allocated funding for mental health and substance abuse services;
- immediate nationwide implementation of clinical programs mandated within the system;
- enforcement of compliance with legislation aimed at maintaining capacity; and
- enhanced recruitment and retention of personnel who will improve the care and lives of veterans with mental illnesses and substance abuse disorders.

The APA is concerned that VA mental health service delivery has not kept pace with advances in the field. State-of-the-art care requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation, pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help veterans recover from a mental illness. The VA's Committee on Care of Veterans with Serious Mental Illness has recognized that this continuum should be available throughout the VA. However, at most, it can be said that some VA facilities have the capability to provide some limited number of these services to a portion of those who need them. The APA recommends that Congress incrementally augment funding for mental illness and substance use disorders by \$500 million each year from FY08 to FY12 above FY06 levels.

Above all, a profound respect for the dignity of patients with mental and substance use disorders and their families must be duly reflected in serving the needs of veterans in the VA system. I appreciate the opportunity to speak with you today on behalf of the American Psychiatric Association.

**Prepared Statement of Gary Ewart,
Director, Government Relations, American Thoracic Society
on behalf of the Friends of VA Medical Care and Health Research (FOVA)**

On behalf of the Friends of VA Medical Care and Health Research (FOVA), thank you for your continued support of the Department of Veterans Affairs (VA) Medical and Prosthetic Research Program. FOVA is a coalition of over 80 national academic, medical and scientific societies; voluntary health and patient advocacy groups; and veteran service organizations, committed to ensuring high-quality healthcare for our nation's veterans. The FOVA organizations greatly appreciate this opportunity to submit testimony on the President's proposed \$411 million FY 2008 budget for VA research. For FY 2008, FOVA recommends an appropriation of \$480 million for VA Medical and Prosthetic Research and an additional \$45 million for medical facilities upgrades to be appropriated through the VA Minor Construction account.

FOVA recognizes the significant budgetary pressures this Committee bears and thanks both the House and Senate Committees on Veterans Affairs for your FY 2007 views and estimates with regard to the VA Medical and Prosthetic Research program. These recommendations, ranging from at least a \$28 million up to a \$51.5 million increase over the President's FY 2007 budget request for the VA research program, affirm your ongoing support for our nation's veterans. These recommendations would still provide at least an \$11 million to \$34.5 million increase over the President's FY 2008 budget. We look forward to working with you to develop views and estimates for FY 2008 that reflect this same commitment to medical research for the benefit of veterans and, ultimately, all Americans.

Medical and Prosthetic Research for Superior Veterans Healthcare

Recent stagnate 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 healthcare for its current population and to develop new solutions for its most recent veterans. For FY 2008, the Bush Administration has yet again recommended a budget that cuts funding for the VA research program. When biomedical inflation is considered—the Biomedical Research and Development Price Index for FY 2008 is projected at 3.7

percent—the research program will be cut even more significantly than the documented \$1 million. Just to keep pace with the previous year's spending, an additional \$15 million, for a total of \$427 million, is required. FOVA's \$480 million recommendation for VA research funding represents an inflation adjustment for the program since 2003; unfortunately, this number does not even consider the additional funding needed to address emerging needs for more research on post traumatic stress disorder, long-term treatment and rehabilitation of veterans with polytraumatic blast injuries, and genomic medicine.

The VA Medical and Prosthetic Research program is one of the nation's premier research endeavors. The program has a strong history of success as illustrated by the following examples of VA accomplishments:

- Developed effective therapies for tuberculosis following World War II.
- Invented the implantable cardiac pacemaker, helping many patients prevent potentially life-threatening complications from irregular heartbeats.
- Performed the first successful liver transplants.
- Developed the nicotine patch.
- Developed Functional Electrical Stimulation (FES) systems that allow patients to move paralyzed limbs.
- Found that an implantable insulin pump offers better blood sugar control, weight control and quality of life for adult-onset diabetes than multiple daily injections.
- Identified a gene associated with a major risk for schizophrenia.
- Launched the first treatment trials for Gulf War Veterans' Illnesses, focusing on antibiotics and exercise.
- Began the first clinical trial under the Tri-National Research Initiative to determine the optimal antiretroviral therapy for HIV.
- Launched the largest-ever clinical trial of psychotherapy to treat posttraumatic stress disorder.
- Studied and demonstrated the effectiveness of a new vaccine for shingles, a painful skin and nerve infection that affects older adults.
- Discovered via a 15-year study of 5,000 individuals that secondhand smoke exposure increases the risk of developing glucose intolerance, the precursor to diabetes.

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 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), such as extensive burns, multiple amputations, compression injuries, and mental stress disorders. These returning OIF and OEF 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.

However, without appropriate funding over FY 2007, VA will be ill-equipped to address the needs of the returning veteran population while also researching treatments for diseases that affect veterans throughout their entire tenure within the VA healthcare system. Additional increases are also 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 VA has a distinctive opportunity to recreate its healthcare system and provide progressive and cutting edge care for veterans through Genomic Medicine. VA is the obvious choice to lead advances in Genomic Medicine as the largest integrated healthcare 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. Innovations in Genomic Medicine will allow the VA to reduce drug trial failure by identifying genetic disqualifiers and allowing treatment of eligible populations; track genetic susceptibility for disease and develop preventative measures; predict response to medication; and modify drugs and treatment to match an individual's unique genetic structure.

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 healthcare system. According to Frances Collins, M.D., Director of the National Institutes of Health (NIH) Human Genome project, the study of genomics will be most beneficial to the patient population by decoding the genetic mecha-

nisms that cause common, complex diseases—many of which are particularly prevalent in the veteran population—such as hypertension and diabetes.

While advances in genomic medicine show promise in aiding the discovery of new, personalized treatments for diseases prevalent among many veterans seeking treatment at VA hospitals, there is also evidence that genomic medicine will greatly help in the treatment and rehabilitation of returning OIF/OEF veterans. New research has recently targeted the human genome for insight into why certain wounds heal while others do not. Additional studies have considered the differences between genes that aid in healing and genes that cause inflammation and its side-effects. Advancements in this field can drastically influence the treatment of injured soldiers and may play a large role in the long-term treatment of amputees.

The VA Genomic Medicine project will require sustained increases for VA Research funding in the coming years. A VA pilot program involving 20,000 individuals and 30,000 specimens (with the capacity to hold 100,000 specimens) provides estimates that approximately \$1,000 will be necessary for each specimen. The potential advances that can be achieved with regard to PTSD and veteran-related diseases point to an expansion of tissue banking activities.

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.

Research Facilities Consistent with Scientific Opportunity

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. Such an environment promotes excellence in teaching and patient care as well as research. It also helps VA recruit and retain the best and brightest clinician scientists. In recent years, funding for the VA medical and prosthetics research program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. Many VA facilities have run out of adequate research space, and ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Under the current system, research must compete with other facility needs for basic infrastructure and physical plant improvements which are funded through the minor construction appropriation.

FOVA appreciates the inclusion within the House-passed Military Quality of Life and Veterans' Affairs and Related Agencies FY 2007 appropriations bill of an additional \$12 million to address research facility infrastructure deficiencies. The House Committee on Appropriations also gave attention to this problem in the House Report accompanying the FY 2006 appropriations bill (P.L. 109-114), which expresses concern that equipment and facilities to support the research program may be lacking and that some mechanism is necessary to ensure the Department's research facilities remain competitive. It noted that 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. However, VA cites that this review, already underway for the past year, will take an additional 3 years to complete.

Meanwhile, 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 Undersecretary of Health's Draft National CARES Plan for VA research. This plan recommended \$87 million to renovate existing research space; however, a complete assessment of research infrastructure needs will likely require a more than \$300 million investment.

FOVA believes 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. To ensure that funding is adequate to meet both immediate and long-term needs, FOVA recommends an annual appropriation of \$45 million in the minor construction budget dedicated to ren-

ovating existing research facilities and additional major construction funding sufficient to replace at least one outdated facility per year until the backlog is addressed.

Preserving the Integrity of VA's Intramural, Peer-Review System

As a prerequisite for membership, all FOVA organizations agree not to pursue earmarks or designated amounts for specific areas of research in the annual appropriation for the VA Research program. We urge you to take a similar stance in regard to FY 2008 funding for VA research for the following reasons:

- *The VA research program is exclusively intramural.* Only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA research awards originating from the VA R&D appropriation. Compromising this principle by designating funds to institutions or investigators outside of the VA undermines an extremely effective tool for recruiting and retaining the highly qualified clinician-investigators who provide quality care to veterans, focus their research on conditions prevalent in the veteran population, and educate future clinicians to care for veterans.
- *VA has well-established and highly refined policies and procedures for peer review and national management of the entire VA research portfolio.* Peer review of proposals ensures that VA's limited resources support the most meritorious research. Additionally, centralized VA administration provides coordination of VA's national research priorities, aids in moving new discoveries into clinical practice, and instills confidence in overall oversight of VA research, including human subject protections, while preventing costly duplication of effort and infrastructure. Earmarks have the potential to circumvent or undercut the scientific integrity of this process, thereby funding less than meritorious research.
- *A research encompasses a wide range of types of research.* Designating amounts for specific areas of research minimizes VA's ability to fund ongoing programs in other areas and forces VA to delay or even cancel plans for new initiatives. Biomedical research inflation alone, estimated at 3.8% for FY 2005 and at 3.5% for FY 2006, has reduced the purchasing power of the R&D appropriation by \$29.7 million over just 2 years. In the absence of commensurate increases, VA is unable to sustain important research on diabetes, hepatitis C, heart diseases, stroke and substance abuse, or address emerging needs for more research on post traumatic stress disorder and long-term treatment and rehabilitation of polytraumatic blast injuries. While Congress certainly should provide direction to assist VA in setting its research priorities, earmarked funding exacerbates ongoing resource allocation shortages.

Again, FOVA appreciates the opportunity to present our views to the Committee. While research challenges facing our nation's veterans are significant, if given the resources, we are confident the expertise and commitment of the physician-scientists working in the VA system will meet the challenge.

Organization Supporting FOVA's FY 2007 Recommendations

Administrators of Internal Medicine	Association of Academic Psychiatrists
Alliance for Academic Internal Medicine	Association of American Medical Colleges
Alliance for Aging Research	Association of Professors of Medicine
Alzheimer's Association	Association of Program Directors in Internal Medicine
American Academy of Child and Adolescent Psychiatry	Association of Schools and Colleges of Optometry
American Academy of Neurology	Association of Subspecialty Professors
American Academy of Ophthalmology	Association of VA Chiefs of Medicine
American Association for the Study of Liver Diseases	Blinded Veterans Association
American Association of Anatomists	Blue Star Mothers of America
American Association of Colleges of Pharmacy	Clerkship Directors in Internal Medicine
American Association of Spinal Cord Injury Nurses	Coalition for American Trauma Care
American Association of Spinal Cord Injury Psychologists and Social Workers	Coalition for Health Services Research
American College of Chest Physicians	Digestive Disease National Coalition
American College of Clinical Pharmacology	Gerontological Society of America
American College of Physicians	Hepatitis Foundation International
American College of Rheumatology	Juvenile Diabetes Research Foundation International
American Congress of Rehabilitation Medicine	Legion of Valor of the USA, Inc.
American Dental Education Association	Medical Device Manufacturers Association
American Diabetes Association	Medicine-Pediatrics Program Directors Association
American Federation for Medical Research	Military Officers Association of America
American Gastroenterological Association	National Alliance for the Mentally Ill

American Geriatrics Society	National Association for the Advancement of Orthotics and Prosthetics
American Heart Association	National Association for Uniformed Services
American Hospital Association	National Association of VA Dermatologists
American Lung Association	National Association of Veterans' Research and Education Foundations
American Military Retirees Association	National Organization of Rare Disorders
American Optometric Association	Nurses Organization of Veterans Affairs
American Osteopathic Association	Paralyzed Veterans of America
American Paraplegia Society	Paralyzed Veterans of America Spinal Cord Research Foundation
American Physiological Society	Parkinsons Action Network
American Podiatric Medical Association	Research!America
American Psychiatric Association	Society for Neuroscience
American Psychological Association	Society for Women's Health Research
American Society for Pharmacology and Experimental Therapeutics	Society of General Internal Medicine
American Society of Hematology	The Endocrine Society
American Society of Nephrology	United Spinal Association
American Therapeutic Recreation Association	Vietnam Veterans of America, Inc.
American Thoracic Society	Washington Home Center for Palliative Care Studies
Association for Assessment and Accreditation of Laboratory Animal Care International	
Association of Academic Health Centers	

**Prepared Statement of Patrick Campbell,
Legislative Director, Iraq and Afghanistan Veterans of America**

Mr. Chairman and Members of the House Subcommittee on Health, on behalf of the Iraq and Afghanistan Veterans of America (IAVA), thank you for this opportunity to address the issue of VA's Mental Health budget for FY 08.

