

**U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET
REQUEST FOR FY 2011 AND FY 2012**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

—————
FEBRUARY 4, 2010
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Serial No. 111-59

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Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

55-227

WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

February 4, 2010

	Page
U.S. Department of Veterans Affairs Budget Request for FY 2011 and FY 2012	1
OPENING STATEMENTS	
Chairman Bob Filner	1
Prepared statement of Chairman Filner	41
Hon. Steve Buyer, Ranking Republican Member	2
Hon. Corrine Brown, prepared statement of	41
Hon. Harry E. Mitchell, prepared statement of	42
Hon. John Boozman, prepared statement of	43
WITNESSES	
U.S. Department of Veterans Affairs, Hon. Eric K. Shinseki, Secretary	4
Prepared statement of Secretary Shinseki	43
AMERICAN LEGION, STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION	
American Legion, Steve A. Robertson, Director, National Legislative Commission	37
Prepared statement of Mr. Robertson	77
AMERICAN VETERANS (AMVETS), RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR	
American Veterans (AMVETS), Raymond C. Kelley, National Legislative Director	35
Prepared statement of Mr. Kelley	73
DISABLED AMERICAN VETERANS, JOHN L. WILSON, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR	
Disabled American Veterans, John L. Wilson, Assistant National Legislative Director	32
Prepared statement of Mr. Wilson	53
IRAQ AND AFGHANISTAN VETERANS OF AMERICA, PAUL RIECKHOFF, EXECUTIVE DIRECTOR	
Iraq and Afghanistan Veterans of America, Paul Rieckhoff, Executive Director	39
Prepared statement of Mr. Rieckhoff	94
PARALYZED VETERANS OF AMERICA, CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR	
Paralyzed Veterans of America, Carl Blake, National Legislative Director	31
Prepared statement of Mr. Blake	51
VETERANS FOR COMMON SENSE, PAUL SULLIVAN, EXECUTIVE DIRECTOR	
Veterans for Common Sense, Paul Sullivan, Executive Director	38
Prepared statement of Mr. Sullivan	98
VETERANS OF FOREIGN WARS OF THE UNITED STATES, ERIC A. HILLEMAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE	
Veterans of Foreign Wars of the United States, Eric A. Hilleman, Director, National Legislative Service	34
Prepared statement of Mr. Hilleman	64
VIETNAM VETERANS OF AMERICA, RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS	
Vietnam Veterans of America, Richard F. Weidman, Executive Director for Policy and Government Affairs	38
Prepared statement of Mr. Weidman	91
MATERIAL SUBMITTED FOR THE RECORD	
Post-Hearing Questions and Responses for the Record:	
Hon. Bob Filner, Chairman, Committee on Veterans' Affairs, to Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs, letter dated March 25, 2010, and VA responses	102
Hon. Steve Buyer, Ranking Republican Member, Committee on Veterans' Affairs, to Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs, letter dated February 12, 2010, and VA responses	112

U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FY 2011 AND FY 2012

THURSDAY, FEBRUARY 4, 2010

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

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Mitchell, Hall, Halvorson, Perriello, Rodriguez, Donnelly, Space, Walz, Adler, Buyer, Stearns, Moran, Boozman, Bilbray, Bilirakis, and Roe.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. Welcome to the hearing of the Committee on Veterans' Affairs of the House of Representatives on the U.S. Department of Veterans Affairs (VA) budget request for fiscal year 2011 and 2012.

I want to be able to move fairly quickly at the beginning and hear the testimony of the Secretary because we have a series of votes, unfortunately, somewhere between 10:15 and 10:30. We will be gone for 40 to 45 minutes, so I would like to get the Secretary's testimony in beforehand.

I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and that written statements be made part of the record. Hearing no objection, so ordered.

Mr. Secretary, you and the President have requested a VA budget of \$125 billion, roughly, including a total discretionary request of over \$60 billion. The VA medical care budget represents 86 percent of the total discretionary budget.

Also, for fiscal year 2011, the Administration is requesting over \$51 billion in resources for VA medical care.

Appropriated resources for fiscal year 2011 have already been provided in last year's consolidated appropriations act and the funding level is an increase of \$4.1 billion or 8.6 percent over 2010 levels.

Rest assured that this Committee will be working closely with our counterparts in the Administration and in the Senate to make sure the process moves forward to ensure veterans have the medical care resources they need when fiscal year 2012 begins.

The veterans' groups that co-author *The Independent Budget*, and who will be testifying today, have recommended a total re-

source level for VA medical care of \$52 billion and an overall discretionary funding level of \$61.5 billion, which is \$1.2 billion above the Administration's request.

We are looking forward to their testimony and the testimony of the American Legion, the Vietnam Veterans of America, Iraqi and Afghanistan Veterans of America, and Veterans for Common Sense who will also testify today.

Mr. Secretary, I am impressed by your robust budget request and your emphasis on funding many of the priorities of this Committee, including addressing the plague of homelessness, rural health care access, access of women veterans, and the mental health care needs of our veterans.

The budget addresses problems faced by our newer veterans while not forgetting the sacrifices and service of veterans from previous conflicts.

We are looking forward to your testimony today.

Before I yield to our Ranking Member, I know I speak for our entire Committee, Mr. Buyer, that our thoughts and prayers are with your family, your wife, and yourself as you go through a very difficult time.

I yield to Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 41.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you very much, especially for your heart-felt comments.

Mr. Secretary, I apologize. I am going to make a quick opening statement. I had requested a hearing for a review of the Comcast/NBC merger. That hearing is now taking place this morning. They are doing opening statements. I plan to be here for your opening statement and then I need to go to that hearing.

So what I will do is I will make a few comments here and then I am going to incorporate two questions that I would ask for you to answer even though I will not be here.

With regard to your budget, I want to congratulate you on your agreed robust budget. There may be some differences we may have as we present the views and estimates to the Budget Committee with regard to where I would place some of those dollars.

The most significant problem, which you also recognize, is the disability claims backlog. The application of the 21st century technology solutions are extremely important.

I applaud you with the VA pilot programs reconfigured to modernize the claims process that are underway in Little Rock, Providence, Baltimore, and in Pittsburgh, and I look forward to their results.

And I also want to congratulate you. You faced the challenges head on with regard to the GI Bill. And much of those challenges, Congress dropped those challenges right in your lap. And there was some politics of the moment that did override the substance and the problem was presented to you. You did not complain. You met them head on and you met the challenge. In that process, some veterans were hurt, but that was no fault of yours. You took a very difficult situation and you did the best you could and I applaud you for that.

And for those veterans out there that did suffer and some of whom did not go back to school this fall because of their particular circumstance, my deepest apologies. But to those veterans out there across the country, please recognize that we have a VA Secretary that is off his heels, on his toes, and is leaning forward.

I also want to commend you for your Consolidated Patient Account Center (CPAC), the expeditious rollout for which you are doing. You and I had a good conversation. I was more than impressed on how you accelerated the timeline and your decision to go with a single contract rather than moving in installments in a timeline as presented to you by your own advisors, even in contracting.

And you have challenged them. You have challenged the system. But you recognize that as you challenge them, those are more VA dollars that will come into the system.

And so I have always felt that I was the one that was always challenging. You out-challenged me. And it is unfortunate that whatever occurred, dollars were not placed there, it is a hiccup in the process, we want to work with you.

If you could outline to the Committee kind of what has happened and what your way forward is on that and your over-the-horizon view for success for the CPAC rollout, I think, is extremely important. And I look forward to that, your response to that.

The other is with regard to the President proposing to use \$30 billion in Troubled Asset Relief Program (TARP) funds to promote small business. I recognize that this will be a—it will be subject to political fodder here on Capitol Hill as to whether it is legitimate or whether that was an intent of Congress and we are in a political season.

My only challenge to you, Mr. Secretary, is to incorporate—please send a message to the President. If he is going to do this, incorporate veterans in the process. So for the last year, I have been asking for that billion dollars in loan guarantees for small businesses for veterans and we are being left out.

So if he is going to actually use those funds and find the legitimate or legal process in order to use those, I would ask you to ask of the President for veterans to be included in that \$30 billion of the TARP funds for small business.

The other point I would like to make, and I do not know why this occurs, maybe this is part of the gamesmanship over the years, but every time we do a budget, somebody likes to whack the Inspector General (IG). And we like the IG Office. We like the IG Office, I guess, as part of our oversight functions, especially Mr. Mitchell over here nodding his head.

It is a multiplier. I think you probably learned that also when you were over in the U.S. Department of Defense (DoD). When those ombudsmen or the IG Office put their eyes on things, yeah, you can upset people at times, but good things result from what they are attempting to do.

Also, when I talked about the added dollars for which you put in the budget, especially on the mandatory side, while I recognize that you have made some judgments with regard to the Agent Orange and for there to be presumptions, I want to make sure that we do not change the paradigm or the matrix with regard to out-

spacing science. We have always made science-based judgments with regard to causal connections and I want to make sure that we are not changing that paradigm.

And at the same time, you know, I look at that and say all of a sudden, we have found this money for mandatory funding while at the same time, part of our values, we sort of pride ourselves when we talk about taking care of the widow and the orphans. But in reality, we are not. And that is why I combined with the Sergeant Major Walz to address and increase Dependency and Indemnity Compensation (DIC) and eliminate the offset of the Survivor Benefit Plan (SBP).

So all of a sudden, we have found these funds, but we are still not taking care of the widows. And I just lay that out there as a challenge for all of us to come together somehow to take care of them.

And with that, I am going to yield back my time, and I respect your efforts.

The CHAIRMAN. Thank you, Mr. Buyer, and I agree with a lot of what you said. I hope the paragraphs on science-based decisions would be made to your caucus in regard to global warming. Okay?

Just a little dig. Do not worry, Mr. Secretary.

We welcome you, Mr. Secretary. You are accompanied by Dr. Gerald Cross, the Acting Under Secretary for Health; Mike Walcoff, the Acting Under Secretary for Benefits; Steve Muro, the Acting Under Secretary for Memorial Affairs; Todd Grams, the Acting Assistant Secretary for Management; and we have Roger Baker, the Assistant Secretary for Information and Technology.

By the way, you might let us know when all these acting positions are going to be dealt with.