My name is SGT Patrick Campbell and I am a combat medic for the DC National Guard, an OIF vet and the Legislative Director for the Iraq and Afghanistan Veterans of America. IAVA is the nation's first and largest organization for Veterans of the wars in Iraq and Afghanistan. IAVA believes that the troops and veterans who were on the frontlines are uniquely qualified to speak about and educate the public about the realities of war, its implications on the health of our military, and its impact on the strength of our country.

As my counselor at the local Vet Center would say, "No one goes to war and comes home the same person." And unfortunately for many soldiers the real battle begins the day they get home.

The Department of Veterans' Affairs proposes spending \$3 billion on Mental Health Programs in FY 08. Of that \$3 billion, 80% "will be devoted to the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder." Another \$360 million will fund the VA's mental health initiative and \$115 million is assigned to readjustment counseling. The VA proposes commendable increases to these vital mental health services, however the President's budget fails at a fundamental level. It assumes that the veterans who need help will ask for it.

Mr. Chair, as I have testified many times before, we in the military are a proud bunch. We are trained to overcome any obstacle and defeat any enemy. For most of my buddies the thought of attending counseling is admitting defeat in the mental war that rages well beyond the days we turn in our weapons and take off our uniforms.

I am a combat medic, a graduate student, an advocate of mental health services for a veterans service group and someone who has counseled many of my battle buddies to seek counseling. When it came time for me to admit that I needed help, I just avoided it altogether. Thankfully I am blessed to have amazing friends who did not let me run away from my issues. After spending a year in denial, last month I was diagnosed with Post Traumatic Stress Disorder (PTSD).

Every time I admit I have PTSD it gets a little easier to say. That being said, I will never be able to shake that feeling that some soldier watching this testimony from home is shaking his head at me and under his breath calling me a whiner. So here I am before you in spite of myself and my own insecurities.

I can say from personal experience that to think that even a majority of veterans who need help will ask for it is just plain naive. The VA's passive approach of waiting for veterans to come to them just isn't working. Returning soldiers **need and deserve** mandatory mental health counseling. We understand this is a radical shift from the incremental and passive approach the VA has undertaken since the begin-

ning of the Global War on Terror. This approach is the only effective way to remove the stigma of seeking mental health counseling.

This Subcommittee should lead the fight to ensure that every veteran receives at least one mental health screening with a trained professional. Every veteran should be required or incentivized to visit their local Vet Center within 6 months of their release of active duty. The VA could model their incentive program after the military's new recruitment plan (e.g., a massive PR campaign combined with paying soldiers to enroll in the program with prepaid credit cards). Lastly, the VA must ensure that those new veterans will be seen in a timely manner.

They say an ounce of prevention is worth a pound of intervention. By requiring all soldiers to submit to a mental health screening today we will be preventing millions and billions of dollars of intervention services.

There is a wooden sign that hangs over the door to the DC Vet Center, that says, "Welcome Home." I will never be the same man that I was before I left for Iraq. But I know that whoever I have become I will always have a home to go to when at the DC Vet Center. I just pray that every one of my battle buddies has the courage to find their way home.

Statement of American Federation of Government Employees, AFL-CIO

INTRODUCTION

The American Federation of Government Employees, AFL-CIO, which represents more than 600,000 federal employees who serve the American people across the nation and around the world, including roughly 150,000 employees in the Department of Veterans Affairs (VA), is honored to submit a statement regarding the VA's Fiscal Year (FY) 2008 budget for the Veterans Health Administration (VHA).

AFGE commends Chairman Michaud for his unwavering commitment to secure adequate funds to treat the physical and mental health needs of our veterans, and his support for assured funding legislation. AFGE agrees that it is time to give veterans more predictability through an assured funding process for VA healthcare. The evidence of a broken discretionary funding process is overwhelming: a \$3 billion shortfall 2 years ago, widespread hiring freezes and hospitals operating in the red last year, while this year, the VA is operating on its twelfth continuing resolution in 13 years.

AFGE members working in VA hospitals and clinics see first hand both the costs of war and the costs of a discretionary VA funding formula. They take tremendous pride in being part of the best healthcare system in this country. At the same time, they express growing anxiety, sometimes bordering on desperation over the lack of resources and staffing they need to do their jobs.

NEED FOR MORE OVERSIGHT

Adequate funding goes hand in hand with adequate oversight. Congress and the public must be able to determine whether these precious dollars are being spent cost effectively and in the best interests of veterans. Unfortunately, there is far too little transparency in VA spending at the present time, as recent Government Accountability Office (GAO) studies have shown. First, GAO found that the VA fails to track healthcare dollars used for illegal cost comparison studies. More recently, it concluded that the VA does a poor job of budget forecasting. Thus, it is no surprise that in the first quarter of FY 2006, VHA treated nearly 34,000 more returning OIF and OEF veterans than it had predicted it would treat for the entire year. Its mental health track record is no better: Last year, GAO found that millions of dollars budgeted for mental health strategic initiatives had not been spent.

Stronger oversight and reporting requirements for VA spending are greatly needed. For example:

- The quarterly reports provided by the VA pursuant to new requirements in the 2006 VA appropriations law do not appear to provide much of a vehicle for oversight. AFGE members continue to report "borrowing" between medical accounts. Along these lines, the proposed budget does not adequately explain why 5,689 food service jobs suddenly fit better in Medical Services than Medical Facilities.
- Despite clear reporting requirements in federal law (38 USC § 305), it appears that the VA has suffered no consequences for repeatedly filing incomplete reports on contracting out by medical facilities.

More transparency is needed in other critical VHA areas to improve forecasting of future need and ensure the best use of precious healthcare dollars. For example:

- **VISN budgets:** It is very difficult to determine how much VHA spends on FTEs that do not provide direct patient care. We are especially concerned about the enormous growth in VISN budgets. One of the original goals of the VISN reorganization was to reduce the need for management positions, and each VISN was expected to have 8 to 10 FTEs. Yet currently, total VISN employment is nearly three times that amount (638 FTEs). Seven of the 23 VISNS have 30 or more employees.
- **Bonuses:** AFGE is very concerned about the diversion of precious patient care dollars to excessive management bonuses.
- **Patient capacity:** AFGE encourages the Subcommittee to conduct oversight of VHA practices for determining patient waiting lists and bed capacity. AFGE is concerned that waiting list statistics are often presented in ways that understate the actual delays that veterans are experiencing. Second, it is a common practice to keep a hospital unit officially open even though there are no available beds.

THE PRESIDENT'S FY 2008 BUDGET PROPOSAL

As a proud and longtime supporter of the Independent Budget (IB), AFGE's overall concern with the President's budget proposal is that the proposed funding levels for VHA fall short of the IB's recommendations, which forecasts veterans' needs using sound, systematic methodology. We also concur with the IB's recommendation to restore eligibility to Category 8 veterans. AFGE rejects doubling of co-pays, new user fees or any other policies that shift costs to moderate income veterans and shrink deficits by pushing veterans away.

Despite the Administration's contentions, this proposed budget is not gimmick-free. Even though drug co-pays and user fees are not part of this year's medical care budget, the Administration acknowledges that these dollars could affect its 2009 appropriations request. Another familiar gimmick is to follow a strong first year budget with a decrease in funding over the next 4 years. According to the Center on Budget and Policy Priorities, veterans' healthcare would undergo large cuts between 2008 and 2012.

Fee basis care: One of the most harmful byproducts of underfunding is excessive reliance on contract care. Federal law and good policy dictate that fee basis care should be provided to veterans in limited circumstances, for example, to increase rural access when other means are not available. AFGE is concerned that the proposed FY 2008 budget continues a dangerous trend toward increased reliance on fee basis care, in lieu of hiring more VA medical professionals and timely construction of new hospitals and clinics. The number of outpatient medical fee basis visits estimated for FY 2008 represents a 27% increase in 3 years. Veterans deserve a better explanation of VA's growing reliance on fee basis care, in the face of constant accolades in the medical community about the quality of VA healthcare. AFGE also has concerns about the potential of VA's newest fee basis initiative, Project HERO, to waste scarce medical dollars by increased use of contract care.

Long term care: The Administration has once again failed to propose adequate funding for institutional long term care. There are insufficient resources in the community to shift large numbers of aging and disabled veterans to noninstitutional care. Some veterans must remain in institutional care and need beds that are currently in short supply. In addition, AFGE questions estimates in the proposed budget that predict declines in operating levels for rehabilitative, psychiatric, nursing home and domiciliary care.

REPORTS FROM THE FRONT LINES

The following examples illustrate how underfunding and financial uncertainty adversely impact the delivery of healthcare to veterans:

Nurses:

- **PAY:** Budget-driven pay policies hurt nurses and veterans alike. Despite widely recognized problems with recruitment and retention, RNs in every VISN report problems with the locality pay process established by 2000 nurse legislation. Managers regularly contend that they lack the funds to provide nurse locality pay increases even after conducting pay surveys.
- **STAFFING:** Poor pay policies directly impact staffing levels, which in turn hurt patient care and patient safety in many ways, for example, not having time to check orders or do blood drawers or IV placements promptly. Staffing shortages in the hospital supply department further impede the RN's ability to access oxygen tubes and other life-saving equipment in emergency situations. RNs in a VISN 23 facility report that their polytrauma unit is short-staffed, requiring nurses to give less time to each veteran and forcing them to limit the number

of veterans admitted to this state-of-the-art new treatment facility. A facility in VISN 16 was recently forced to place geropsychiatric patients in a more costly medical unit with one on one nursing care because of a loss of psychiatric ward beds.

- **CONTRACT NURSES:** Turning to contract nurses as a stopgap solution wastes scarce dollars and impacts quality. A facility in VISN 9 is about to spend more than a half million VA healthcare dollars on contract nurses because of difficulties in recruiting and retaining in-house staff (at a lower cost) and too few staff in the personnel department to bring in new hires.
- **FLOATING:** Another frequently used stopgap solution that hurts patient care and lowers nurse morale is rotation of nurses between units because of short staffing. Nurses are then forced to work in areas where they feel less competent.
- **MANDATORY OVERTIME:** Despite provisions in 2004 legislation to reduce mandatory nurse overtime, hospitals continue to rely on mandatory overtime to address staffing shortages.
- **PATIENT SAFETY EQUIPMENT:** AFGE urges this Subcommittee to ensure that all VA hospitals have the funds to purchase patient lifting equipment that reduces the incidence of nurse back injuries and patient skin tears.

Physicians and dentists:

In every VISN, physicians and dentists report difficulty getting adequate market pay increases and performance pay awards, despite clear language in 2004 physicians pay legislation. Facility directors have contended that they lack the funds to increase pay and give awards, even before they convened any panels to set market pay or conducted evaluations of individual physician performance. Management also cries "budget" in refusing to reimburse physicians for continuing medical education, again despite clear language in Title 38 entitling full-time physicians to up to \$1000 per year.

On call physicians are routinely scheduled for weekend rounds and are not provided any compensation time for weekend work. Primary care panel sizes are at maximum levels regardless of the complexity of various cases. Physicians with heavy workloads must also cover large patient loads of other doctors on leave as there are no additional physicians available.

The results of these ill-advised policies are widespread shortages of specialty physicians throughout the VA, and shorthanded primary care clinics with enormous patient caseloads. In turn, these shortages require increased reliance of costly fee basis care by non-VA providers.

Delays in diagnostic testing: Short staffing causes significant delays in medical testing. According to a recent report from a VISN 20 facility, veterans face significant delays in obtaining sleep studies because the sleep clinic lacks adequate staff to review the results. As a result, it takes 5 to 6 months to get reports read (over double the wait time a year ago). The facility is also experiencing extensive delays in getting the results of bone density studies because the Imaging Department has only one part-time employee to read the scans.

Mental Health: Due to a chronic shortage of psychiatrists in many facilities, new veterans entering the VA healthcare system must wait several months to see a psychiatrist. While there has been an increase in hiring of new social workers, the level is still below that of 10 years ago. Heavier caseloads prevent social workers from spending more time with patients and providing other support such as visiting patients at homeless shelters.

CONCLUSION

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Subcommittee on Health. We look forward to working with Chairman Michaud and other Members of the Subcommittee to ensure that the VA budget adequately meets the healthcare needs of our veterans in FY 2008 and beyond. We believe assured funding, increased oversight and carefully measured use of contract care are essential to meeting that goal.

**Statement of Shannon Middleton, Deputy Director,
Veterans Affairs and Rehabilitation Division, American Legion**

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to submit The American Legion's views on the Veterans Health Administration's budget request for Fiscal Year 2008. 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.

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

*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* (July 18, 2005) 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* (August 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 copayments 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 copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal Government. The American Legion supported legislation to allow VA to bill, collect, and reinvest third-party reimbursements and copayments; 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 results in real budgetary shortfall. Seeking an 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. Servicemembers 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. In an effort to provide a tangible voice for the frustrations expressed by veterans affected by the delay in CARES funding, The American Legion has recently produced a publication entitled *CARES Dead or Alive?* This seven-part series of articles provides a candid view of how the absence of CARES-promised facilities has impacted veterans and the challenges they face when seeking care. 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 Presi-

dent's budget request. This additional funding will address more pending life-safety projects and new construction projects.

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.

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 servicemembers who will soon return home. You have the power to ensure that their sacrifices are indeed honored with the thanks of a grateful nation.

Thank you for allowing me the opportunity to present the views of The American Legion to you today.

Statement of David G. Greineder, Deputy National Legislative Director, American Veterans (AMVETS)

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee: AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs Veterans Health Administration 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 VHA.

As you know, AMVETS is 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 health-care services, including long-term care. And, veterans must be assured burial in a state or national cemetery in every state.

As an aside, Mr. Chairman, AMVETS is honored that you are the recipient of the 2007 Congressional Silver Helmet award. You have been a strong and steadfast supporter of veterans throughout the years, and we look forward to presenting you with the Silver Helmet in March.

Veterans Health Administration

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.

This week, Congress will finish work on a continuing resolution that will cover the rest of the 2007 fiscal year. We thank the leadership in the House, from both sides of the aisle, for their work in adding an additional \$3.6 billion for VA in the continuing resolution. Since the start of the current fiscal year in October 2006, VA has been forced to ration care and place freezes on hiring medical staff. Furthermore, because VA resources has been strained for the nearly 5 months, it had to raid accounts from many important programs and functions. Frankly, Mr. Chairman, we cannot do this every year. We hope we can work together with you to find viable solutions to this yearly recurrence.

For fiscal year 2008, the Administration requests \$34.2 billion for veterans' healthcare, a \$1.9 billion increase over the House-passed continuing resolution. AMVETS recognizes this increase is more than what VA has seen in other years, however it still falls short. *The Independent Budget* recommends Congress provide \$36.3 billion to fund VA medical care for FY08, an increase of \$4 billion over the FY07 appropriation and \$2.1 billion over the Administration request.

AMVETS, along with our *Independent Budget* partners, reaffirm our belief that Priority 8 veterans should be allowed to access VA if they so chose, and we encourage VA to overturn its current policy banning these so-called "high-income" veterans. VA estimates that more than 1.5 million category 8 veterans will be denied enrollment in 2008. This is unacceptable and we will continue our fight for them and all veterans when it comes to accessing the quality services VA has to offer.

We are disappointed, and quite frankly irritated, that the Administration once again recommended an increase in prescription drug copayments from \$8 to \$15 and an indexed enrollment fee, based on veteran incomes. Although VA has not clearly explained the ramification of such a policy proposal, we estimate that as many as 200,000 veterans will leave the system and more than one million veterans will choose not to enroll. Is this the message VA wants to send to the 26 million veterans that are alive today, and thousands more returning home from operations overseas? Congress has soundly rejected these proposals in the past, and we ask you do the same this year.

Assured Funding

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 underfunding has led to rationing of care through reduced services, lengthy delays in appointments, higher copayments and, in too many cases, sick and disabled veterans being turned away from treatment.

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.

AMVETS is encouraged from the positive responses we received from the Leadership in the House in holding hearings on the subject of mandatory funding. This is a start, and one AMVETS looks forward to. We feel that discussing the topic in a public forum, and reviewing and critiquing the merits of different proposals is how the democratic process should work. We are anxious to begin the dialogue, Mr. Chairman, and are available as a resource to you and your staff.

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 Hon. Corrine Brown, a Representative in Congress from the State of Florida

Chairman Michaud, thank you for holding this hearing and inviting the Under Secretary to discuss the health budget of the Department of Veterans Affairs.

I would like to thank the groups here today to speak on the VA health budget. The American Psychiatric Association, Friends of VA Medical Care and Health Research and the Iraq and Afghanistan Veterans of America.

Mr. Under 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.

I look forward to hearing new information from you on the specific health budget.

However, why do you continue to put forward 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.

Last week the Secretary said there were 1.6 million Priority 8 veterans. Also that it would cost \$1.7 billion to include them in the system. Isn't that the point—to include all veterans in the VA healthcare system?

Every year, the Congress, Members of both the Republican and Democrat 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?

No matter what the Secretary said last week, you are cutting VA medical and prosthetic research. At a time when ever more young men and women are coming back from Afghanistan and Iraq without limbs, we need to fund this.

Thank God that more soldiers than ever are surviving their battlefield injuries. Why does it seem to me you are doing all you can to push them out of the system.

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.

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.”

Statement of Paralyzed Veterans of America

Mr. Chairman and Members of the Committee, on behalf of the four co-authors of *The Independent Budget*, Paralyzed Veterans of America (PVA) is pleased to present our views for the record 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, as of 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 copayments 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 our statement. We would be happy to answer any questions that you might have for the record.

Statement of Hon. Cliff Stearns, a Representative in Congress from the State of Florida

Mr. Chairman, thank you for holding this hearing today on the proposed budget. Health services are a cornerstone of the Veteran's Affairs mission, and I am looking forward to discussing proposals for improvement in delivering critical services to our veterans.

I am encouraged that the Administration request includes an increase in medical care of \$1.9 billion over fiscal year 2007, and in particular I am pleased by the \$56 million increase in the VA's Mental Health Initiative, for a total of \$360 million. This has been a neglected area in the past, but it needs increased focus now as more and more veterans coming home from Iraq and Afghanistan are suffering from Post-Traumatic Stress Disorder. We need to make sure that they and their families receive the counseling they need.

Our veterans have provided this country with invaluable service, and yet too often the disability claims process is complicated and frequently delayed. It is imperative that we work quickly to resolve this overwhelming backlog in processing claims. The most time consuming process would be processing new claims, and with the VA anticipating more than 54,000 veterans returning from Iraq and Afghanistan in 2008, we must reform the process to make it efficient and thorough.

An additional area of delay is filing ratings claims, which takes on average 155 days to process! The VA anticipates seeing 5.3 million veterans in 2008, which represents an incredible administrative burden, and portends of even longer claims processing delays. We must seek ways to allocate staff efficiently and utilize advancements in technology to reduce this burdensome backlog.

Thank you again, Mr. Chairman, for holding this hearing, and I look forward to hearing the vision for veterans healthcare 2008 from today's panel.

Statement of John Rowan, National President, Vietnam Veterans of America (VVA), Patricia Bessigano, Chair, VVA National Veterans Healthcare Committee; and Thomas J. Berger, Ph.D., Chairman, VVA National PTSD and Substance Abuse Committee

Chairman Michaud, Ranking Member Miller and distinguished Members of the Subcommittee, on behalf of all of our officers, Board of Directors, and members, I thank you for allowing Vietnam Veterans of America (VVA) the opportunity to submit this statement for the record regarding the President's fiscal year 2008 budget request for the Veterans Health Administration of the Department of Veterans Affairs. VVA looks forward to working with you and all of your distinguished colleagues to address the needs of the unique system created to serve our Nation's veterans.

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 hope you have read and shared with others. We hope that you will remain a strong supporter of legislation to achieve assured funding. There is a clear and urgent need for such a mechanism to correct the problems in the current system of funding. As we have this discussion in regard to the FY08 budget for VHA, 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 & 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 recommendation 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, 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, virtually 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.

The Veterans Health Administration of the Department of Veterans Affairs has had many successes, and been recognized by numerous prestigious awards in recent years. The veterans' service organizations are often seen as critics of the Department, but while it's true that we sometimes take exception to its policy decisions we are, in fact, 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. (Unfortunately, they have gone way too far in staff reductions through attrition, which now urgently needs correction.) It has developed hundreds of Community Based Outreach Clinics (CBOCs). VHA has received many prestigious awards for excellence and innovation. While VVA remains extremely concerned about recent breaches that compromised veterans' personal data to the outside world, and we remain equally concerned regarding the privacy of a veterans' personal health and other information *within* the VA structure, VVA does appreciate 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 a 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 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 so-called "temporary" decision to bar these veterans is still standing and is reflected now in the long-term planning for the VHA. This 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 in the past, 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. 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 the House Veterans' Affairs 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 axe has fallen hard on long-term care programs in 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 pharmaceutical therapies 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 led them to the streets or even suicide.

Mental Health, PTSD, and Other Needs Underestimated

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 and Traumatic Brain Injury (TBI). 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 Under Secretary 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 rever-

berated 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 FY08. VVA and others believe that well more than 300,000 “new” veterans will use the VHA system in FY08.

Poor Projection Formula Inappropriate for Military Veterans Healthcare Needs

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 just happens to see veterans if the VHA is to properly and adequately address the needs of veterans, particularly veterans who are sick or injured in military service. The model developed by Millman & Associates that 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) per patient as opposed to the five to seven per veteran patient that is the average at VHA. Some adjustment to this is done on the basis of clinic stops or visits, but it still underestimates the total usage rate per individual veteran that is actually needed. 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 CBOCs, which will be sought after as more troops (including demobilized National Guard members and Reservists) 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.

Improperly High Doctor-Patient and Nurse-Patient Ratios Must Be Addressed

To assist in developing these programs and augmenting all areas of veterans’ care, VVA recommends funding to accommodate the staff-to-patient ratio VA had in place before VA had dismantled so much of its neuro-psychiatric and long-term care infrastructure. 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 all too closely corresponds to the funding from unspecified (so called) “management efficiencies” VA has had to shoulder throughout this Administration for this to be a coincidence. 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—FY03 and 04—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.” The cuts (and they were indeed budget cuts) were met by reductions in staff. (This was done primarily through attrition and then just not filling positions, although some RIFs and buyouts probably occurred during this timeframe as well.) These so-called management efficiencies have resulted in staff deficiencies across the spectrum of medical disciplines, and across the country. VVA hopes Congress will agree that this is no way to fund our veterans’ healthcare system.

Further, the staff cuts referenced above have caused VA to often rely on contracting out using such gimmicks as the inaptly named "Project HERO" that VHA is about to use to further contract out services instead of hiring full time staff clinicians and properly training them in the wounds and maladies particular to military service, depending on what branch one served, when they served, where they served, their military occupational specialty, and what actually happened to them (e.g., SHAD biological and chemical exposures). While the VHA has created such curricula, as part of the Veterans Health Initiative (www.va.gov/vhi), most clinicians and no contractors even know of the existence of these curricula.

The extensive use of contracting out medical services by VHA is both the result of underfunding, and a costly, wasteful solution to the problem created by the staff shortages resulting from the same underfunding. This is not a rational or proper way to run a healthcare system, much less one for our nation's veterans, who have already given so much.

Agent Orange Healthcare

For our last point under Medical Services, 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. Despite VVA's repeated requests, Congress did not reauthorize it. Had Congress simply reauthorized existing authority, VA would have realized no new costs. Now we understand 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 issue now is to reinstate veterans with these conditions for the higher priority access to services that they deserve.

Vet Centers (Readjustment Counseling Service)

VVA believes that announced expansion of the Readjustment Counseling Service by opening 23 new Vet Centers is great, and a much needed move on the part of the VA. However, this will be a great thing only if the Readjustment Counseling Service (RCS) is accorded at least another 300(+) FTEE. The RCS already needs at least another 250 full time professional staff members to provide one family counselor cross trained in PTSD and bereavement counseling at each of the 209 existing Vet Centers, and to provide 40 more staff members RCS-wide, so that the Director of RCS does not have to juggle vacancies just in order to keep operating. That is the case today, before the addition of these 23 new Vet Centers.

In addition to these needed additional FTEE, VVA strongly encourages changing Chapter 41 of Title 38 to require a full time DVOP be permanently out-stationed at each VA Vet Center, with the appropriate computer support, travel allowance, etc. to be able to develop jobs in the community for the vets utilizing that Vet Center. The best of the Vet Centers around the country have some sort of arrangement like this, but the state workforce developments in many cases are ending that support, even where it exists.

Helping a veteran get to the point where he or she can obtain AND sustain meaningful employment at a living wage is still the central event in the readjustment process. We have not paid sufficient attention to this fact in the past, and we need to ensure insofar as possible that we provide sufficient resources for employment for those coming home today.

If the U.S. Department of Labor and the workforce development agencies that actually employ the DVOPs won't do this properly (as is currently the case), then there must be new VA Vocational Rehabilitation specialists, skilled in job placement as well as education and training issues, who are located one counselor in each Vet Center.