You have the floor, Mr. Secretary, and we appreciate all your efforts on behalf of our veterans.

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GERALD M. CROSS, M.D., FAAFP, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; MICHAEL WALCOFF, ACTING UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEVE L. MURO, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; W. TODD GRAMS, ACTING ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND HON. ROGER W. BAKER, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary SHINSEKI. Thank you, sir.

Chairman Filner, Ranking Member Buyer, distinguished Members of the Committee, thank you as always for this opportunity to present the President's 2011 budget and 2012 advanced appropriations requests for the Department of Veterans Affairs.

I also appreciate the generosity of your time in meeting with me prior to this hearing. Those are always invaluable opportunities for me to gain insights.

Let me also acknowledge the presence of representatives from our veterans service organizations (VSOs) in attendance today. Their insights have also been helpful to me personally and to the Department in helping meet our obligations to all of our veterans.

Thank you, Mr. Chairman, for introducing the members of the panel today. I would just point out that Mike Walcoff sits to my left. Todd Grams here is our new Principal Deputy and Acting Assistant Secretary for Management. Dr. Cross to my right. To his right, Steve Muro and then Roger Baker, our Chief Information Officer (CIO), on the end.

Mr. Chairman, I have a written statement, a longer written statement that I would ask be submitted for the record.

The CHAIRMAN. Yes. So ordered.

Secretary SHINSEKI. Okay. Thank you.

This Committee's long-standing commitment to our Nation's veterans has always been unequivocal and unwavering. That has been clear. And such commitment on your part and then the President's own steadfast support for our veterans resulted in a 2010 budget that was quite remarkable in providing the Department the resources to begin renewing itself in fundamental and comprehensive ways.

And that translates to the efforts, the transformation that we have been talking about. I report that we are well-launched on that effort and are determined to continue that transformation throughout this year, 2010, and carry over into 2011 and 2012.

We have crafted a new strategic framework around three governing principles that you have heard me espouse for the past year. It is about being people-centric. It is about being results-oriented. We want to measure what we say we are going to do and we want to be able to see what we got for the investment.

And then, finally, we want to be forward-looking. We think that there is much yet to be gained out of the potential of this Department.

This new strategic plan delivers on President Obama's vision for VA and is in the final stages of review. And we are prepared to share that plan with you once that review is done.

The strategic goals we have established will do several things. First, continue to raise the bar on quality and accessibility of VA health care and benefits while optimizing value.

The plan also improves our readiness to protect our people, both our clients as well as our workforce, and our assets day to day as well as in times of crisis.

The plan enhances even more veteran satisfaction with our health, education, training, counseling, financial, and burial benefits and services.

And, finally, the plan invests in our human capital, both in their well-being and then in their development as leaders.

In order to attain the kind of excellence in our management and IT systems, as well as our support services, which I consider vital if we are going to achieve the kind of mission performance I have

described you should expect out of this Department, we intend to be the model of governance in about 4 years.

These goals got our people to focus on producing the outcomes veterans expect and have earned through their service to our country.

Now, to support VA's efforts, the President's budget provides \$125 billion in 2011, as you have pointed out, Mr. Chairman, \$125 billion, \$60.3 billion in discretionary, \$64.7 billion in mandatory funding.

Our discretionary budget request represents an increase of \$4.2 billion and, as you have pointed out, it is 7.6 percent over the President's 2010 enacted budget.

VA's 2011 budget focuses on three critical concerns that are of primary importance as I pick these up in speaking with veterans.

First, better access to benefits and services.

Second, reducing the disability claims backlog and wait time for receipt of earned benefits.

And, third and finally, ending the downward spiral that often enough results in veteran homelessness, those three.

Access, this budget provides the resources required to enhance access to our health care system and our national cemeteries. We will expand access to health care through activations of new or improved facilities, providing health care eligibility for more, primarily through Priority Group 8 veterans, but others as well, and then making greater investments in telehealth, which I have described as sort of the next major step in delivery of health care. We will also increase access to our national cemeteries through the establishment of five new cemeteries.

The backlog, we are requesting an unprecedented increase for staffing in the Veterans Benefits Administration (VBA) to address the growing increase in disability claims receipts even as we continue to reengineer our processes, develop a paperless system integrated with the VLER, the Virtual Lifetime Electronic Record.

Ending homelessness, we are also requesting a substantial investment in our homelessness program as part of our plan to eliminate veterans' homelessness in 5 years through an aggressive approach that includes housing, education, jobs, and health care.

In this effort, we partner with the U.S. Departments of Housing and Urban Development, probably our closest collaborator, but also with Labor, Education, Health and Human Services (HHS), Small Business Administration, among others. Taken together, we intend to meet veterans' expectations in each of these three areas to be successful in our mission in access, working the backlog, and in ending homelessness.

We will achieve this by developing innovative business processes and delivery systems that not only better serve veterans' and families' needs for many years to come but will also dramatically improve the efficiency and cost control of our operations.

Our budget and advanced appropriations requests for 2011 and 2012 provide the resources necessary to continue our aggressive pursuit of the President's two overarching goals for the Department, to transform and to ensure client access to timely, high-quality care and benefits. We still have much work to accomplish—well-launched but still lots of room for work to be done.

So, again, Mr. Chairman and Members of the Committee, thanks for this opportunity to appear before you, and I look forward to your continued unwavering support and I look forward to your questions.

If I have time, I will address the question that was asked by Mr. Buyer. This budget allows VA to more than double the number of CPACs between 2010 and 2011, growing from three in 2010 to seven in 2011.

Moreover, this budget would allow VA to realize significant revenues from a 5-year deployment with a third-party collections increase of about \$280 million through 2013 and about \$1.6 billion increase to 2018.

There is an opportunity to go faster and I am looking for ways to accelerate if those opportunities present themselves.

Hopefully I have addressed the question, Mr. Buyer.

[The prepared statement of Secretary Shinseki appears on p. 43.]

Mr. BUYER. Thank you.

The CHAIRMAN. Thank you. Thank you, Mr. Secretary.

Mr. Snyder, you are recognized for 5 minutes.

Mr. SNYDER. Thank you, Mr. Chairman.

Thank you all for your service, Mr. Secretary.

The issue of medical research is one that I generally ask about at the hearing. And I think the staff analysis is that your number on medical research does not keep pace with the medical research inflation rate which is higher. And the problem with that is research projects do best if researchers do not have to come and go and lay off staff.

And may I ask you, Mr. Secretary or Dr. Cross, do you agree with that analysis that your number does not keep pace with the medical research inflation rate?

Secretary SHINSEKI. Let me call on Dr. Cross, thank you for the question, to enter into the medical aspects of this and then I will pick up after him.

Dr. CROSS. Congressman, thank you for that question.

Mr. SNYDER. Is your microphone on, Dr. Cross?

Dr. CROSS. No.

Mr. SNYDER. Thank you.

Dr. CROSS. Thank you for that question, Congressman.

And for 2011, comparing it to 2009, it is a 16 percent increase. We do value the—

Mr. SNYDER. No, no. My question is, the analysis does not keep pace with the rate of inflation of medical research in real medical research dollars. I know what the lines are, but do you agree with that analysis, it does not keep pace with the rate of medical research inflation?

Dr. CROSS. I agree that we are moving forward with a research budget that meets the needs of our veterans. I am not sure what the exact percentage increase is in the research budget. But the percentage increase that we are looking at for inflation medically is around four percent, four and a half.

Mr. SNYDER. Well, let us do this as a question for the record then. I believe that your budget does not keep pace with the increasing costs that occur in medical research, whether it is within the VA or outside of the VA. If I am right, then it means that your

researchers are going to have to lay off people or cut back on projects.

So why don't you get back to us on whether you think your budget number keeps pace with the actual real dollars in medical research. Can we do that that way?

Secretary SHINSEKI. I will be happy to provide that for the record.

[The VA provided the answer in Question #8 in the Post-Hearing Questions and Responses for the Record, which appear on p. 107.]

Mr. SNYDER. Yeah. That would be great.

The CHAIRMAN. Mr. Snyder, we looked at that and we are going to—I think our Views and Estimates work to reflect an increase.

Mr. SNYDER. An increase, yeah.

The second thing, Mr. Secretary, in your—I do not remember if you mentioned it in your oral statement, but in your written statement, you referred to not just the number of claims but the complexity of claims.

In the time you have been on the job, why do you believe, what is your conclusion about why claims are more complex? Why are they increasing in complexity?

Secretary SHINSEKI. Let me call on Mike Walcoff.

Mr. SNYDER. Yes.

Secretary SHINSEKI. He has a little better working knowledge of the claims.

Mr. WALCOFF. Congressman, I think this is a continuation of a trend that we have seen over a number of years. The increase in complexity deals with, first of all, the number of issues that are being filed with each claim.

It used to be, 15 years ago or so, we would average between two and three issues per claim. Now that average on all of our claims is up over four, and the average on the claims that are coming out of our benefits delivery at discharge sites is over eleven.

So when you have that many issues coming in on a claim, it does make it a lot more complex.

Mr. SNYDER. Do we know why that is occurring? Are people being advised by attorneys or advised by the internet or advised by advisors? I mean, what—

Mr. WALCOFF. I think part of it is. I think veterans are becoming more aware of what they are potentially entitled to. I think our outreach is better. I think service organizations are doing a good job in working with them. I think that it is a combination of a lot of things, and I do not necessarily think that is a bad thing.

Mr. SNYDER. Right.

Mr. WALCOFF. I think it is a good thing, but it does add to the complexity of the work.

Mr. SNYDER. Right. And then Dr.—

Secretary SHINSEKI. I would add—

Mr. SNYDER. Yes.

Secretary SHINSEKI [continuing]. In addition to complexity, it is also the volume of claims that is also part of this equation. Last year, VBA processed 977,000 claims and received a million new claims on top of that. So complexity and volume are part of the equation here.

Mr. SNYDER. Well, I think I will yield back given that I have only got 20 seconds left.

Thank you, Mr. Chairman.

Thank you all.

The CHAIRMAN. Mr. Michaud, would you like to speak before we recess for our votes?

Mr. MICHAUD. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for coming here today and for bringing us this budget.