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 FY06, 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 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 appar-

ently 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.

Agent Orange Research

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.

When VVA pressed VA last Fall in this regard, they for the first time made available the results of some mortality studies done by VA’s Public Health & Environmental Hazards staff member Dr. Han Kang. (VVA has supplied your staff with copies of the results of these studies as we have received them from VA.)

VA tried to say that this was sufficient for research into the deleterious health-care effects of Agent Orange, other herbicides used in the Vietnam War, and all of the other toxins that were rife in Vietnam during the war. With the permission of the Committee, Mr. Chairman, I ask that the results of these studies be entered into the record, as VA has never made any effort to publicize or follow up on the results which indicated that there are many more maladies that should be service connected presumptive for those who served in Vietnam, but which are not so today. This is largely the function of there not being enough studies in this area, and VA is not funding even internal research, much less outside studies that the veterans’ population is more inclined to believe would be objective and scientifically valid research. I have submitted these studies to the Subcommittee under separate cover for your consideration, Mr. Chairman.

VVA unequivocally takes the position that this total lack of funding further research that is indicated as needed by the VA’s own mortality and morbidity studies by Dr. Kang is simply unacceptable, and urges the Subcommittee to demand to know why this is the case.

Women Veterans and Mental Health

In the Iraq and Afghanistan wars “combat support troops” are just as likely to be affected by the same traumas as infantry personnel. This has particularly impor-

tant implications for our female soldiers, who now constitute about 16 percent of our fighting force. Returning female OIF and OEF troops face ailments and traumas of a different sort. For example, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. And according to a Pentagon study released in March 2006, more female soldiers report mental health concerns than their male comrades, 24 percent compared with 19 percent. In addition, roughly 40 percent of these women have musculoskeletal problems that doctors say likely are linked to lugging too-heavy and ill-fitted equipment. A considerable number—28 percent—also return with genital and urinary system infections.

There are also gender-related social issues that make transitioning tough for women. For example, women are more likely to worry about body image issues, especially if they have visible scars, and their traditional roles as caregivers in civilian life can set them back when they return. In other words, they are the ones who have traditionally had the more nurturing role within our society, not the ones who need nurturing. And last, female veterans now number 1.7 million. The VA projects that by 2010, 10 percent of all veterans will be women, compared with 2 percent in 1997. And although the VA's budget for women's healthcare service has also grown, from \$21 million in 2000 to an estimated \$43.5 million in 2006, services are not evenly distributed throughout the VA system.

While the VA has made vast improvements in treating women since 1992, especially in treatment of PTSD and the other after effects of Military Sexual Trauma (MST) at VA Medical Centers; there are very few clinicians within the VA who are prepared to treat combat situation-induced PTSD as opposed to MST-induced PTSD. Additionally, there are already cases where returning women service personnel have a combination of the two etiologies, making it extremely difficult for the average clinician to treat, no matter how skilled in treating either combat-incurred PTSD in men, or MST-induced PTSD in women.

Because of the number of women who are now de facto combat veterans based upon the nature of the conflicts in Afghanistan and particularly Iraq, Vietnam Veterans of America (VVA) believes there is an immediate need for research on effective, evidence-based, integrated dual diagnosis treatment modalities for women veterans suffering from PTSD and related mental health disorders.

National Vietnam Veterans Longitudinal (Readjustment) Study

No one really knows how many of our troops in Iraq and Afghanistan have been or will be affected by their wartime experiences. Despite the early intervention by psychological personnel, no one really knows how serious their emotional and mental problems will become, nor how chronic both the neuro-psychiatric wounds (particularly PTSD) will be or how these wounds will impact their physiological health. However, reports from researchers at Walter Reed have suggested that troops returning from service in Afghanistan and Iraq are suffering mental health problems at rates comparable to or higher than the levels seen in Vietnam War veterans.

In fact, Vietnam Veterans of America (VVA) has no reason to believe that the rate of veterans of this war having their lives significantly disrupted at some point in their lifetime by PTSD will be any less than those estimated for Vietnam veterans by the National Vietnam Veterans Readjustment Study.

Results from the original NVVRS demonstrated that some 15.2 percent of all male and 8.5 percent of all female Vietnam theater veterans were current PTSD cases (i.e., at some time during 6 months prior to interview). Rates for those exposed to high levels of war zone stress were dramatically higher (i.e., a four-fold difference for men and seven-fold difference for women) than rates for those with low-moderate stress exposure. Rates of lifetime prevalence of PTSD (i.e., at any time in the past, including the previous 6 months) were 30.9 percent among male and 26.9 among female Vietnam theater veterans. Comparisons of current and lifetime prevalence rates indicate that 49.2 percent of male and 31.6 percent of female theater veterans, who ever had PTSD, still had it at the time of their interview. Thus the NVVRS was a landmark investigation in which a national random sample of all Vietnam theater and era veterans, who served between August 1964 and May 1975, provided definitive information about the prevalence and etiology of PTSD and other mental health readjustment problems. The study over-sampled African-Americans, Latinos, and Native Americans, as well as women, enabling conclusions to be drawn about each subset of the veterans' population.

The NVVRS enabled the American public and medical community to become aware of the documented high rates of current and lifetime PTSD, and of the long-term consequences of high stress war zone combat exposure. Because of its unique scope, the NVVRS has had a large effect on VA policies, healthcare delivery and

service planning. In addition, because the study clearly demonstrated high rates of PTSD and strong evidence for the persistence of this disease, it was generally accepted that the VA would pursue a follow-up or longitudinal study of the original participants in this seminal research project.

Thus in 2000 the Congress, by means of Public Law 106-419, mandated the VA to contract for a subsequent report, using the exact same participants, to assess their psychosocial, psychiatric, physical, and general well-being of these individuals. It would enable it to become a longitudinal study of the mortality and morbidity of the participants, and draw conclusions as to the long-term effects of service in the military period, as well as about service in the Vietnam combat zone in particular. The law requires that VA use the previous report as the basis for a longitudinal study.

Shortly after enactment of the law, in early 2001 the VA solicited proposals for non-VA contractual assistance to conduct a longitudinal study of the physical and mental health status of a population of Vietnam era veterans originally assessed in the NVVRS. It is apparent that a longitudinal follow-up to the NVVRS is necessary in order to meet the requirements of the law, and to adequately satisfy policy and scientific questions. However, not only has the VA failed to meet the letter of the law, there has been no effort to build upon the resources accumulated from this unique and comprehensive study of Vietnam veterans in a highly cost-efficient and scientifically compelling manner.

Such a longitudinal study would provide clues about which VA healthcare services are effective and about ways to reach the veterans who receive inadequate services or do not seek them at all. And this has important consequences for America's current and future veterans.

At that same hearing on Research & Development on June 7, 2006, the VA also said that they could not do the study because they could only find 300 of the original more than 2,500 persons in the statistically valid random sample chosen by the Gallup Organization at a public cost of more than \$1 million in 1984 dollars. VVA suggest that a more intensive effort to locate these veterans be undertaken before the VA is allowed to scuttle a longitudinal study for this reason. If that were true (which strains credulity at best) that all but 300 are dead, then that would mean that 85% of that valid national sample has died in the past 25 years. VVA would suggest that this is unlikely.

The VA has tried to claim they would be better off using the widely discredited and failed "twins" study database now controlled by the Institute of Medicine, that has no women at all, and not nearly enough African-Americans, Hispanics or Asian-Americans in the database to make valid conclusions about each of these important sub-groups in the Vietnam veteran population. Furthermore, the "twins" database is even so small that it is not a statistically valid random sample for anybody. One can speculate that the VA refuses to obey the law because they do not want a longitudinal study, or perhaps they do so because they do NOT want to have validated the results of what the NVVRS may demonstrate in regard to very high mortality and morbidity of Vietnam veterans, especially those most exposed to combat.

It is now clear that the VA is ignoring the law and the Congress and plain refusing to do the study. It also seems clear that they intend to continue thumbing their nose at the Congress, and regarding laws they do not like as cute ideas put forth by the Congress that can be ignored anytime and in any way they choose.

The VA has said in Congressional testimony that "the Inspector General stopped the study," when in fact the IG has no line authority at all to do any such thing. The Under Secretary and the Secretary stopped the study. The only real criticism by the IG was for VHA failing to follow proper contract procedures or exercise proper oversight. Certainly the specious to the point of being just plain silly reasons that the Director of Medical Research and others from VA give convince no one that this is anything but politically motivated and ordered to try and minimize possible future costs to the VA.

Because the VA has still not moved forward and contracted to finish the National Vietnam Veteran Readjustment Study (NVVRS), Vietnam Veterans of America (VVA) strongly urges that the VA follow the law, and contract to get this study completed as soon as possible, as it will provide both the medical community and America's veterans' community valuable insight into chronic PTSD and other socio-psychological readjustment problems of combat theater veterans and when and how these problems will be likely to manifest themselves in the current generation. However, VVA frankly does not anticipate that VA will do the right thing, or even obey the law, unless they are compelled to so by means of the power of the purse.

It has now come to our attention that VA, through their contract officer, is demanding of the Research Triangle Institute (RTI) to know the names and Social Security numbers of the participants in the original study, who had been assured ano-

nymity. The previous, and some of the current VHA leadership not only has tried to besmirch the reputation of this respected research institution by citing things in a report by the Inspector General (IG) at VA that the report did not contain, but now they are threatening RTI with legal and or other punitive action, through the contract officer, if they don't violate privacy rights of the human participants in this study. This unconscionable effort to compromise the study population, to violate basic scientific principle of protection of human subjects, as well as violate the privacy rights of the individuals concerned, must be stopped by the Congress before the VA totally foils efforts to conduct a proper followup study ever being done on this population.

Mr. Chairman, finally VVA urges this Subcommittee 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 of VA to advise the Subcommittee on steps it will take to complete this study properly within 2 years, as a comprehensive mortality and morbidity study.

Traumatic Brain Injuries

Medical experts say traumatic brain injuries (i.e., TBIs) are the "signature wound" of the Iraq war, a by-product of improved body armor that allows troops to survive once-deadly attacks. Unfortunately, the armor does not fully protect against the blast effects of roadside explosive devices and suicide bombers. These injuries have become so common that both Army and the VA have set up special traumatic brain injury centers. For this both the VA and the Army are to be commended. Symptoms include slowed thinking, severe memory loss, and coordination and impulse control problems.

TBI shares some symptoms with, but is markedly different than Post Traumatic Stress Disorder (PTSD), which is triggered by extreme anxiety and permanently resets the brain's fight-or-flight mechanism. Battlefield medics and medical supervisors often miss traumatic brain injuries, and many troops don't know the symptoms or won't discuss their problems for fear of being sent home with the stigma of mental illness. In this war, it is the blast waves themselves that cause the most damage and have proven the most problematical, the most disabling, and the most difficult to treat, primarily because they severely damage a soldier's nervous system.

Primary injuries to the brain include concussions which can result in the loss of consciousness and what neurologists used to call "coup-contra-coup" injuries, a term formerly restricted to central nervous injuries resulting from severe blows to the head.

Indeed, soldiers walking away from blasts have later discovered that they suffer from memory loss, short attention spans, muddled reasoning, headaches, confusion, anxiety, depression, and irritability.

In a 2004 article in *The Journal of Brain Injury* entitled "Depression, Cognition and Functional Correlates of Recovery Outcome after Traumatic Brain Injury," neurologists acknowledge that patients with mild to traumatic brain injuries are more affected by their emotional problems than by their residual physical disabilities. The article ends with an admonition that it is important to screen blast injury patients for depression and to conduct neuropsychological testing as soon as possible after the head injury in order to initiate treatment and ensure successful re-entry back into civilian life. Yet to date the Pentagon has been unwilling to fund a screening program for returning soldiers for mild brain injuries, arguing that the long-term effect of brain injuries needs more research. Researchers have found that up to 10% of the troops suffer from concussions during their tours, a figure that rises to 20% for those in combat units. One thing is clear: Subtle TBIs can and do result in PTSD like symptoms, even if actual PTSD due to combat stressors is not present.

Certain TBI symptoms, such as seizures, can be treated with medication, but the most devastating effects of TBIs—depression, agitation and social withdrawal—are difficult to treat with medications, especially when loss of brain tissue occurs. In troops with documented TBIs, the loss of brain function is often compounded by other serious injuries that affect physical motor coordination and memory functions. These patients need a combination of psychological, psychiatric and physical rehabilitation treatment that is difficult to coordinate in a traditional hospital setting, even when it is properly diagnosed at an early date.

Furthermore, as more and more troops return home with even mild brain damage, their families must contend not only with the shock of seeing the physical and psychological destruction to their loved ones, but also with how their own lives change dramatically. In addition, there are issues about the intensity and drains of vitally needed family support that will be hard to sustain, as well as significant issues regarding the complexity of the medical and other specialized needs that have to be addressed.