I appreciate your willingness and your concern about the issues you talked about today with homeless veterans, dealing with veterans in rural areas.

And I also appreciate the fact that the different Veterans Integrated Services Networks (VISNs) are having their Mini-Mac meetings back in their individual States, which is actually very helpful for the veterans service organizations and they are very informative.

That gets to my question as it relates to rural health. As you have heard, a lot of Members of this Committee on both sides of the aisle are very concerned about rural health issues, making sure that veterans have access to rural health.

I just attended actually a Mini-Mac meeting in Maine and some of the same concerns I have heard throughout the country. And we had a hearing not too long ago where actually we were talking about the distribution of funding the Veterans Equitable Resource Allocation (VERA) model.

Here is the concern, and it is not unique to Maine. The fact that rural veterans travel a lot of distance, we increased the mileage from 11 cents to 41 cents. What we are seeing in Maine, and I am sure other areas, is Maine funding was \$1.5 million that they have given to our veterans in rural areas. It actually cost over \$5 million. There is a shortage.

So what VA Togus is going to have to do, and I am sure it is the same in other areas because of the VERA model, is they are going to have to cut back on fee-for-service or not hire or lay off staff. They are getting penalized because they live in a rural area.

And it gets right back to the VERA model is have you done a comprehensive analysis of the VERA model and what are the driving forces of that model because if they have to cut back on fee-for-service or cut doctors in rural areas, it actually is counterproductive in what we are actually not—what we are talking about not doing.

The other issue is when you look at the Office of Rural Health, which has been great, they actually have funded good projects in different regions of the country relating to rural health, the problem being is these pilot projects that they are funding, once that money dries up, then that is put back on to the facilities which, here again, they will have to make those very tough choices.

What do you plan on doing for some of these pilot projects that are currently working in the Office of Rural Health, whether they will have continuing operational funding versus forcing a rural medical facility to actually make these tough choices? Are they going to cut doctors or are they going to cut back fee-for-service, which is counterproductive?

Secretary SHINSEKI. Mr. Michaud, I am going to call on Dr. Cross here in a minute, but let me just describe for you.

This is one of the challenges I have wrestled with for the past year and I do not know that it is the VERA model, but I do not know that is not either. And we are, as you have pointed out, we are looking at this very closely to try to understand the dynamics here.

When we talk about delivery of health care, as you know, we talk about everything from our medical centers to our community-based outpatient clinics (CBOCs) to our Vet Centers, fee service and contract and telemedicine. We spend a significant amount of money on fee basis.

Mr. Chairman, do we have time for me to finish or——

The CHAIRMAN. I think we should wait——

Secretary SHINSEKI. Okay.

The CHAIRMAN [continuing]. Because we have 5 minutes to vote. There are five or six votes. We will recess until 11:00 a.m.

Secretary SHINSEKI. Okay.

[Recess.]

The CHAIRMAN. I am sorry that the recess took so long. You never know with votes, and I apologize for holding everybody up. When we recessed, Mr. Michaud had asked a question and Mr. Shinseki was answering.

Do you want to briefly rephrase your question, Mr. Michaud?

Mr. MICHAUD. One of the driving forces as it relates to the VERA model getting funding back to rural, you know, medical facilities because some of the concerns I have heard not only in Maine but nationwide is the fact that you have got regional rural hospitals are actually going to have to cut back on fee services or eliminate positions in order to meet their balanced budget.

Secretary SHINSEKI. Let me just say that your concerns about the VERA model, I have similar questions I have asked. We are taking a look at it. And the rural aspects of this will be part of the review.

Let me ask Dr. Cross to address the specific issues you talk about there in Maine.

Dr. CROSS. Congressman, thank you for the question.

First of all, in regard to any specific concerns in regard to Maine, Togus in particular, I and my staff are ready to come over on very short notice and provide you any details that you require and go through that very thoroughly.

And the broad answer to your question, VERA has had nine external reviews thus far since it was created, by organizations like the U.S. Government Accountability Office (GAO). But VERA is also being supplemented because we recognize the needs in the rural community.

One of those supplements that we are working with, I think this Committee and you and others were very instrumental in passing it and making it possible, and that relates to Public Law 110–387, Section 403 in particular. That puts \$100 million in 2011 for contractual and fee-basis care in rural communities. And I think that would help in Maine as well.

In addition, what we are doing with the rural health outreach is more CBOCs, more outreach clinics, more telemedicine. We anticipate that our telemedicine work in 2011 will reach 100,000 vet-

erans in rural communities to make a difference in their lives for the better.

And I appreciate the work that the Committee has supported us with on this very important initiative because without your support, this would not have been possible.

Secretary SHINSEKI. Mr. Michaud, let me just say the issue of rural resourcing comes up frequently enough. We will respond to you and also provide back to the Committee a response to that question.

[The VA provided the answer in Question #7 in the Post-Hearing Questions and Responses for the Record, which appear on p. 107.]

Mr. MICHAUD. Thank you very much.

My second question actually relates to State Veterans Nursing Home. As you know, we passed a law back in, I believe it was 2006, to deal with the per diems for State Veterans Nursing Homes. Ironically, since the VA has begun implementing the law, State Veterans Nursing Homes are being paid less, less than what they were being paid before.

And some of the concerns that I have heard from Veterans Nursing Homes nationwide is the fact that they might be going out of business since they are not going to be able to sustain that, the reduction in costs. And this here really hits hard those that are Medicare, Medicaid certified Veterans Homes.

We are having a hearing next week on H.R. 4241, which would allow for increased flexibility in payments to State Veterans Nursing Home.

I would like to know, have you heard anything about this or what are your comments as it relates to payments and State Veterans Nursing Homes?

Secretary SHINSEKI. Let me just say that we are working with the Department of Health and Human Services in looking at these rates. This goes beyond just VA. There is Medicare, Medicaid involvement here.

Let me ask Dr. Cross to address this in detail.

Dr. CROSS. Sir, you asked if we have heard anything about this, absolutely, and we share your concerns. It is my intention, and I understand the Secretary's intention, to move forward with a resolution as cooperatively as possible.

Let me say that we have 137 of these homes at the moment. They are very important to us and to our veterans. They do great work. They are run by the States and supported in part by the VA.

There was a Public Law passed, 109-461, several years ago, about 2006. We understand that there were some unanticipated, perhaps technical, issues that have arisen and become clearer since then.

We are going to have some upcoming hearings with you, and other sessions. We are going to bring forward our best experts to propose resolutions.

Mr. MICHAUD. Great. Thank you very much, Dr. Cross and Mr. Secretary. Look forward to working with you as we move forward in making sure our veterans get the best quality care that they can regardless of where they live. So I appreciate both of you. Thank you.

Secretary SHINSEKI. Thank you.

Mr. MICHAUD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Michaud.

I will ask the Secretary that when your team offers to give a specific briefing to someone who asks a question that usually reflects something we are all interested in. I would ask that any briefing materials that you give to one that you please share with the whole Committee.

If it was the other side, I would accuse them of a tactic of divide and conquer, but I would not accuse you of that.

Secretary SHINSEKI. Happy to do that.

The CHAIRMAN. Just make sure we all are briefed as well as the person who asked the question.

Secretary SHINSEKI. I will do that.

The CHAIRMAN. Thank you, sir.

Mrs. Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here.

I, too, want to reiterate that if you are doing anything with regards to State Veteran Homes somewhere else, I would like to know about it. I have two of them, Manteno and La Salle, both in Illinois, in my district that I, too, want to make sure and keep up on and do something about.

I also want to thank you for working out a date with my staff and I know we continue to do that so that you can come to the district which you have agreed to do sometime in March so that you can see firsthand the issues of the veterans that are going on and the things.

And I would be remiss if I did not talk about Silver Cross Hospital in Joliet. And if I could get an update, I would love to hear from Dr. Cross or somebody with regards to what is going on with the medical facility in my district.

Secretary SHINSEKI. Dr. Cross.

Dr. CROSS. Congresswoman, thank you for your support and for working with us on this very important issue in Illinois.

We have a CBOC there and it is about 100 miles, as I understand, from Hines VA. That is quite a distance. And we think that that CBOC needs to be expanded.

We are very interested in the proposal that I think you have been very instrumental in, with regard to a possible option for Silver Cross Hospital or a portion of it.

And what we are doing is our engineers at Hines VA have already been out taking a look. The construction staff at the headquarters of VA here in Washington is getting ready to send, this month, a further assessment team out to look at it again.

But I wanted to assure you, Congresswoman, that we are interested. We think that this is a possible option for us. No final decision has been made yet, but we are moving forward.

Mrs. HALVORSON. Thank you.

The CHAIRMAN. Would the gentlelady yield?

Mrs. HALVORSON. Absolutely, Mr. Chairman.

The CHAIRMAN. I have been to that facility and other buildings around the country. This one is one and there happens to be one in San Diego. I am sure there are others that may have outlived their usefulness for a given purpose but can fit in very nicely with

your announced and wonderful policy of zero homelessness in 5 years.

It seems to me that those buildings could be viewed as a shelter for those who are now homeless. Not only do the old hospital buildings have medical facilities, they have private room space for all kinds of other social service support programs, which would seem to be a very cost-effective way to serve our homeless population. They are generally in places that we do not have the NIMBY (not in my backyard) reaction to deal with.

I would see this not just as an isolated use of a surplus building, but as a method to really help solve the problem. Mr. Secretary, you know how tough it is to build a facility, even for 30 homeless veterans, and to get the local permits, the zoning, and all that stuff. It seems to me we have some perfect places that could really help with the plan you have announced.

I hope it would be seen in a very wide context and not just a surplus building, whether we need it or not. I thank Mrs. Halvorson for taking the leadership on that.

Mrs. HALVORSON. Thank you, Mr. Chairman.

The CHAIRMAN. I yield back.

Mrs. HALVORSON. Thank you.

And I do appreciate the time that you have taken and it is very, very important to our district because of the traffic and the amount of veterans that are in the area right there where that would serve. So, you know, I appreciate your diligence so that I do not have to keep making it, you know, a top priority for you also.

Secretary SHINSEKI. We are happy to follow up, Congresswoman.