A TBI to a 35-year-old with two children at home is a wound that also affects the future of the whole family. For the majority of head injuries there is the inability to concentrate, the mood swings, depression, anxiety, even the loss of a job. The economic and emotional instability of a family can be as terrifying and as real as any difficulty focusing or simply waking and crying in the middle of the night.

But Vietnam Veterans of America's (VVA) real concern is that many significant closed head injuries are going undiagnosed, and we fear that subtle but real neurological and related psychological problems are missed in soldiers who are exposed to blasts, but who are not visibly injured enough to enter the medical evaluation chain. The limited medical research on blast injuries clearly shows that such injuries are notorious for their delayed onset.

Vietnam Veterans of America (VVA) strongly urges this Subcommittee to push for more R&D funds, and push hard that part of these funds be used to foster enhanced research efforts to determine the relationship and long-term impacts of TBIs, especially so-called "mild" brain injuries, to the delayed onset of Post Traumatic Stress Disorder (PTSD).

Assured Funding for Veterans' Healthcare

Once this Congress provides a budget that shores up VA medical services and facilities, it will need to assure 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.

Accountability at VA

So much of what VVA and the Congress on both sides of the aisle find wrong or disturbing at the VA revolves around the general and all-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 are 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 21 Veterans Integrated Service Networks (VISNs) was a key element enabling VA to be the first large agency to reach the goal mandated by law. Some 85% of all VA procurement is through VHA, primarily through the VISNs is the key factor in this achievement.

There is an expression that "what is measured, matters." Hard-working people with many responsibilities will understand the priority their leaders give certain policy by whether it is measured and has consequences. Putting procurement from service disabled veteran owned businesses 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, have 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 allowing 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 de-mobilized 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, it turns out that no one that we have spoken

to, including VA officials, can fully explain at least \$200 million-plus of this “adjustment” either. And this is *before* they get their hands on the dollars.

VVA urges this Subcommittee, 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 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, for allowing Vietnam Veterans of America (VVA) to submit this statement for the record regarding the level of resources necessary for the veterans’ healthcare so vitally needed by veterans of every generation. We hope these thoughts and recommendations prove to be of some use to you in the vital work of helping to ensure that the resources, and the accountability mechanisms, are in place to get the job for every generation of veterans that has earned the right to medical care by virtue of their service.

VVA urges you to leave no veteran behind.

We look forward to working with you and the distinguished Members of this Subcommittee to obtain an excellent budget for VA in FY08, and to ensure the next generation of veterans’ well-being by enacting assured funding.

VVA will be happy to answer any questions you and your colleagues may wish to tender to us in writing.

MEDICAL SERVICES (in millions \$)	
FY 2007 Est. Baseline (Includes Projected Collections)	27612
Medical Services Payroll	
Annualization costs for 136,000 FTE (FY 07 and FY 08)	959
Address 8% Increase in Demand	1088
Restore and Enhance LTC and MH Services	1000
Restore Adequate Staff to Patient Ratio to Address Timeliness and Assure Quality of Care	2200
	5247
Other Inflation and Increase in Demand	
Drugs	543
Other Med. Products	211
Contracted Medical Services	488
CPI (non medical)	84
	1326
New Initiatives	
Restore Services for Agent Orange exposed Veterans	300
	300
Subtotal, Medical Services	6873

[The following attachments are being retained in the Committee file: Watanabe, Kevin K., Kang, Han K., “Military Service in Vietnam and the Risk of Death from Trauma and Selected Cancers,” *Elsevier Science Inc.* (1995); Watanabe, Kevin K., Kang, Han K., “Mortality Patterns among Vietnam Veterans, a 24-Year Retrospective Analysis,” *American College of Occupational and Environmental Medicine*; “Health Status of Army Chemical Corps Vietnam Veterans Who Sprayed Defoliant in Vietnam,” *American Journal of Industrial Medicine*; Dalager, Nancy A., Kang, Han K., Thomas, Terry L., “Cancer Mortality Patterns Among Women Who Served in the Military: The Vietnam Experience,” *American College of Occupational and Environmental Medicine*.]

POST-HEARING QUESTIONS FOR THE RECORD

Questions from Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary for Health, Veterans Health Administration

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC
March 7, 2007

Michael J. Kussman, M.D., M.S., MACP
Acting Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Kussman:

In reference to our Subcommittee on Health hearing on the VA Fiscal Year 2008 budget held on February 14, 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 and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Enclosure

Enrollment Fees—Last year you estimated that your enrollment fee proposal would cause 199,667 veterans to leave the VA. This year, your budget submission does not include an estimate as to the number of veterans you believe will leave the VA if your proposal is enacted and the VA begins charging an enrollment fee in FY 2009. In addition, in contrast to last year, you deem any revenue that would be collected from an enrollment fee to be “mandatory” revenue instead of “discretionary” revenue and subtracted from total VA mandatory amounts.

Question 1: How many veterans do you estimate would leave the system beginning in FY 2009 as a result of the enactment of your enrollment fee proposal?

Response: The tiered enrollment fee for priority 7 and 8 enrollees would charge \$250 for veterans with family incomes between \$50,000 and \$74,999; \$500 for veterans with family incomes between \$75,000 and \$99,999; and \$750 for veterans with family incomes equal to or greater than \$100,000 beginning in fiscal year (FY) 2009. The Department of Veterans Affairs (VA) estimates that approximately 420,000 enrollees would choose not to pay the annual enrollment fee in FY 2009.

Question 2: What policy decisions led you to decide in this budget submission to deem these fees “mandatory” revenues instead of “discretionary” revenues?

Response: In the past, VA was criticized for reducing its budget request prematurely before Congress had enacted the fee proposal. This year the VA's budget request did not prematurely assume approval of the fee proposal, but rather proposed the fee revenue become “mandatory” revenues only if and when the proposal was enacted by Congress.

Question 3: Each year you submit budgets to Congress that include an enrollment fee proposal, and each year Congress rejects these. Why do you believe that this year will be any different?

Response: The enrollment fee proposal allows VA to focus its resources on its core medical care mission of serving veterans returning from combat and those with military disabilities, lower incomes, and special needs. This year the budget request was not reduced before the proposal was enacted by Congress and if it is not enacted the budget will not require any adjustment.

Pharmacy Copayment Increase—Your budget submission includes a legislative proposal that would increase the pharmaceutical copayment from \$8 to \$15 for certain veterans. In comparison to previous years when you have advocated increasing pharmaceutical copayments, the revenues received would be treated as “mandatory” dollars instead of “discretionary” dollars.

Question 4: How many veterans do you estimate would leave the VA in FY 2008 as a result of the enactment of your pharmacy copayment proposal?

Response: VA does not expect any priority 7 and 8 veterans will choose to end their enrollment in VA healthcare system as a result of increasing the pharmacy co-pay from \$8 to \$15 in FY 2008. An increase in the pharmacy copayment will affect the services and medications priority 7 and 8 veterans seek from VA. We project this reduction in priority 7 and 8 services and medications will decrease FY 2008 expenditures by \$36 million.

Question 5: What policy decisions led you to decide in this budget submission to deem these fees “mandatory” revenues instead of “discretionary” revenues?

Response: In the past, VA was criticized for reducing its budget request prematurely before Congress had enacted the co-pay proposal. This year the VA’s budget request did not prematurely assume approval of the co-pay proposal, but rather proposed the co-pay revenue become “mandatory” revenues only if and when the proposal was enacted by Congress.

Question 6: Each year you submit budgets to Congress that include an increased pharmaceutical copayment proposal, and each year Congress rejects these. Why do you believe that this year will be any different?

Response: This year the budget request was not reduced before the proposal was enacted by Congress and if it is not enacted the budget will not require any adjustment.

Workload—The VA’s FY 2008 budget submission estimates that in 2008 the VA will see 5.3 million veterans. Your numbers seem to indicate that you plan on 5.2 million veterans in 2007 and 2006. Out of the 125,000 new priority 1–6 veterans you estimate for in 2008, 54,000 will be veterans returning from Iraq and Afghanistan.

Question 7: Given the VA’s difficulties in estimating workload in the past, how confident are you that your estimate of 5.3 million veterans for FY 2008 is accurate? Failing enactment of some of your legislative proposals, should we estimate a larger number of veterans seeking care?

Response: VA uses an actuarial model to forecast patient demand and associated resources needs. Actuarial modeling is the most rational way to project the resource needs of a healthcare system like the Veterans Health Administration. The estimates in the 2008 President’s submission represent the best possible estimates based on the information available at that time. Failure to enact the legislative proposals will have no effect on the forecasted workload estimates in the 2008 President’s submission.

VA continues to have confidence in the estimates that were developed for the FY 2008 budget submission. It should be noted that the number of 125,000 new priority 1–6 in the question represents the net change between the current estimate for FY 2007 and the FY 2008 estimate. There is significant mortality in the priority 1–6 enrolled population. VA expects to enroll 312,000 new priority 1–6 enrollees in FY 2008. The 125,000 figure is the net increase after accounting for current enrollee mortality.

Question 8: Given the VA’s difficulties in estimating the demand for services from veterans returning from Iraq and Afghanistan, how confident are you that the VA will see only 54,000 new returning veterans in FY 2008? How in fact have you estimated this number, and does this estimate reflect recent events in the Middle East?

Response: The 54,000 increase in the number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans expected to be treated by VA in FY 2008 represents the net increase. This figure does not mean that only 54,000 new returning veterans will be treated. As with any healthcare plan, VA recognizes that not all beneficiaries will seek care every year. For example, of the 48,000 new OEF/

OIF enrollees who were patients in FY 2005, only 69 percent returned to seek care in FY 2006.

VA's estimate represents the best possible estimates based on the information available at that time. VA's ability to project enrollment and use for OEF/OIF veterans is limited by the data available for input into the model. VA's only source of data specifically related to OEF/OIF veterans is a list of separating OEF/OIF servicemembers provided by Department of Defense (000). This data enables VA to identify those that have enrolled, whether they enrolled before or after deployment, determine their diagnoses, and identify their healthcare use patterns. VA will continually incorporate updates to the roster into the model.

“Efficiencies”—In your FY 2007 budget submission, you estimated a base level of “efficiencies” of \$884 million for FY 2006, and estimated additional “efficiencies” of \$197 million (\$107 million in clinical efficiencies and \$90 million in pharmaceutical efficiencies) for a total level of “efficiencies” of \$1.1 billion. The GAO last year found that you were unable to document previous claims of “efficiencies.” In this year’s budget submission you claim clinical and pharmaceutical “cost avoidance,” which seems to me to be “efficiencies” without being called “efficiencies.” Furthermore, you fail to provide any specific dollar amounts attributable to clinical and pharmacy “cost avoidance.”

Question 9: Did you achieve \$197 million in “efficiencies” in FY 2007 for a total level of \$1.1 billion?

Response: The FY 2008 budget submission included revised pharmacy and clinical efficiencies for both FY 2007 and FY 2008. The increased efficiencies in FY 2007 is shown below in four separate categories (\$ in Millions):

	<i>FY 2007</i>
Pharmacy Cost Efficiencies	\$150.213
Inpatient Clinical Efficiencies	\$181.332
Outpatient Clinical Efficiencies	\$ 26.425
Pharmacy Clinical Efficiencies	\$ 15.584
Total New Efficiencies	\$373.554

Question 10: Can you document these “efficiencies”?

Response: The first two categories (pharmacy cost and inpatient clinical efficiencies) can be measured and can be reported after the completion of each fiscal year. The pharmacy cost efficiencies reflect VA's expected inflationary trend for pharmaceuticals is expected to be lower than the expected private sector trend. The inpatient clinical efficiencies reflect a reduction in potentially avoidable inpatient days. VA will be able to document and report on these efficiencies after the close of each of the respective years. VA cannot measure the achievement of the outpatient and pharmacy clinical efficiencies for two reasons. One, the relative size of the expected improvement makes them difficult to measure with any credibility. Two, we cannot determine whether changes in levels of service use are due to improvements in providing the appropriate level of care or because enrollees chose to receive that care from their other healthcare providers. However, we incorporated these assumptions in the budgets after careful consideration of the Veterans Health Administration's (VHA) current management practices and the expected impact of initiatives to improve clinical efficiency, such as advanced clinical access, and believe that they are achievable.

Question 11: What are the estimates as to “efficiencies” or “cost avoidance” for FY2008?

Response: The FY 2008 budget submission included revised pharmacy and clinical efficiencies for both FY 2007 and FY 2008. The increased efficiencies in FY 2008 is shown below in four separate categories (\$ in Millions):

	<i>FY 2008</i>
Pharmacy Cost Efficiencies	\$ 85.342
Inpatient Clinical Efficiencies	\$184.313
Outpatient Clinical Efficiencies	\$ 30.380
Pharmacy Clinical Efficiencies	\$ 11.195
Total New Efficiencies	\$311.230

OEF/OIF Veterans—Last year, the VA's budget submission estimated that it would treat 110,566 OEF/OIF veterans in 2006, and 109,191 in 2007. Your budget submission this year estimates that you will have treated 155,272 in 2006, 209,308 in 2007, and 263,345 in 2008.

Question 12: Given the VA's failure to properly estimate the demand for healthcare from OEF/OIF veterans in the past, can we be confident that your estimates are closer to the mark this year?

Response: Over the past 2 years, VA has updated the model twice, using the most current baseline data available and has made several enhancements to the model methodology. Significant improvements to the actuarial model supporting the FY 2008 budget include enhanced veteran enrollment projections and the inclusion of a more detailed analysis of enrollee reliance on VA healthcare versus other providers.

VA has added several new data sources, including the social security death index, which improved the projections by providing a more accurate count of enrolled veterans. In addition, the new 2000 census long-form has provided more detailed information on the income of non-service-connected veterans and has enabled us to more accurately assign veterans into the income-based enrollment priorities.

The methodology for projecting the needs of OEF/OIF veterans has also been enhanced based on the actual enrollment and use patterns of OEF/OIF veterans since FY 2002. These include specific assumptions regarding their enrollment, morbidity, and reliance on VA healthcare.

VA has made every effort to account for the needs of OEF/OIF veterans within the actuarial model. However, there are several unknowns that will impact the number and type of services that VA will need to provide, including the duration of the conflict and when OEF/OIF veterans are demobilized. Therefore, we have included additional investments for OEF/OIF in the FY 2008 budget to ensure that VA is able to care for all of the healthcare needs of our returning veterans. VA will continue to monitor this situation closely and make adjustments to the model projections and budget assumptions as needed.

As VA continues to gain more longitudinal knowledge of the needs of OEF/OIF veterans, particularly through the VA/DoD post deployment healthcare reassessments (PDHRA), we will use this insight to further enhance our projections for this important population.

Question 13: 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: The methodology for projecting the needs of OEF/OIF veterans has been enhanced based on the actual enrollment and use patterns of OEF/OIF veterans since FY 2002. These include specific assumptions regarding their enrollment, morbidity, and reliance on VA healthcare.

VA has made every effort to account for the needs of OEF/OIF veterans within the actuarial model. However, there are several unknowns that will impact the number and type of services that VA will need to provide, including the duration of the conflict and when OEF/OIF veterans are demobilized. Therefore, VA has included additional investments for OEF/OIF in the FY 2008 budget to ensure that VA is able to care for all of the healthcare needs of our returning veterans. VA will continue to monitor this situation closely and make adjustments to the model projections and budget assumptions as needed.

CBOCs/Facility Activations—The VA's FY 2008 budget submission request \$21 million for facility activations. The VA has also been promising a number of new Community Based Outpatient Clinics over the last few years.

Question 14: Of the \$21 million requested, how much will go to activating new CBOCs, and where will those CBOCs be located?

Response: Community based outpatient clinics (CBOC) are funded from within existing veterans integrated service network (VISN) budgets, so none of the \$21 million for facility activations will go toward activation of new CBOCs. The \$21 million for facility activations is used for operating expenses on completed construction projects, primarily for initial equipment and supplies to support the opening of new facilities, and as such are one time or non-recurring expenses.

Question 15: How much have you budgeted in FY 2007 for activations, and of this amount, how much will for activating new CBOCs?

Response: The 54 clinics listed below are currently approved and planned for activation in either third quarter FY 2007 or during FY 2008.

VISN	Facility Name	State	Planned Activation Date	Date of Approval
18	NW Tucson	AZ	July 2007	March 2005
21	American Samoa	HI	July 21, 2007	March 2006
23	Bemidji	MN	July 12, 2007	March 2006
6	Norfolk	VA	August 1, 2007	March 2006
21	Fallon	NV	August 6, 2007	March 2006
7	Stockbridge	GA	September 2007	April 2007
22	South Orange County	CA	September 2007	March 2006
19	Cutbank	MT	October 2007	April 2007
4	Dover	DE	December 2007	March 2006
7	Aiken	SC	December 2007	April 2007
7	Childersburg	AL	December 2007	April 2007
8	Camden County	GA	December 2007	April 2007
9	Morristown/Hamblen County	TN	December 2007	June 2006
15	Daviess County	KY	December 2007	April 2007
8	Jackson County	FL	January 2008	April 2007
19	Lewistown	MT	January 2008	April 2007
15	Jefferson City	MO	February 2008	April 2007
9	Perry County/Hazard	KY	March 2008	March 2006
20	Bellingham Area (Whatcom County)/NW Washington (Skagit County)	WA	March 2008	January 2007
16	Branson	MO	Second quarter FY 2008	April 2007
16	Eglin AFB	FL	Second quarter FY 2008	March 2006
16	Pine Bluff	AR	Second quarter FY 2008	April 2007
23	Carroll	IA	Second quarter FY 2008	April 2007
23	Cedar Rapids	IA	Second quarter FY 2008	April 2007
23	Holdrege	NE	Second quarter FY 2008	March 2006
23	Marshalltown	IA	Second quarter FY 2008	April 2007
23	Watertown	SD	Second quarter FY 2008	April 2007
4	Morgantown (Monongalia)	WV	Second quarter FY 2008	April 2007
8	Putnam County	FL	April 2008	April 2007
9	Madison County	TN	April 2008	April 2007
15	Hutchinson	KS	April 2008	April 2007
11	Elkhart County	IN	May 2008	April 2007
18	SE Tucson	AZ	May 2008	March 2005

VISN	Facility Name	State	Planned Activation Date	Date of Approval
5	South Prince George City/ Andrews AFB	MD	June 2008	April 2007
9	Hawkins/Sullivan County	TN	June 2008	April 2007
11	Alpena County	MI	June 2008	April 2007
11	Clare County	MI	June 2008	April 2007
18	Thunderbird	AZ	June 2008	June 2003
7	Spartanburg	SC	July 2008	April 2007
15	Knox County	IN	July 2008	April 2007
6	Charlottesville	VA	August 2008	April 2007
6	Franklin	NC	August 2008	March 2006
6	Hickory	NC	August 2008	March 2006
6	Lynchburg	VA	August 2008	March 2006
20	Metro West	OR	Summer 2008	December 2002
9	Berea	KY	September 2008	April 2007
9	Grayson County	KY	September 2008	April 2007
19	West Valley Salt Lake	UT	September 2008	April 2007
10	Parma	OH	Fourth quarter FY 2008	April 2007
20	North Idaho	ID	Fourth quarter FY 2008	April 2007
23	Shenandoah	IA	Fourth quarter FY 2008	April 2007
23	Wagner	SD	Fourth quarter FY 2008	April 2007
23	Bellevue	NE	Fourth quarter FY 2008	April 2007
18	Globe/Miami	AZ	December 2008	March 2006

Priority 8 Veterans—As you are aware, in January, 2003, the Administration stopped the enrollment of new Priority 8 veterans. We understand that the VA estimates that if this ban on enrollment was rescinded, 1.6 million Priority 8 veterans would seek care from the VA at a cost of \$1.7 billion for FY 2008, and \$33 billion over the course of 10 years. The Independent Budget has provided a radically lower cost estimate. The Independent Budget applies a utilization rate of 20 percent for a total cost of \$1.1 billion. The Independent Budget then takes an average amount received in collections from Priority 8 veterans and subtracts this amount to come up with a total amount of \$366 million.

Question 16: Do you believe that your estimate, or the Independent Budget's estimate, is more accurate as it relates to lifting the enrollment ban on Priority 8 veterans?

Response: VHA has several advantages in assessing the budgetary impact of opening enrollment to priority 8. First, VHA has developed an actuarial model for use in projecting veteran enrollment and use of healthcare services. It also has access to vast amounts of detailed information to support the development of assumptions about the impact of policy changes. These data include: insurance, health status, and use of healthcare service from the annual VHA survey of enrollees; income data from the 2000 census long form; data on veterans' enrollment history and their historical use of VA healthcare services; and enrollees' use of healthcare services paid for by Medicare.

In addition, the actuarial model allows VHA to assess the impact of opening priority 8 enrollment at a very detailed level. For example, we use 6,072 distinct monthly enrollment rates, ranging from 0.02 percent to 4.20 percent, to project enrollment in priority 8. The rates are based on historical priority 8 veteran enrollment patterns and are developed separately for service-connected and non-service-

connected veterans in three age bands and 506 geographic areas (counties or adjacent rural counties). The model then projects the expected use of 55 different healthcare services for these new enrollees based on their age, morbidity, and expected reliance on VA healthcare versus other healthcare providers.

These detailed projections are then aggregated to provide a national estimate of the impact of opening priority 8 enrollment. At the aggregate national level, we expect that approximately 4 percent of the non-enrolled priority 8 veteran population would enroll each year if enrollment was reopened. In addition to the veterans expected to enroll in FY 2008, the projections assume that approximately 1.6 million priority 8 veterans who would have enrolled in 2006 and 2007 if enrollment had not been suspended will enroll when enrollment is reopened. We believe this is a realistic assumption due to the publicity that will be generated as Congress and the veteran service organizations communicate the policy change to their constituents.

Again, aggregated at the national level, we expect that about 55 percent of the 1.6 million new priority 8 enrollees in FY 2008 will be patients in FY 2008. Based on their expected use of VA healthcare services, we project their healthcare to cost to be \$2,683 on average. We expect to collect, on average, \$685 from each new priority 8 patient and his/her insurer, or 26 percent of the cost of their healthcare based on historical collection rates.

Question 17: What particular elements of the Independent Budget's estimate do you disagree with?

Response: Aggregated at the national level, VA expects that about 55 percent of the 1.6 million new priority 8 enrollees in FY 2008 will be patients in FY 2008. Based on their expected use of VA healthcare services, we project their healthcare to cost to be \$2,683 on average. We expect to collect, on average, \$685 from each new priority 8 patient and his/her insurer, or 26 percent of the cost of their healthcare based on historical collection rates.

Homeless Veterans—Over the course of the year VA estimates that 400,000 veterans will experience homelessness at some time. Through an array of programs, VA assists 25 percent of that number and the community based organizations serve 50,000. The FY 2008 budget reflects \$107 million in obligations and 2 FTE for the Grant and Per Diem Program and Special Needs Grants. Last year Public Law 109-461 authorized \$130 million.

Question 18: Please explain why you did not ask for more money for these programs?

Response: VA does not estimate there are 400,000 homeless veterans in the course of a year. VA does a point-in-time estimate. Our latest estimate was 195,000 homeless veterans. Congress noted again last year that the Department's primary mission is to provide service to homeless veterans who are chronically homeless. Therefore the Department's focus is to provide healthcare and other supportive services to chronically homeless veterans. VA provides a comprehensive array of services, including the grant programs with the goal of ending homelessness for chronically homeless veterans.

We provide healthcare services to more than 100,000 homeless veterans each year. We are pleased to serve all homeless veterans although statistically there are far less than 100,000 chronically homeless veterans.

The two full time employees (FTE) identified are new staff to work within the program office. During this fiscal year an additional 40 FTE have been added to work liaisons with community service providers. In addition, during the current fiscal year, we have or will add between 1,500-2,200 new transitional housing beds; double special needs funding to \$12 million and adding new technical assistance grants. We expect to expend \$107 million this year.

We are adequately funded to provide service to all existing providers and to provide expanded services appropriate to the long-term goal of ending chronic homelessness.

Question 19: Last Year, in its report, the GAO reported an estimated 9,600 bed shortfall in the number of beds available to veterans seeking to escape homelessness. How does the VA's budget project this need?

Response: As you noted, the government Accountability Office (GAO) reported on the number of community transitional housing beds estimated to meet community demands. We have carefully reviewed this and are taking appropriate action. We have already awarded funding to create 1,800 new transitional housing beds and

have a current notice of funding availability (NOFA) that is expected to add 1,000–1,400 new beds. Since the estimate of 9,600 beds is an estimate of community future need and we are increasing the number of beds by more than 3,000 or more this year we believe we have responded appropriately with the transitional funding covered from the Grant and Per Diem (GPO) Program.

Question 20: Do you plan to increase the number of beds available for homeless veterans?

Response: Yes. Our funding is appropriate to increasing the number of quality beds with strong service provisions for homeless veterans. We are adding additional beds under the GDP Program, opening new domiciliary care beds and new contract care for those homeless veterans with serious mental illness.