And I would, in response to your comment and the Chairman's also, we are taking a strategic look at all of our facilities. We have 5,300 facilities in the system, and also looking at what is available to right size our footprint as we look 10 years in the future where we think veterans are going to be, long-term care, homelessness, how do we accommodate all of this.

So we are happy to—

Mrs. HALVORSON. Great.

Secretary SHINSEKI [continuing]. Take a look at a facility like that.

Mrs. HALVORSON. And the only other thing I would like to add on that is just to hope that you do not get bogged down in bureaucracy. You know, that is something that sometimes happens with these sort of things, that we just move quickly.

The only other thing that I would like to touch on is, you know, since 2007, the VA has increased its workforce by, I think, about 7,000 people in order to address our most favorite subject, the backlogs.

However, the backlogs have continued to grow. And I know that in this budget, you have asked for 4,000 more employees. What I heard yesterday is even though we are asking and we hire more employees, it takes 2 years to train them.

What is happening and what do we hope is going to come from continuing to hire more employees, taking time to train them? What is happening with regards to the backlog that does not seem to be getting under control?

This is the thing that people call my office for over and over again and it is very, very frustrating, I think for all of us.

Secretary SHINSEKI. Thank you.

The backlog is something, a year ago when I arrived, I said I am going to go after. We spent effort on it last year, but not as much as I would have liked. The GI Bill came along and we needed to get that put in place.

I would say we succeeded in the fall semester. We started with zero students in August, and we had 173,000 registered and being paid by December. So it was an effort that required that kind of attention.

In the meantime, the attention that I wanted to devote to the disability claims process was deferred. This year is my year to spend time getting inside of all of our processes. It is a convoluted and complex process.

What we have done with the claims process is pulled it apart and created four pilots. The pilots are running now, one in Pittsburgh, one in Little Rock, one in Providence, and one in Baltimore.

The whole purpose here is to take apart the pieces, let us see what we can do to refine them, and then put them back in a way that gets us momentum in claims handling.

Right now the inventory on claims is about 420,000. Of that, my guess day-to-day, is that we run about 150,000 to 170,000 claims in backlog, and that is any claim that is longer than 125 days.

The last several years we have taken the processing time on claims from about 190 days down to 180 and 178. Right now we are at 161 days moving towards 125 days. So there has been progress.

I reported earlier that last year we processed 974,000 claims, which is an eight or nine percent increase over our previous performance. At the same time, we got in a million new claims. So this is an area we are going to have to spend a good bit of effort on.

I compounded the problem when we make a decision on Agent Orange. It is the right decision. It was long overdue, needed to be done, but it adds to this challenge.

So as these four pilots are working to take the processing time of 161 days and moving it in the right direction, we have an Agent Orange decision here later this year that is going to come to play and it could increase processing time. It will certainly increase the inventory.

We are looking at ways to fast track the Agent Orange decisions so we do not compound the problem here. What we are looking for in the Agent Orange claims is proof of presence in Vietnam to meet the rules. It does not matter whether it was 1 day or 360 days. All we need to do is validate presence, validate the disease, which a competent medical authority does, and then adjudicate the extent to which the disease warrants a disability rating.

We think getting to that kind of focused decision-making we can take these Agent Orange decisions and move them quickly, at the same time working on the normal disability claims process.

My estimate is over the next year to 2 years, the inventory will grow and processing time may get longer. It probably will get longer, but by 2013, we will be back to where we are today at about 161 days.

At that point, with the learning that comes out of the pilots already in the program and within a couple years, we expect to have eliminated the backlog. We are, although our incremental budgets talk about reducing, each year reducing the backlog, the plan is by 2015 for that backlog to be zero. That is what we are talking about.

Mrs. HALVORSON. Thank you. I yield back.

The CHAIRMAN. Thank you, Mrs. Halvorson.

Mr. Rodriguez.

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

Thank you very much, Mr. Secretary, also for coming by the district and reaching out throughout the country.

Your budget provides \$468 million for minor construction projects, which is \$235 million or 33 percent below the amount provided in 2010. And the budget also requests for \$85 million for grants for construction of State extended care facilities which is \$15 million or 15 percent below what was provided in 2010.

We had some dialogue about the fact that there might be about \$9 billion out there in terms of construction needs and we know that of the 153 hospitals that are out there, most are 50 to 60 years old. We know we have some 70 or so clinics that are also in need of construction. And roughly, once again, I think that you had quoted in the past needing some \$9 billion just to take care of some immediate needs.

With this kind of budget, how do we expect to look at this and be able to come up to par with the existing facilities that we have when we only asked for this low amount?

Secretary SHINSEKI. Congressman, let me just put into perspective the construction budget. And I may not have the details on the State construction that you describe. And if I do not, I will be happy to provide it for the record.

For major construction, we are requesting in 2011 nearly the same level at which we requested in 2010, which was fairly significant, \$1.19 billion in 2010 for major construction and 2011 is 1.15 billion. And it will enable us to stay on track with constructing three medical facilities, design two new projects, and also expand cemeteries in three locations.

Minor construction appears to be the concern. But in 2011, we have \$468 million going to minor construction. It is the second largest minor construction budget ever requested. And the reason it seems to be a drop-off is because the largest minor construction budget ever requested is in this year, 2010, when we increased it significantly to \$600 million. In comparison, this minor construction budget for 2011 is a very strong investment.

On nonrecurring maintenance in 2011, our request is for \$1.1 billion in nonrecurring maintenance. That is the largest nonrecurring maintenance request ever made by a President. Between 2000 and 2008, the average request for nonrecurring maintenance has been about \$550 million. That has been the average across those 8 years.

And so we think this nonrecurring maintenance investment is—

Mr. RODRIGUEZ. Is it accurate to say that there is a need of over \$9 billion right now that is required?

Secretary SHINSEKI. There is a backlog on maintenance that has accrued over many years. It is about \$9 billion. You are correct. And so we are hopeful that if there is a job's bill that the VA will be seen as an appropriate—

Mr. RODRIGUEZ. And I would also support you in that. What better way to get Americans back to work than to look at redoing our hospitals and our clinics throughout the country for the veterans.

And I think the Committee would also be supportive if there is a job's bill out there to move in that direction and try to get some job creation, at the same time we build up our infrastructure for those veterans.

Secretary SHINSEKI. Thank you.

Mr. RODRIGUEZ. Thank you very much, sir.

The CHAIRMAN. I just want to note, Mr. Rodriguez, that in our Views and Estimates to the Budget Committee, we are going to recommend a plus-up in that account—

Mr. RODRIGUEZ. Thank you, sir.

The CHAIRMAN [continuing]. As one of the main items. Mr. Stearns?

Mr. STEARNS. Thank you, Mr. Chairman.

And I thank Mr. Boozman for the opportunity. I will have to leave here to go to another hearing.

Mr. Secretary, it is always a pleasure and an honor to have you to testify before us and thank you for what you do.

I think all of us will agree that this time, the Veterans Administration is experiencing an increase in the number of disabled veterans. I think that is a given. But it appears the decision to cut the Vocational Rehabilitation and Employment staff by nine while at the same time increasing the Compensation and Pension (C&P) staff by almost 4,000 seems to be puzzling to us.

The vocational rehabilitation employment counselors all have at least a Master's Degree. They are obviously highly qualified and capable of rendering services almost from day one.

On the other hand, the nearly 4,000 new C&P staff will require, and that is according to the VA, 2 to 3 years to become effective claims adjusters. Thus, the roughly 4,000 new C&P staff will have little or no impact on the claims backlog while the VA will lose 18,000 hours, in our estimate, of rehabilitation counseling.

So I guess the logic of this is somewhat puzzling to us and we would like your comment.

Secretary SHINSEKI. Thank you, Congressman.

Let me call on Mike Walcoff to sort of frame this issue and then I will add if anything is necessary.

Mr. STEARNS. Is the information we have correct?

Secretary SHINSEKI. In terms of the Voc Rehab—

Mr. STEARNS. Yes.

Secretary SHINSEKI [continuing]. Adjustment? I think that is correct.

Mr. STEARNS. Yes. Yes.

Secretary SHINSEKI. The specific numbers I will turn to Mike on, but there is an increase authorized in this budget of 4,000 to VBA. We have increased the resourcing of VBA by 27 percent in this budget to go after long-standing issues about the backlog and to address Agent Orange requirements that are coming on.

But the voc rehab question is an important one and let me ask Mike to address that.

Mr. WALCOFF. Certainly we recognize the importance of the Voc Rehab Program, but let me just explain a couple of things.

The decrease of 9 positions off of 1,155 is totally a result of the reallocation of management overhead. We use a formula to allocate that by business line. And the addition of such a large number of new employees just when we applied the formula resulted in a loss in that overhead category of nine for voc rehab. There will not be one person taken out of direct services to veterans in terms of voc rehab.

Number two, I want to point out that we have added \$8.3 million to the contracting budget for voc rehab. That money gives us flexibility to either use this for contracting or to go ahead and turn it into a full-time equivalent (FTE). That money would buy 130 FTE if we decide to use it for that. So that is the second thing.

And the third thing is that, yes, right now we are talking about 4,000 additional claims examiners. In managing both programs as we evaluate the workload that is coming into Voc Rehab, we have the ability to move FTE from C&P to Voc Rehab. We will certainly do that if it appears that—

Mr. STEARNS. So money is fungible that you can take it from one—

Mr. WALCOFF. That money is, yes.

Mr. STEARNS. What is the average vocational rehabilitation employment caseload for 2011 compared to 2010?

Mr. WALCOFF. I do not have that.

Mr. STEARNS. Okay.

Mr. WALCOFF. I can get back to you on that.

[The VA subsequently provided the following information:]

VA anticipates a 10 percent increase in the 12-month average caseload for Vocational Rehabilitation and Employment services, with an increase from approximately 111,000 in FY 2010 to 122,100 in FY 2011.

Mr. STEARNS. The budget my staff tells me has indicated it is a 10 percent increase in the budget in caseload.

Mr. WALCOFF. We are projecting a 10 percent increase. But, frankly, that is something that at this point we are estimating because we are still trying to evaluate the impact that the Chapter 33, the new GI Bill, is having on the voc rehab program.