Long-Term Care—Your FY 2008 budget request for long-term care further reduces the Average Daily Census (ADC) level to 11,000 for nursing home care. The Veterans Millennium Health Care and Benefits Act (P.L. 106–117), which was enacted in 1999 requires the VA to maintain an ADC 13,391. With the veterans' population demographically growing older, I would imagine that there is quite a lot of demand for nursing home care.

Question 21: When do you plan to submit a budget request for long-term care that meets your statutory obligations for nursing home care?

Response: P.L. 106–117 (the *Millennium Act*) states that “The Secretary shall provide nursing home care . . . (1) to any veteran in need of such care for a service-connected disability, and (2) to any veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more.” To the best of our knowledge, VA is providing nursing home care to all such veterans who have sought to receive it from VA. The VA long-term care demand model estimates that there are approximately 9,300 such veterans during the current fiscal year. Therefore, the FY 2008 budget request is more than sufficient to provide nursing home care for those veterans for whom such care is required by the *Millennium Act*. Of note, the total average daily census in institutional long-term care programs supported by VA (including VA, State, and community nursing homes and VA and State domiciliaries) was 42,879 in FY 1998 and 42,620 in FY 2006; expenditures increased from \$2.031 billion in FY 1998 to 3.539 billion in FY 2006.

Question 22: How much more long-term care funding would be required to meet the VA's statutory mandate to maintain an ADC of 13,391?

Response: The cost to increase VA nursing home average daily census (ADC) from the demand-based budgeted level of 11,000 to the arbitrary level of 13,391 would be approximately \$492 million.

Question 23: If you were at the mandated level of 13,391, could you fill the 2,391 more beds with veterans needing that type of care?

Response: The VA long-term care demand model estimates that there are approximately 9,300 veterans during the current fiscal year for whom nursing home care is required by the *Millennium Act*. Therefore VA could not fill an additional 2,391 beds with such veterans.

Activation Fees—In your Summary of Program Request Medical Services FY 2008 Estimate there is an obligation of \$18,802 million for activations. In your Summary of Program Request Medical Facilities FY 2008 Estimate there is an obligation of \$2,564 million for activations.

Question 24: Please explain what the activation obligations are for.

Response: Activation obligations are in the medical facility and service fund appropriations for one-time initial requirements. Facility activations provide operating resources, primarily for initial equipment and supplies that are non-recurring to activate completed construction projects. It includes obligations of projects completed in the prior year, some funding for projects to be completed in succeeding years and operational resources for new leased space.

**Questions from Hon. Jeff Miller, Ranking Republican Member,
Subcommittee on Health, to Dr. Michael Kussman,
Acting Under Secretary for Health, Veterans Health Administration**

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC
February 28, 2007

Michael J. Kussman, M.D., M.S., MACP
Acting Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Kussman:

Thank you for your testimony at the Wednesday, February 14, 2007, the Subcommittee on Health hearing on the President's FY 2008 Budget for the Veterans Health Administration (VHA). As a followup to the hearing, I am requesting the following questions be answered in written form for the record:

1. A November 2006 GAO report on VA's spending plan for Mental Health showed that VA had not adequately allocated funding to the facilities for mental health initiatives. (a) What is VA doing to track the funds allocated for mental health? (b) How does VA plan to ensure that each facility is allocated an amount to fully fill the mental health needs of its veteran population? (c) What is VA doing to improve its ability to estimate the number of servicemembers who may access VA PTSD services?
2. The VA budget includes \$115 million for readjustment counseling and VA plans to add an additional 2 Vet Centers for a total of 209 Vet Centers in FY 2008. Has VA established performance measures to determine veteran and family member utilization and satisfaction with the counseling they receive through Vet Centers?
3. As cochair of the VA/DoD Health Executive Committee, what initiatives are being considered for enhancing mental health services and coordinating these services within "Seamless Transition"?
4. Prior to 1989, NIH funds gave VA investigators a 15% indirect administrative add-on to all VA grants. NIH has since discontinued paying indirect costs to VA and other federal agencies. NIH, however continues to pay indirect costs to private and public universities and even to foreign institutions that receive its grants. What impact does NIH's refusal to pay indirect costs have on carrying out VA research?
5. VA is currently undertaking a survey to determine the financial needs of the physical and operational infrastructure and equipment used for conducting research. When can we expect VA to begin implementing an asset management plan based on the data collected from the survey?
6. Regarding construction, (a) how many major construction projects are currently underway? (b) How many of these projects are behind schedule? (c) What are the causes for these delays?
7. In 2006, VA was given supplemental funds to cover unexpected dental care costs. How has VA spent these funds? Did VA's actuarial model for the FY 2008 budget request take into consideration dental care services?
8. The budget shortfall VHA faced in both FY 2005 and 2006 was in part due to inaccurate long-term care costs. Has VA integrated a long-term care model into the development of the FY 2008 budget request?
9. The September 2006 GAO report recommended that VA improve reporting its budget execution to Congress. In order to improve reporting to Congress, VA needs to ensure accurate reporting by facilities and VISNs on budget execution. (a) How does VA maintain facility and VISN accountability on budget execution? (b) What can be done to improve accountability on budget execution?

Additionally, I would request you respond to Congressman Brown's questions for the record. Your attention to these questions is much appreciated, and I request that they be returned to the Subcommittee on Health no later than close of business, 5:00 p.m., Wednesday, March 14, 2007. If you or your staff have any questions,

please call the Republican Staff Director for the Subcommittee on Health, Dolores Dunn at 202-225-3527.

Respectfully

Jeff Miller
Ranking Republican Member
Subcommittee on Health

Attachment

Question 1: A November 2006 GAO report on VA's spending plan for Mental Health showed that VA had not adequately allocated funding to the facilities for mental health initiatives.

Question 1(a): What is VA doing to track the funds allocated for mental health?

Response: The GAO report that addressed the use of funds for the Mental Health Initiative (comprising about \$200 million or 8.3 percent of the \$2.4 billion spent in fiscal 2006 for mental health services) addressed delays in enhancing services, not limitations in services delivered. The delays were related to factors such as the time required to formulate new programs, to allow sites to be ready for their implementation, and to hire new staff.

Actions taken this year to ensure efficient use of funds from the Mental Health Initiative include accelerated notices of award to the field and increased tracking of positions filled and workload generated. There are also plans to reinvest any funding not executed as a result of unavoidable delays in hiring and use these funds to address other mental healthcare initiatives identified by the Veterans Integrated Service Networks (VISN) that could be met with non-recurring funds.

Question 1(b): How does VA plan to ensure that each facility is allocated an amount to fully fill the mental health needs of its veteran population?

Response: The total projected costs for mental health services are \$2.805 billion for fiscal year (FY) 2007 and \$2.960 billion for FY 2008. Mental Health funding for each facility comes from two separate funding streams. Most of the funding comes through the VISN through the Veterans Equitable Resource Allocation (VERA). VERA is based on complex models that include both past services provided, associated costs, and actuarial projections. The other component, the Mental Health Initiative to expand and enhance mental healthcare, is funded for \$306 million in FY 2007, and for \$360 million in FY 2008. The adequacy of these funds are tracked through quality measures, by analyses conducted by the three program evaluation centers associated with the Office of Mental Health Services, and through each VISN's evaluations of their own needs.

Question 1(c): What is VA doing to improve its ability to estimate the number of servicemembers who may access VA PTSD services?

Response: The Veterans Health Administration (VHA) is working to enhance its ability to project the number of servicemembers with post traumatic stress disorder (PTSD) through two mechanisms. In an ongoing collaboration, the Under Secretary for Health's Special Committee on PTSD is working with VHA's Office of the Assistant Deputy Under Secretary for Health for Policy and Planning to extend current actuarial approaches to model needs within this single diagnosis. In a separate strategy, trends over time for the total number of veterans treated for PTSD from each service era are being closely monitored.

Projections of the demand for PTSD services are complex, and subject to rates of deployment, redeployment and separation of servicemembers. The most straightforward way to project demand is to monitor ongoing trends in diagnoses and mental health service use among enrollees. This is being done through quarterly reports from the VA epidemiology services. Another approach is to work with the Department of Defense (000) to track responses from the Post-Deployment Health Assessment completed at the time that service men and women return from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), and the Post-Deployment Health Reassessment completed 3-6 months later.

Funding for the Mental Health Initiative has been allocated to expand PTSD specialty care programs. The funds are also being used to implement programs to disseminate time-limited evidence-based psychotherapies for PTSD throughout VHA.

Question 2: The VA budget includes \$115 million for readjustment counseling and VA plans to add an additional 2 Vet Centers for a total of 209 Vet Centers in FY 2008. Has VA established performance measures to determine veteran and family members utilization and satisfaction with the counseling they receive through Vet Centers?

Response: VHA has established the following performance measures:

- Market penetration of eligible veterans being provided Vet Center services. The “Market” is defined as veteran population.
- Market penetration of OEF/OIF veterans being provided Vet Center services. With the “Market” defined as the number of separated OEF/OIF veterans as reported by DoD Defense Manpower Data Center (DMDC) roster.
- Veteran satisfaction is measured annually with an established standard of 98 percent of veterans reporting satisfaction and that they would recommend the Vet Center to a fellow veteran. In FY 2006, actual veterans satisfaction was 99.7 percent.
- Quality of Life measures from the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) such as Global Assessment of Functioning (GAF) scores, pre- and post-service provision.

Question 3: As co-chair of the VA/DoD Health Executive Committee, what initiatives are being considered for enhancing mental health services and coordinating these services within “Seamless Transition”?

Response: The Department of Veterans Affairs (VA)/DoD Health Executive Committee (HEC) Mental Health Work Group has identified the following initiatives for 2007–2009:

- Plan and implement shared training programs to increase the use of evidence-based psychotherapy, e.g. cognitive processing therapy and prolonged exposure therapy, and pharmacotherapy approaches for primary care providers in both Departments for the treatment of PTSD.
- VA will collaborate with the National Guard and Reserve, and State and regional coalitions to address the mental health and readjustment needs of OEF/OIF veterans to develop improved patient care methods and strategies for Guard and Reserve members who are released from active duty.
- VA outreach staff will work with DoD military treatment facility staff to identify mental health conditions for poly trauma patients and others with serious injuries and will coordinate the continuity of care for these patients.

In addition to VA/DoD HEC Mental Health Work Group, VA’s readjustment counseling centers (Vet Centers) provided the following services to OEF/OIF veterans:

- VA Vet Centers participate in the 000 sponsored Post Deployment Health Reassessment (PDHRA) screenings which are conducted 90 to 180 days following the servicemember’s return home. Vet Center and VHA medical facility staff are on-site at all PDHRA events, providing followup services for all veterans who screen positive for readjustment problems.
- The Vet Center program has taken a lead role in providing timely outreach and readjustment services to the new OEF/OIF veterans. Since 2003 through the first quarter of FY 2007, the Vet Centers have provided services to 165,153 OEF/OIF veterans. Of the total OEF/OIF veterans seen, 119,615 were provided outreach services at active military, National Guard, and Reserve demobilization sites and other community events featuring veterans and family members. The other 45,538 veterans were provided comprehensive readjustment services in Vet Centers.

Question 4: Prior to 1989, NIH funds gave VA investigators a 15% indirect administrative add-on to all VA grants. NIH has since discontinued paying indirect costs to VA and other federal agencies. NIH, however continues to pay indirect costs to private and public universities and even to foreign institutions that receive its grants. What impact does NIH’s refusal to pay indirect costs have on carrying out VA research?

Response: The Department of Health and Human Services, including the National Institute of Health (NIH), has determined that it may not pay facilities administrative (indirect) costs that directly support VA infrastructure and administrative operations. Because the research that NIH funds in VA facilities is of direct relevance to veterans’ health, these grants help VA support its mission of caring for

veterans. Since NIH grants do not provide funds that help to maintain VA facilities, routine maintenance and repair must be borne entirely by the VA budget.

Question 5: VA is currently undertaking a survey to determine the financial needs of the physical and operational infrastructure and equipment used for conducting research. When can we expect VA to begin implementing an asset management plan based on the data collected from the survey?

Response: VA's Office of Research and Development has established a VA research infrastructure evaluation and improvement project (Infrastructure Program). In early 2006, a detailed questionnaire regarding current research space allocation and condition was disseminated to all field sites to gather preliminary information. To better document and prioritize issues identified in that preliminary assessment, a comprehensive evaluation instrument designed to ensure a thorough and consistent system-wide review of research space was developed and tested at three pilot sites (June–August 2006). Survey methodology included a detailed physical examination of research structures and supporting systems. Reports included identification of deficiencies; the estimated cost for correcting the deficiencies, and estimated cost for replacing the structure. In analyzing its physical infrastructure, VA performed condition assessments of all of its medical facilities as part of the Capital Asset Realignment for Enhanced Services (CARES) study. VA plans to issue three reports describing the efforts undertaken in FY 2007, 2008, and 2009.