At one point, we anticipated that there would be possibly a decrease in participants because they would be going over to the GI Bill benefit which is financially a little bit greater. We do not see that at this point, but it is still early. We put a 10 percent increase in there as an estimate, but we are going to be keeping an eye on it.

I think we have enough flexibility in this budget that we can address the additional work. If it winds up coming to Voc Rehab, we are in a position to be able to adjust to it.

Mr. STEARNS. So the basic thrust to my question is, and I think you agree then, that we really do not want to be cutting back the Vocational Rehabilitation and Employment staff considering the number of disabled veterans that are coming into there. And so that is, you know, what I think our main point is.

Mr. WALCOFF. Yes. I think we agree. We both recognize how important this program is and we are going to make sure that as we monitor the workload that, if necessary, we will move FTE into that program.

Mr. STEARNS. Okay.

Thank you, Mr. Chairman, for the courtesy.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here as always and, of course, the work you do. And to each and every one of your staff, thank you for your continued service to our country.

And I would like to say how much I appreciate, Mr. Secretary, your thanking those VSOs, those folks that literally have your back right behind you right now. They are there every step of the way.

We have held some wonderful roundtables with the Chairman and the Ranking Member to get their priorities out and it is that collaboration through *The Independent Budget*, the things that are being brought to our attention by those on the front line of this, and I am appreciative. You have clearly understood that from your beginning of your tenure. So I appreciate that.

Just a quick followup. I think Mr. Stearns asked a very good question and it is one I am hearing quite a bit about. I absolutely understand your answer on this and understand that you are addressing it and agreeing with the living allowance and the new GI Bill, how that would affect.

I am hearing a lot, though, of the need to do something more with the voc rehab. So it is starting to percolate up. It is there. Mr. Stearns' question was well put and I am appreciative that you are on to that and looking at it from that regard.

So, Mr. Walcoff, I do not know if there is any response, but that is what I was going to ask.

Mr. WALCOFF. No. I appreciate what you are saying.

Mr. WALZ. Yeah. Well, thank you for addressing it and we will stay tightly on it.

Just two things. The Chairman started out talking about it. I am, too, a big fan of the IG. I am concerned. One of my biggest concerns as we increase budgets, if we do not increase that oversight and we know for many years as the IG budget was sinking, we did not have that there. The worst crime I think we can commit is, are how dollars allocated by the taxpayers meant for our veterans do not end up there.

And so I am really sensitive to that and I would like to, Mr. Secretary, just whatever we can do and know what your plan is on that.

Something that was brought up in our roundtable by the Vietnam Veterans of America (VVA), they, too, agree that the IG is wonderful on fraud and abuse. It is the waste part they are a little concerned with we may not catch.

And I think all of us together have to figure out a way to make sure that these newly allocated dollars get to where they are supposed to go.

Secretary SHINSEKI. Congressman, you and I come from a background where the IG is an important part of the organization. It is almost cultural and I—

Mr. WALZ. Yeah.

Secretary SHINSEKI [continuing]. Would assure you that IG and the Department of Veterans Affairs have the same status and respect.

On the budget, I would say if you looked at 2010 to 2011, you would probably be concerned about it being flat. But if you looked at from 2009 to 2010 to 2011, you will see a 25 percent increase in the VA's budget over 2 years.

VA's funding of its IG operations is second or third across the Federal Government and—

Mr. WALZ. Are you comfortable, Mr. Secretary? They are your eyes and ears. Are you comfortable that they are there?

Secretary SHINSEKI. I am comfortable with where we are. And, you know, this is dialogue that, you know, I have from time to time with the IG himself. And so I am comfortable with where we are.

Mr. WALZ. Okay.

Secretary SHINSEKI. But, again, if you take a 2-year look across government, 25 percent, VA has done well in resourcing our IG operation.

Mr. WALZ. Well, I think it is everyone's desire here to hit that sweet spot on providing the resources that are necessary in providing the checks and oversight. I am not going to hit on it.

But just, again, it—I would not call it a red flag. It is a yellow flag on the information technology (IT) budgeting as the Virtual Lifetime Electronic Record goes forward to make sure you have the ability to do that.

This is one that every one of you, everybody behind you, and everybody up here is frustrated. There is very little confidence right now and I think it is important that we give you that, that we give you this opportunity to fix this.

And I would segue to my final point that, I cannot ever leave this room without saying it, this idea of seamless transition to get to the systemic problem. I think medical records, personnel records are a start, but I think all of us know seamless transition is truly leadership and cultural.

And I guess my question to you, Mr. Secretary, would be is if you could give just a brief update on that, that Office of Seamless Transition, because that is another one of these issues. There are some pretty gray-haired folks behind you that said I have been fighting this since I was a young strapping troop and it is still not done. Why is this different this time?

Secretary SHINSEKI. It is difficult. I think, Congressman, you bring up a good point. I would tell you that between VA and DoD, you have the two largest Departments in government. You also have the two Departments who have led the way nationally in developing the most comprehensive electronic records maybe in the world, certainly in this country, between VistA and AHLTA. And so culturally two large institutions are going to have to put their heads together and bring some harmony out of this.

Part of the reason I worked so hard to get Secretary Baker to be part of our team is because he comes with the expertise that, you know, has the skills, knowledge, and attributes to drive this forward.

I would just say that we are not there yet. The Virtual Lifetime Electronic Record is where we are headed and when that happens, all of what we are talking about is going to be facilitated.

But, as you say, seamless transition is not technology. It is leadership. And I would offer that Secretary Gates and I are partners in this and working it very hard.

Between the two Departments, we are already able to share 86 million standard ambulatory data records, 76 million lab results, 78 million pharmacy records, 12 million radiology reports, 3.5 million consultations, and I could go on.

So the technology is beginning to arrive. And I will let Mr. Baker talk about probably one of our more promising steps and that was a visit here to San Diego where we demonstrated we could also share this electronically.

Mr. BAKER. So just briefly, because we believe it is quite important, we have incorporated the private sector into the VLER vision as well and working with HHS now on a national standard for information exchange with the private sector. And we will move to that standard for the way we exchange information with the DoD as well.

Much of the services we provide for veterans or many of the services provided veterans are done by the private sector and that ability to incorporate the information that they generate into our electronic record and the ability to deliver to them what we have in our electronic record to let them provide better care to the veteran is representative of the Secretary's view of VA as the veteran's advocate. It is do whatever we can do, including delivering our information to the private sector under appropriate privacy controls to provide better service to the veteran even if it is us not providing it.

Mr. WALZ. Well, I know that many of us feel that this time might be different. We have had our hearts broken many times, but I am a Vikings fan and I keep coming back for more. So on this one, I will keep—we are going to do it one of these years. So thank you, Mr. Secretary.

Secretary SHINSEKI. I got you, Congressman. And let me just add here, I realize that I am out of time here, but leadership, technology, but it is broader than just medical. DoD and VA just held a joint mental health conference. We just met together in a national forum on suicides. VA has hosted a homeless summit as well.

But it goes to the whole spectrum of ways and reasons we have to be better at this. It is about benefits delivery at discharge. That program has to work. It is about DES and being better at that. We have expanded it, e-benefits portals and we have to be better at demobilization briefings with the Guard and the Reserve when they come back so that this seamless transition is not just technology. It is all the ways in which we quickly, safely, accurately get youngsters who wear the uniform 1 day picked up in our system rapidly.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Space.

Mr. SPACE. Thanks, Mr. Chairman.

Just let me start by thanking you, Mr. Secretary, for the extraordinary leadership that you have displayed in the last year. And

certainly that is beginning to make its way to the veterans on the street and in our district. And I am very grateful for your leadership.

I would like to thank Dr. Cross also for working with us in the past. He has actually been to our district for a field hearing and helped us accentuate some of the special challenges that veterans in rural America face.

And I am grateful for you, Mr. Secretary, in being mindful of that as well.

The budget expands eligibility of Priority 8 veterans for health care in 2011 by almost 100,000 new enrollees. And if you compound that with the fact that we have got, given the current recession, many Priority 8 veterans who are because of financial circumstances becoming eligible per se for benefits, one of the problems, however, we face is in creating awareness of that eligibility. And we face some special challenges in reaching out to those folks back in rural Ohio.

My question to you, Mr. Secretary, is, what does this budget or, more generally, what is the Administration doing right now to reach out to those Priority 8 veterans who are going to be newly eligible for health care services?

Secretary SHINSEKI. Congressman, you mentioned two things here, Priority Group 8s and the rural issues. And in some ways, they bump into each other.

Our efforts to reach out to rural veterans, eight million veterans enrolled with us, three million of them are in rural or highly rural areas, and so the challenge is not just getting health care to their locations, which we are doing a lot, it is also the outreach to find them, inform them, and make sure that we are meeting needs.

That also addresses some of the challenges with Priority Group 8s. We program by the end of this first year 266,000 Priority Group 8s. We are a little slow getting started. But at this point, we started in July enrolling them, we are about 7 months into that program and we have probably 30,000 registered.

We anticipate that part of this is the Priority Group 5 and 7 veterans who have enrolled with us as well. This is part of this mix. Taken together, we are probably at this point about 74,000 total unique veterans between 5, 7s, and 8s.

We still expect that by the end of this year, 2010, we will be at 190,000 or so with another 99,000 in 2011 Priority Group 8s, which will put us about 290,000, a little bit off, but still on a track that we think the 500,000 estimate for 2013 is still valid. We are not ready to come off of that just yet. But as I say, we are a little slow getting started, but we are 7 months here.

And if you had questions on rural, I am happy to go—

Mr. SPACE. Well, you know, given the time constraints, we will not be able to get into everything I would like to talk to you about. And you have been kind enough to meet with us personally on some of these issues and I appreciate that.

I do want to, however, reference one issue and that is telehealth and the importance that that issue or that approach has to helping to overcome some of the challenges that we have in accessing health care in rural Ohio.

One of the dilemmas, however, with regards to telehealth is that the places where it can do the most good oftentimes lack the technological resources to take advantage of it. And access to broadband is certainly a big part of that. It has been a very important initiative that I have been trying to lead in southeastern Ohio.