Question 6: Regarding construction:

Question 6(a): How many major construction projects are currently underway?

Response: There are currently 41 projects underway in design and construction.

Question 6(b): How many of these projects are behind schedule?

Response: Of the 41 projects, 11 are behind schedule.

Question 6(c): What are the causes for these delays?

Response: A major cause for delay has been the impact of the volatile construction economy in the United States and the rapidly increasing pricing for labor and building materials. While many projects have been affected by this robust economy, five projects have had significant schedule delays as a result of bid pricing or estimates exceeding available funds. These include projects in Atlanta, GA; Des Moines, IA; Palo Alto, CA; San Antonio, TX; and Tampa, FL.

Projects to construct new hospitals at Orlando, FL, and Denver, CO, have experienced delays associated with site selection. Sites at both locations have now been selected.

In addition, four projects have been delayed by their own unique circumstances.

- Biloxi, MS—Restoration of Hospital—Start of design was initially delayed in the immediate post-Katrina period because the VA medical center needed to address more urgent matters. The design architect was selected and is under contract to prepare a master plan for the facility. More recently, VA and the U.S. Air Force have been exploring the potential for co-location of services. Schematic design is scheduled to start in April 2007.
- Fayetteville, AR—Clinical Addition—The master plan and space program were revised and completed in November 2006. The architect/engineering (AE) contract is being negotiated.
- San Juan, PR—Seismic Corrections Building 1—Design is in the second phase of schematics. Award of a construction document contract is anticipated by July 2007.
- Syracuse, NY—Spinal Cord Injury Center (SCI)—After approval, it became apparent that the parking shortage at the site would be significantly exacerbated by this new construction. A parking component was added to the project as a first phase. Construction award of the parking garage expansion is scheduled for August 2007. Design efforts for both the garage expansion and SCI are ongoing. Additional funds have been requested in the FY 2008 budget request.

Question 7: In 2006, VA was given supplemental funds to cover unexpected dental care costs. How has VA spent these funds? Did VA's actuarial model for the FY 2008 budget request take into consideration dental care services?

Response: By the close of FY 2006, supplemental funds provided additional dental care to veterans in the following amounts and categories:

- \$41.7 million for contract or fee basis dental care for all eligible veterans.
- \$26.5 million to increase capacity to provide dental services in the form of equipment, supplies and minor remodeling.
- \$10 million for contract or fee basis care of OEF/OIF veterans.
- \$6.7 million for increase in dental staff.

Use of the above supplemental funds has decreased the waiting list for eligible veterans waiting for dental care greater than 30 days by 63 percent.

Eligibility for dental care is different than medical care and VA is now exploring the feasibility of developing an actuarial model to project demand for dental services based on current eligibility criteria. Currently, VA's FY 2008 budget request includes the total funding needed for the Department to continue to provide timely, high quality dental care to veterans including one-time Class II benefits dental care to all newly discharged veterans.

Question 8: The budget shortfall VHA faced in both FY 2005 and 2006 was in part due to inaccurate long-term care costs. Has VA integrated a long-term care model into the development of the FY 2008 budget request?

Response: Yes. VA has integrated the Long Term Care Planning Model into the development of the FY 2008 budget proposal. 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.

Question 9: The September 2006 GAG report recommended that VA improve reporting its budget execution to Congress. In order to improve reporting to Congress, VA needs to ensure accurate reporting by facilities and VISNs on budget execution.

Question 9(a): How does VA maintain facility and VISN accountability on budget execution?

Response: VHA has numerous methods to track accountability on budget execution which are listed below:

- Frequent communication with VISN chief financial officers (CFO) to review budgets and to evaluate spending targets.
- A Finance Committee which meets monthly as a subcommittee of the National Leadership Board and provides fiscal oversight of VHA organizational performance, and the formulation and execution of the budget process. The Committee a/so works to develop sound financial models and effective resource allocation methodologies that are aligned with the goals of VA.
- Within VHA, the CFO has bi-weekly conference calls with field CFO's where budget execution is discussed. This has proved to be an excellent venue for discussing barriers to staying within assigned budgets, and developing solutions to keep field facilities on budget.
- Monthly indicators are in place from both the Office of Finance and the Central Business office to track both financial and revenue processes.
- Monthly Performance Reviews, chaired by the Deputy Secretary, focus on financial and program performance. The Department's leadership discusses and makes decisions on performance, budget, and workload targets. Using financial metrics as the basis, each administration and staff office reports on progress in meeting established monthly and/or fiscal financial goals.

Question 9(b): What can be done to improve accountability on budget execution?

Response: There should be continual management focus on financial indicators and budget targets to ensure clean audits and eliminate any areas of internal control weaknesses. Resource management is a key component of network director and facility director performance plans. At the end of the 2007 rating period, facility directors and network directors will be asked to describe actions and accomplishments that reflect significant achievement in this area.

**Questions from Hon. Henry E. Brown, Jr., a Representative in Congress
from the State of South Carolina, to Dr. Michael Kussman,
Acting Under Secretary for Health, Veterans Health Administration**

Charleston VAMC

Question 1: Last week, Secretary Nicholson and I talked about the VA's views on the development of a joint-use facility in Charleston. I was frustrated during this exchange because the Secretary did not seem to be able to separate the advanced planning study as authorized by Congress late last year, and the complete construction of a facility. Is this normal practice within the VA, especially when Congress specifically gives authorization for a project in phases?

Response: When Congress appropriates funding for a project the Department considers that to be directive and takes action to proceed. In the case of Charleston, although the project was included in the authorization bill, no funding has been provided. The major construction funding is appropriated by project.

Question 2: Isn't it true that the VA budgets planning and construction dollars differently? In fact, isn't there a \$40 million account within the budget specifically for advanced planning?

Response: The FY 2008 budget request includes \$40 million for advanced planning. These funds will be used for several purposes including the planning and design of priority projects planned for the FY 2009 budget, assisting VISNs in developing capital asset applications for projects to be proposed for the FY 2010 budget, updating VA standards, space criteria, construction specifications and other tools which support the capital improvement program and studies such as master plans and environmental compliance studies.

Question 3: Didn't section 804 of Public Law 109-461 specifically require Congress to provide separate authorization for any joint-use facility construction at Charleston?

Response: Section 804 of Public Law 109-461 specifically authorized the Secretary to enter into an agreement for planning and design of a co-located, joint-use medical facility in Charleston, South Carolina to replace the Ralph H. Johnson Department of Veterans Affairs Medical Center in Charleston, South Carolina in an amount not to exceed \$36,800,000.

ALS

Question 1: What resources are allocated by the VA for research and treatment of ALS, especially as it relates to our gulf war veterans? Where does ALS research fit into the VA's Designated Research Areas listing on page 10-20 of Volume 1 of FY08s Budget Justification?

Response: In FY 2006 VA Office of Research and Development (ORO) devoted over \$6.8 million to Amyotrophic Lateral Sclerosis (ALS) research, of which \$5.6 million directly examines ALS, and over \$1.2 million is relevant to this debilitating disease. Of this total, over \$3.6 million is considered part of VA's ongoing portfolio of gulf war related research. ALS research is included in the topic "Central Nervous System (CNS) Injury and Associated Disorders" listed on page 10-20 of Volume 1 of FY 2008 Budget Justification.

ORO is particularly excited about several ongoing and planned projects in this important area:

- *National VA ALS Research Consortium:* This is a 15-site clinical trial to determine the tolerability and efficacy of sodium phenylbutyrate (NaPS) as a new therapy for ALS.
- *Arginase NO Synthase and Cell Death in ALS:* The focus of this project is to further study a compound that has been shown to delay the onset of ALS symptoms in animal models of the disease.
- *National Registry of Veterans with ALS:* This registry is designed to identify veterans with ALS and to track their health status; collect Deoxyribonucleic acid (DNA) samples and clinical information; and provide a mechanism for VA to inform veterans with ALS about research studies for which they may be eligible to participate. The following website provides more details: <http://www.va.gov/durham/alsregistry.asp>.

- *Biomarkers Discovery in ALS*: VA investigators recently identified three proteins that were significantly lower in concentration in the cerebrospinal fluid (CSF) from patients with ALS than in normal controls. The combination of these proteins correctly identified patients with ALS with 95 percent accuracy, 91 percent sensitivity, and 97 percent specificity from the controls. Independent validation studies confirmed the ability of the three CSF proteins to separate patients with ALS from other diseases. The current work is focused on creating new assays to detect these biomarkers that can be used in the routine clinical laboratory setting.
- *Brain-Computer Interfaces (BCI) for Patients with ALS*: ORO is in the advanced planning stages of a clinical demonstration project that will be done in collaboration with the Brain-Computer Interface Laboratory of the Wadsworth Center (New York State Department of Health) which has pioneered BCI technology that enables paralyzed people, including those locked-in by advanced ALS, to communicate. The goal of this project is to demonstrate the practicality of such systems and their impact on quality of life for both patients and caregivers.

Question 2: I have recently learned of a number of cases in my district from veterans who have developed ALS where the VA has denied their claims because their service was not within the presumptive timeframe of August 2, 1990 through July 31, 1991. How many incidents like this have there been since the gulf war ended?

Response: Compensation claims for ALS are granted if the veteran meets one of the following criteria: served in the Southwest Asia Theater of Operations from August 2, 1990 through July 31, 1991 and later developed ALS; developed ALS during service; or developed ALS not later than one year after service. Due to lack of medical evidence supporting a definitive diagnosis of ALS, VA denied 31 claims for service connection of ALS of veterans who served in the Southwest Asia Theater of Operations from August 2, 1990 through July 31, 1991. VA also denied 67 claims for service connection of ALS because the veteran did not serve in theater during the requisite timeframe, develop ALS in service, or develop ALS within one year after service. Of that number, 64 veterans served on or after August 2, 1990, but were not deployed to the Southwest Asia Theater of Operations, and three veterans served in the Southwest Asia Theater of Operations after July 31, 1991.

Question 3: Why did the VA determine that special action is only provided for veterans claiming service-connected ALS during the Gulf War timeframe?

Response: In 2001, VA led a joint epidemiologic study with DoD regarding ALS among gulf war veterans. This study provided preliminary evidence that active duty military personnel deployed to the Southwest Asia Theater of Operations between August 2, 1990 and July 31, 1991, were nearly twice as likely to develop ALS. The study involved nearly 700,000 service members deployed to Southwest Asia and 1.8 million servicemembers who were not deployed to Southwest Asia. VA decided to take special action on claims for veterans who were deployed to the Southwest Asia Theater of Operations from August 2, 1990 to July 31, 1991.

In September 2006, the Institute of Medicine (IOM) published a report, "Gulf War & Health Volume 4: Health Effects of Serving in the gulf war," that found gulf war veterans might be at increased risk for ALS. VA is deferring any recommendations, policy options, or conclusions on ALS among veterans of the 1991 Gulf War pending review of a more recent IOM report, which reviewed the literature on possible increased risk of ALS among all servicemembers.

Question 4: How many veterans have been diagnosed with service-connected ALS? Can you break this down by conflict and/or theater of operations?

Response: VA grants claims for service connection of ALS if the veteran meets one of the following criteria: served in the Southwest Asia Theater of Operations from August 2, 1990 through July 31, 1991 and later developed ALS during service; or developed ALS not later than 1 year after service.

VA granted 55 claims of ALS from veterans who served in the Southwest Asia Theater of Operations from August 2, 1990 through July 31, 1991. VA also granted 98 claims of ALS in cases where the veteran developed ALS during service or within 1 year after service. Of that number, 14 veterans served in the Southwest Asia Theater of Operations after July 31, 1991, and 84 veterans served on or after August 2, 1990, but were not deployed to the Southwest Asia Theater of Operations.

General Budget Questions

Question 1: Funding for “other home-based care” under the long-term care account has increased from \$25 million in FY06 to \$95 million in the current budget request. What type of services are provided with these dollars? How many veterans have utilized services under this account over the past 5 years? Are the funding increases simply in response to increases in number of veterans utilizing the services?

Response: Other home-based care consists of purchased skilled home care, home hospice and outpatient respite care. Since FY 2003 (earliest year that data is available) the number of patients receiving these non-institutional long-term care services, as measured by the average daily census increased from 2,600 to over 3,000 in FY 2006. In FY 2008 the number of patients receiving all non-institutional long-term care services combined will increase to over 44,000. This represents a 19.1-percent increase above the level VA expects to reach in FY 2007 and a 50.3-percent rise over the FY 2006 average daily census. The funding increase in other home-based care is a component of the \$4.6 billion for extended care services, 89 percent of which will be devoted to institutional long-term care and 11 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.