And the question I have is, have you had an opportunity or do you plan on working with other Federal agencies, such as the National Telecommunication and Information Administration, for example, to experience an expansive or an expansive access to broadband for purposes of telehealth medicine?

Secretary SHINSEKI. Congressman, let me just up front tell you that we have \$42 million increased in 2011 for telehealth, telemedicine.

And then let me call on Secretary Baker to address the more technical aspects of the question.

Mr. BAKER. So briefly the answer is yes. We are talking primarily with the Federal Communications Commission and their broadband expansion initiative, trying to get them to focus on areas that we believe are going to have the most benefit for veterans.

As you can imagine, other folks have other things they would like them to focus on as well. But we think that is key.

I will tell you that there is a substantial telehealth effort inside of VA right now that is based on what we technically call POTS, which is a plain old telephone system, and communications that way. And those devices are pretty helpful for the people that have those in their homes at this point. I do not know the exact number of homes those are in, but it is, you know, certainly hundreds of thousands that are in right now.

The CHAIRMAN. What did you call that?

Mr. BAKER. It is the plain old telephone system.

The CHAIRMAN. Oh, I thought you were telling us the VA was giving out pot there.

Mr. SPACE. We are not going to go there.

Thank you, gentlemen. Again, Mr. Secretary, thank you for your fine leadership.

Secretary SHINSEKI. Thank you, Congressman.

The CHAIRMAN. Thank you, Mr. Space.

Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

On just an editorial note, it is interesting that you go around the world to third-world countries and have internet connections through satellite connections and everything else which is something that I think too often some of us in the first world ought to go look around to see how other people have been able to connect into the network. And it is extraordinary how innovative a lot of people have been when they cannot just plug into the system.

Mr. Secretary, you know that there is one big concern I have and that is the fact that we have for almost a decade had a joint co-partnership on this electronic records issue. I still believe strongly that we need to give you the lead agency status on this issue.

And you may disagree with that, and I appreciate that your—especially your diplomatic approach with cooperation with other departments, but I really think that we need to either talk to the ex-

ecutive, or the Chairman needs to lead the battle legislatively to give you lead status so somebody has the lead responsibility to close this circle down the line.

And I think that is not just critical for veterans, not just critical for active-duty military, I think it is absolutely essential for this country to finally start moving towards that electronic system that the President keeps talking about and all the great benefits it could bring with it.

But I think it really comes down to us having the leadership to give you the leadership authority and the responsibility to close the circle.

Do you have any comments about that approach?

Secretary SHINSEKI. Congressman, thank you very much. Thanks for the compliments, first of all.

I would offer to you that electronic health records at VA have been around about a dozen years, but there were many years of hard learning before that until we sort of worked it out. And all the benefits that come from that, we have realized now for the last 12 years and others are benefitting from it. And we share what we know, we share what we learn with others.

We worked this very hard with DoD and VA. As I mentioned earlier, two very large departments and two very good departments in terms of electronic health records and now we are working on bringing the culture together.

The San Diego demonstration is where we were able to pass electronic records with Kaiser Permanente, a civilian health care system. Huge step. And we think this will bode well for offering to Health and Human Services a model to look at. It does not have to be the one they settle on, but a model to look at of where we have come as they think about the responsibilities of creating electronic health records for all Americans.

Part of it is cost, affordability out in the civilian sector. We have invested heavily in it. I think there will be some savings to others as a result. We will continue to work this hard. We think we have some great capability here and intend to keep that lead in this area of electronic health records.

It is because of that experience that we are so confident that we need to make the same inroads into VBA, which is still paper-bound. We do that, we are going to realize the efficiencies, the power, and the capabilities that we have been enjoying for the last 12 years.

Let me turn to the CIO to address some of the technical aspects of this, Secretary Baker.

Mr. BAKER. I think, Congressman, to respond, it has got to be a partnership no matter who is in the lead on this. And, you know, the partnership is good. As the Secretary points out, they are two large organizations and DoD has a mission to fight wars.

You know, we continue to move down the path. We have lots of great statistics on the amount of information that is exchanged. And remember that DoD and VA certainly lead the Nation in exchanging the electronic health information. We get a lot of benefits information from them as well.

We are far from where we would like to be and we will continue to move it forward, continue to move current systems and the VLER system forward for exchanging more and more information.

Mr. BILBRAY. And, look, my concerns are not anti-DoD, but the DoD more than anybody else knows how essential chain of command is. And the fact is there was a big reason why, you know, even Rome abandoned the twin governance concept of chain of command.

I just think that in reality, I think we all agree that it may be a very high profile for them, I mean, a very high priority. But the fact is there is a lot on their plate. There is a lot on your plate.

I think that when it comes down to a discussion between our Chairman and, you know, my cousin Ike over in Armed Services that you can agree that I think even the Chairman here is probably more aware, more sensitive to this than anybody in the system. And that should be reflected in the command structure.

So, again, I will continue to raise this issue. I think giving you the authority and the responsibility is the fastest way to move forward and, again, not just to serve our active duty and our veterans, but to create that prototype that the rest of America is waiting for you to deliver.

So thank you very much. I appreciate it, and yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bilbray.

Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman. And first of all, let me thank you for calling this hearing today so we can hear about the 2011 and 2012 fiscal year budget.

I want to thank you, Mr. Secretary, for your decades of service defending the freedom in this Nation and thank you for your commitments to the veterans that have also served this Nation.

I am very pleased under your leadership, Mr. Filner, that we passed the largest VA budget increase in the history of the United States. So I am very proud of that and I want to thank you for that.

I am also very pleased with the increase in the health care funding and other priorities. And I am very pleased that more Priority 8 veterans will be back in the fold. These men and women have served their country, paid their dues. They deserve the health care. However, we need to speed up the time table. I see that we are looking at about 100,000 a year. I am interested in seeing what we could do to get additional veterans back in the fold.

And I am also concerned about the increase in the waiting time veterans are being subject to. I know we have been working it, but I would like to know what kind of plans you have to speed it up.

And on a personal note, I want to thank you and the VA for what we are doing as far as the VA medical center in Orlando. If the figures do not add up, if there are some problems, I want to know up front so we can fix it.

I always think of the first President of the United States, George Washington, and I always like to repeat what he said: "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 are treated and appreciated by their country.”

And with that, I was very pleased that we passed the new GI Bill for the 21st Century. I think, you know, we should have gotten a lot of good press, but there were a few problems with it. I want to know the status of the program and how we worked it out because for veterans, with this economic downturn, the best thing to do is get additional training and education.

So with that, thank you.

Secretary SHINSEKI. Thank you, Congresswoman.

Let me just say on the Priority Group 8s, it is a 5-year program, 500,000 is the target. We estimated that the 1st year would be 266,000. We began last July. We are really in about the 7th month here. It is a little slow picking up.

Part of that is that we may not be reaching all the Priority Group 8 veterans as we need to. And we have attacked that issue in lots of ways in terms of outreach, through contacts that we have, through advertising using, I think they call it, social media as well now.

We still expect, by the end of this year, to have something around 190,000 Priority Group 8 veterans enrolled with us. By the end of 2011, we have enough funds that we expect about 290,000 Priority Group 8 veterans will be enrolled with us as well.

As we go through this year, understanding we made an estimate at 266,000, if it does not look like we are keeping pace, then we will look at perhaps opening the aperture a little bit so we let people who would be in the next phase of enrollment to begin to creep forward so we get momentum going.

On the backlog, I would just inform that this is my year to focus on the backlog. Last year was Post-9/11 GI Bill, which required getting students into school and we successfully did that. We are well on our way in the spring semester. We have automated tools coming, one April, one July. By the end of the year, we should be fully automated and that program will continue to get better.

Backlog requires attention this year. Four pilots. We are working those hard. And at some point, we will harvest. We will not let this run for years. We will harvest what we learned out of that and put together a virtual regional office of the future that begins to take advantage of quality claims, new relationships between VA and veterans and our VSOs, a sense of advocacy that I am pushing, and we all are, reengineered business processes, and the automation tools that will accelerate all of this. We expect a lot of work to be done this year and we will go after the backlog.

Having said that, Agent Orange decisions made last year will increase the number of claims. We are going to have to manage and shape that. Inventory will grow for the next year, maybe 2 years. Maybe even processing time will increase from the 161 days we have today.

But the intent is to fast track Agent Orange claims and also to work on the backlog through the pilots I described and shape that so that by 2013, we are back to where we are today, about 161 days, but at that point moving towards eliminating the backlog by 2014, 2015 time frame.

Post-9/11, I think I mentioned we are in good shape there. Again, zero students enrolled in August of last year, 173,000 enrolled and being paid on 31 December. No carryover of a backlog into the spring semester. Zero in August. At this point, we have 153,000 enrolled, so that is a huge change between the semesters of which on 1 February, 131,000 checks were being distributed to those 153,000 students.

The difference here, the claims that have come in since the 19th of January, we are processing those at about 7,000 a day. So we will have that caught up here very shortly.

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

The CHAIRMAN. Thank you, Mr. Secretary, and thank you for your leadership.

I just want to bring up two points, if I may. One is the backlog that you just talked about. I mean, it seems to me that we have hired over 7,000 new claims processors and Mr. Walcott said another 4,000 are coming. I do not know if that number includes claims processors that were there temporarily or these are new hires. That is a lot of people.

What you are promising is that in a couple years, we may be back to where we are in terms of time when you took over and then you promised it will go to zero, but I do not believe it.

As we talked many times, you are trying to use brute force to deal with this. We know the training times and the attrition, and we end up treading water.

I would like for you to briefly explain the four pilot programs in place to try to speed this up. I am not sure how those programs are doing or what is different about them than what we are doing. As you know, I favor just cutting through this bureaucracy as did the Internal Revenue Service (IRS).

There is a whole model from Professor Bilmes, which says basically to accept the claim when it comes in and send out a check. Audit it in whatever time frame it takes.

I have tried to build in some protections against trivial or fraudulent claims by requiring that the VSOs that are certified around the Nation that help develop the claim that we should accept it. That would reduce your time to zero. You send out the check, or we pick a minimal 30-percent rating and send out the check. Audit that later.

I think you have to break through this bureaucracy of which we have now added 11,000 new positions and we do not see any results. The backlog number seems to grow everyday.

And, I hope you will tell me what the four models are doing differently than what we are doing now, but I think you need to try the Bilmes model. Deputy Secretary Gould is pretty familiar with it. I do not think you are going to get this by brute force. I just cannot see it.

Secretary SHINSEKI. Fair enough. You and I have discussed this, Mr. Chairman, and thanks for your leadership in this area because, you know, as I admitted before, I did not grow up in the VA. I am not a clinician. So there is lots here that I have learned.

Let me just very quickly summarize the four pilots. The process of disability claims is complex enough that we have had to pull it apart, sort of try to get the goodness on each of those parts, and

then put it back together again and try to get momentum out of the processing.

First is in Pittsburgh. That model is designed to address the quality of the claim, show me how to write or prepare the best quality claim that will pass through the system with a high probability potential for the best outcome for the veteran one time. That is part of the backlog issue.

To do that, we have created a relationship that the veteran and VA work together. We are advocates here. Veterans, VA, and VSOs sit down in an effort to put together the best quality claim.

The CHAIRMAN. By the way, in that model or—

Secretary SHINSEKI. The pilot.

The CHAIRMAN [continuing]. Pilot. I have heard some of the problems. We have some artificial or arbitrary caseload standards or expectations. In order to meet them, some of the analysts may not be as accurate as they should in order to meet the pressure of the quotas. This then leads to even further problems.

Does the pilot include not using these arbitrary quotas or do you still have that in there?

Secretary SHINSEKI. Well, part of your concern and part of my concern is getting to the quality claim and the quality outcome. And right now we have, you know, 11,400 good folks trying to put together the claims.

And usually when we talk about claims, it is a stack of paper with lots of personnel and lots of medical records. And what we are trying to create here, what are the essential elements of information that go into establishing that high-quality claim so that the majority of the effort is creating that quality claim and then reserving to a fewer number of highly experienced adjudicators who have the best outcome for both accuracy and, you know, and processing time to then make the adjudication.

So it is changing the relationship between VA and the veteran. That is the pilot number one. It is sort of like trying to put together the best legal brief to win an argument in court. How do we put together the best argument possible.

The second pilot in Little Rock is business process reengineering and it is the issue of a claim arrives, who touches it first, how many people get to touch it, have to touch it, how long is the claim here, and what is the relationship of the members of the team, how long does it take to pass that around and how do they work together. So it is business process.

The third pilot is in Providence and it is automation, the automation tools that would accelerate all of this. The reason we pulled it apart was to assure ourselves that we were not automating bad processes and getting bad outcomes faster. So sort of a discrete look.

And the fourth pilot in Baltimore was how to put all of these together in a regional office with, you know, better relation, new relationships, reengineered processes, higher quality claims with automation, and try to get us a better outcome here.

You and I have talked about the IRS model. We have investigated it and we will continue to look at that.

The CHAIRMAN. We do not have enough time here for you to develop it enough so that I can really understand it, but it sounds

to me that what you are doing in these models is breaking up the process and just examining them. You are not really trying a new way to do it. You are monitoring who is touching what, how that is done, or how the relationship is handled between the veteran and the VA. It is just taking parts of it and just looking at it more closely, probably to see where there are efficiencies of time or motion or whatever.

However, it is not really a new model as to the Bilmes model. You are just looking at how you can do the current process faster. It is simply more efficient brute force, perhaps. Again, I do not know enough about your four pilots, but it does not sound like you are trying a different way, and that is what I think we have to do.

It is an insult to the veterans to take years to resolve these claims. These are your comrade. You feel that, I am sure. I think we have to try a new way, not just break down what we are doing and try to make it more efficient.

That is just my sense of looking at it for so many years, and we keep trying new idea and the claims keep building. We have 11,000 new claims adjusters. But I do not know how many thousands of people we have got now doing claims and the backlog keeps building.

Secretary SHINSEKI. It is not 11,000 new, it is 11,000 that we have today. The new budget adds 4,000 and that is—most of that—

The CHAIRMAN. I thought the previous budgets added 7,000 in the last few years.

Secretary SHINSEKI. I think our numbers are 11,000 today and 4,000 in the 2011 budget to address Agent Orange. But I will get you more accurate numbers?

The CHAIRMAN. Thank you. Maybe we will talk about it further in another forum, but I do not see us trying something different. I think you need a whole revolutionary approach.

Let me just mention one other thing that we have talked about. We live in both an age and a country where there is incredible development of new technologies. In very small, organizations, they are great for inventions for medical treatment technology and for internal operations, whether it is automation for the GI Bill or improvements for third-party collections.

The technology really moves fast. Bureaucracies by definition, move slowly. There are people who come to me and my colleagues every day that have new ideals or inventions and they cannot get access to the VA. It just takes forever to break through this bureaucracy.

We have to figure out a way to be better in touch. I do not think the existing structure is working because somebody will look at new technology and then they have to go through a whole new bureaucracy.

Maybe you need an Office of Revolution or something like that where people have a chance to really demonstrate their ideas. People need guidance to figure out how to introduce their products to one of the biggest systems in our Nation.

Whatever we talk about from prosthetics to post-traumatic stress disorder (PTSD) to third-party billing, I have talked to people who claim, they have new technologies. We try to get the VA to look at

them and it is like butting up against a stone wall because every one of the people who work for you is already working very hard. They say, uh-oh, a new idea. Rather than see it as a way to really strengthen the whole organization, it means a heavier workload for them.

You have a deputy who comes from IBM who is used to introducing new technology into a static environment. I think we need to figure this out and I think it would be a boon to every agency in the government if we figured out how to get new technology quicker.

I just go crazy when I hear something that could help improve brain injury by 50 percent more than what we are doing now and nobody will listen. I cannot tell if they are right or wrong, but they cannot even get someone to listen. I mentioned to you a new kind of textile for our soldiers that is a million times better than what we use now. What would that save us in treatment if we have ways to protect our soldiers?

It is just a thought. I hope you will start thinking about it. I think we have to find a new way to break through the bureaucracy. It is an inevitable tendency of bureaucracy to say that we have enough work to do, do not bring us something else.

Mr. BILBRAY. Mr. Chairman, may I—

The CHAIRMAN. Yes, please.

Mr. BILBRAY. Just to reinforce or it is sort of classic that a lot of civilians realize that the outdoor community had a product called Gortex for over a decade before Armed Services actually included it into the process. They were so wrapped up with leather, leather.

And here was a new break-through material that was very user friendly or whatever and the bureaucracy had that. And so you are right. There is this and that is why, I guess, we are supposed to go around to help sensitize it and encourage them along.

I yield back.

Ms. BROWN OF FLORIDA. Mr. Chairman.

The CHAIRMAN. Please, Ms. Brown?

Ms. BROWN OF FLORIDA. You know, I think that we should think out of the box in many, many different ways, but keeping in mind the Secretary inherited an agency that has been underfunded for years. It is a big agency and it is just like government. It turns slowly.

And I want to commend him. I think the Secretary is doing a good job. I have been here for 18 years and I have listened to several Secretaries and this is one that when he says something, he is going to try do it and I really think we should salute him.

The CHAIRMAN. I second—

Ms. BROWN OF FLORIDA. And I know you are doing it, but—

The CHAIRMAN. I second your comments. I just want to make us—

Ms. BROWN OF FLORIDA. I want to be clear.

The CHAIRMAN [continuing]. Move a little faster.

Ms. BROWN OF FLORIDA. Yeah, I know.

The CHAIRMAN. Thank you for clarifying this.

Ms. BROWN OF FLORIDA. But we are dealing with an old, I mean, not an old agency, but one that has been underfunded for years.

The CHAIRMAN. Thank you, Ms. Brown.

Secretary SHINSEKI. Mr. Chairman, may I respond. And my thanks to Congresswoman Brown here for her very kind comments and also her leadership in much of this area where we talk about health care.

Mr. Chairman, I think you know I come from a background with a lot of contact with research and development. And I share your impatience here and I think we ought to go faster. I will look for ways to go faster, smart and fast.

Right now I am trying to put into place an Assistant Secretary for Acquisition, Logistics, and Construction to address many of the issues that you are describing.

Like you, I get a lot of calls about good ideas or things that if we would take aboard right now would solve many of our problems. And like you, my frustration is I do not know enough about it to make that judgment.

But having an office that is equipped with the right skills, right number of people that can take these on, address them and very, very quickly, turning them around, I think, would be helpful.

And that is part of my request is support for considering an Assistant Secretary with the appropriate number of Deputies to provide us that kind of innovative, thoughtful, and yet responsible action, reaction to these good ideas, I think, would be very helpful to the Department.

The CHAIRMAN. Thank you.

I echo what Ms. Brown said, that we have confidence that you will.

Let me just conclude by thanking you for this budget. I think the Administration and your Department have produced a great blueprint for the future unlike other departments that are not subject to cuts. You have fought hard both personally and institutionally. I thank you for bringing us a budget that we can be proud of and that will do what has to be done for our Nation's veterans. We thank you and all of your team for being here today.

Secretary SHINSEKI. Great. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thanks so much.

We look forward to panel number two. Please come forward. Panel two consists of the major organizations that have put together *The Independent Budget* which I carry around as my Bible.

We will bring forward Carl Blake, National Legislative Director for the Paralyzed Veterans of America (PVA); John Wilson, the Assistant National Legislative Director for Disabled American Veterans (DAV); Eric Hilleman, the Director, National Legislative Service of the Veterans of Foreign Wars (VFW); and Raymond Kelley, National Legislative Director for AMVETS.

Mr. Blake, you have the floor.

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOHN L. WILSON, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; ERIC A. HILLEMANN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS)

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman.

On behalf of the coauthors of *The Independent Budget*, Paralyzed Veterans of America is pleased to be here today to present our views from *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs' health care system for fiscal year 2011.

Let me say up front that we are pleased that on balance, this budget is as good as any budget we have seen and we are pleased to see that the VA looks like they are moving in a very positive direction.

Despite the fact that Congress has already provided advanced appropriations for fiscal year 2011, the IB chose to still present budget recommendations for the medical care account specifically for fiscal year 2011.

Included in Public Law 111-117 was advanced appropriations for fiscal year 2011. Congress provided approximately \$48.2 billion in discretionary funding combined with \$3.3 billion projected for medical care collections, leading to a total of \$51.5 billion for the operating budget authority.

Accordingly, for fiscal year 2011, *The Independent Budget* recommends approximately \$52 billion for total medical care, an increase of \$4.5 billion over the fiscal year 2010 operating budget level established by the consolidated Appropriations Act.

We believe that this estimation validates the advanced projections that the Administration developed last year and has carried forward into this year.

Furthermore, we remain confident that the Administration is headed in a positive direction that will ultimately benefit the veterans who rely on the VA health care system to receive their care.

For fiscal year 2011, *The Independent Budget* recommends approximately \$40.9 billion for medical services. Our medical services recommendation includes approximately \$39 billion to maintain current services, \$1.3 billion to address our projected increase in patient workload, \$275 million to address the significant increase in prosthetics expenditures that is projected, and, lastly, a \$375 million initiative to restore the VA's long-term care average daily census to the level mandated by Public Law 106-117, the Veterans Millennium Health Care and Benefits Act.

Finally, for medical support and compliance, the IB recommends \$5.3 billion and for medical facilities \$5.7 billion.

The Independent Budget recommendation also includes a significant increase in funding for information technology. For fiscal year 2011, we recommend that the VA IT account be funded at approximately \$3.55 billion. This amount includes approximately \$130 mil-

lion for an information systems initiative to be carried out by the Veterans Benefits Administration.

We are concerned that the Administration is short-changing this account for fiscal year 2011 in a budget in which the VA and the Department of Defense are called on to jointly implement the Virtual Lifetime Electronic Record and in which the Administration proposes to automate claims processing to improve the accuracy and timeliness of veterans' benefits, particularly for disability compensation and the new Post-9/11 GI Bill.

Public Law 111-81 requires the President's budget submission to include estimates of appropriations for the medical care accounts for fiscal year 2012 and the VA Secretary provide detailed estimates of the funds necessary for these medical care accounts in his budget documents submitted to Congress.

Consistent with the advocacy by *The Independent Budget*, the law also requires a thorough analysis and public report of the Administration's advanced appropriations projections by the Government Accountability Office to determine if that information is sound and accurately reflects expected demand and costs to be incurred in fiscal year 2012 and subsequent years.

We are pleased to see that the Administration has followed through on its responsibility to provide a detailed estimate for the medical care accounts for the VA for fiscal year 2012. It is important to note that this is the first year that the budget documents have included advanced appropriations estimates.

The Independent Budget looks forward to examining all of this new information and incorporating it into our future budget estimates.

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*.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you might have.

[The prepared statement of Mr. Blake appears on p. 51.]

The CHAIRMAN. Thank you.

Mr. Wilson.

STATEMENT OF JOHN L. WILSON

Mr. WILSON. Thank you, Mr. Chairman and Members of the Committee.

I am glad to be here today on behalf of the DAV, AMVETS, PVA, and VFW to present our collective budget and policy views for the 2011 *Independent Budget*.

My testimony focuses primarily on the variety of VA benefits programs available to veterans. Preparing this 24th IB, the IBVSOs draw upon our experience with veterans' programs, our knowledge of the needs of America's veterans, and the information gained from monitoring workload demands, and performance of the veterans benefits and services system.

This Committee has previously acted favorably on many of our recommendations to improve services to veterans and their fami-

lies. We ask that you give our recommendations serious consideration again this year.

My oral testimony today focuses on four items. One, concurrent receipt of VA disability compensation and military longevity retired pay; two, the survivor benefit plan offset of dependency indemnity compensation; three, automobile grants; and, four, the disability claims process.

First, concurrent receipt. Current law still provides that service-connected veterans rated less than 50 percent who retire from the Armed Forces on length of service will not receive both their VA disability compensation and full military retired pay. The IBVSOs recommend Congress enact legislation to repeal this inequitable requirement.

Second, the offset of survivor benefit plan or SBP compensation by an amount equal to the dependency indemnity compensation benefits. Under current law, as you know, recipients SBP income is reduced by an amount equal to any DIC for which they are otherwise eligible.

This offset is also inequitable because no duplication of benefits is involved. It penalizes survivors of military retirees, of veterans whose deaths are under circumstances warranting the government to provide compensation for such loss. It is the recommendation of the IBVSOs that Congress repeal the offset between DIC and SBP.

Third, automobile grants. The current \$11,000 automobile grant is only 39 percent of the average cost of a new car. To restore equity, the allowance should be set at a minimum of 80 percent of today's average new cost for a vehicle which is \$22,800. It is the recommendation of IBVSOs that Congress enact legislation to increase the automobile allowance to at least 80 percent of the average cost of a new automobile.

Fourth and finally, the disability claims process. To illustrate my point regarding the claims process, let me recount a story. Between August 25th and September 2nd of last year, the Roanoke VA Regional Office was visited by the VA's Office of Inspector General. They found the office did not meet 6 of 14 important operational areas. Inspectors found 29 of those 118 claims that they reviewed contained errors, a 25 percent error rate. And they found nearly 11,000 folders sitting on top of full file cabinets. An engineer stated the load on floors 10, 11, and 12, of this 14-story building, is double what is considered safe and heavy enough to cause a potential collapse.

This story provides a timely illustration of the need to reform the veterans benefits approval system before the very weight of it destroys the structural integrity of the system and it collapses in upon itself.

Today, too many disabled veterans and their survivors must wait too long for disability compensation and pension rating decisions that are too often wrong or inaccurate. VBA must develop a work culture that emphasizes quality at all steps of the process.

It must begin with the development of a management culture that measures and rewards the quality of results, not just the quantity, and which provides sufficient training of both VA's management and workforce in order to achieve accurate outcomes.

VBA must modernize its IT infrastructure and optimize its business processes. The current paper heavy system must be replaced with a secure and accessible paperless system that readily moves and organizes information necessary to help rating specialists reach correct decisions. The new system must optimize both the workflow and the business processes.

Finally, VBA must implement a simpler and more transparent benefits application and approval process. There should be a universal and simple application procedure that provides veterans with regular updates on the progress of their claims and allows them to access the records in a pending claim securely from any location.

It has been a pleasure to appear before this honorable Committee today. I would be happy to answer any questions you may have. [The prepared statement of Mr. Wilson appears on p. 53.]

The CHAIRMAN. Thank you, Mr. Wilson. That is a pretty apt metaphor that the system is going to collapse under its own weight, I mean, literally.

Mr. WILSON. Yes, sir.

The CHAIRMAN. Mr. Hilleman.

STATEMENT OF ERIC A. HILLEMAN

Mr. HILLEMAN. Thank you, Mr. Chairman, Members of the Committee.

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars and our auxiliaries, it is my pleasure to testify and present our views before you today.

The VFW works side by side with AMVETS, the Disabled American Veterans, Paralyzed Veterans of America to produce a policy and budget recommendation document known as *The Independent Budget*. The VFW is responsible for the construction portion of the IB, so I will limit my remarks to that portion of the budget.

VA's infrastructure, particularly within its health care system, is at a crossroads. The system is facing many challenges, including the average age of buildings 60 years or more, significant funding needs for routine maintenance, upgrades, modernization and construction.

VA is beginning a patient-centered information reformation in the way it delivers care and manages infrastructure to meet the needs of sick and disabled veterans in the 21st century.

Regardless of what the VA health care system of the future looks like, our focus must remain on the lasting and accessible VA health care system that is dedicated to unique needs of veterans.

VA manages a wide portfolio of capital assets throughout the Nation. According to its latest capital asset plan, VA is responsible for 5,500 buildings and almost 34,000 acres of land. This vast network of facilities requires significant time, attention from the capital asset managers.

Capital Asset Realignment for Enhanced Services (CARES), a VA data-driven assessment of their current and future construction needs, gave VA a long-term road map and has helped guide its capital planning process over past fiscal years. CARES showed a large number of significant construction priorities that would be necessary to fulfill the needs of VA in the future and Congress has

made significant end roads into funding these priorities. It has been a huge but necessary undertaking and VA has made slow and steady process in these critical areas.

The challenge for VA in the post-CARES era is that there are still numerous projects that need to be carried out and the current backlog of partially funded projects that CARES has identified is large. This means that VA is going to continue to require significant appropriations for major and minor construction accounts to live up to the promises of CARES.

VA's most recent asset management plan provides an update of the status of CARES projects, including those in the planning and acquisition process. The top 10 major construction projects in queue require \$3.25 billion in appropriations. This is just the tip of the iceberg. There are 82 additional ongoing or partially funded projects that demonstrate the continued need for VA to upgrade and repair its aging infrastructure and that continuous funding is necessary to address the backlog of projects.

A November 17th, 2008, letter to the Senate Veterans Affairs' Committee, Secretary Peake said that the Department, "Estimates that the total funding requirement for major medical facility projects over the next 5 years would be in excess of \$6.5 billion."

It is clear that the VA needs a significant infusion of cash for its construction priorities. VA's own words and studies state this.

The total major construction request that the IB estimates is \$1.295 billion. The minor request is \$785 million.

The IB recognizes that money was provided for military and veterans' construction in the American Recovery and Reinvestment Act of 2009 (ARRA). The IB is not requesting plus-ups of funds in those accounts. However, we recognize that the Administration numbers are below the IB recommendation.

We would ask that this Committee examine the amounts remaining in the construction accounts, left over from the American Recovery and Reinvestment Act. Thank you. I look forward to your questions.

[The prepared statement of Mr. Hilleman appears on p. 64.]

The CHAIRMAN. Thank you.

Mr. Kelley.

STATEMENT OF RAYMOND C. KELLEY

Mr. KELLEY. Chairman Filner, thank you for inviting AMVETS to testify on behalf of *The Independent Budget* today.

As a partner of *The Independent Budget*, AMVETS devotes a majority of its time with the concerns of the National Cemetery Administration (NCA) and I would like to speak directly to these issues and concerns surrounding NCA.

In fiscal year 2009, \$230 million was appropriated for the operations and maintenance of NCA, \$49 million over the Administration's request.

NCA has awarded 49 of 56 minor construction projects that were in the operating plan.

The State Grant Cemetery Service awarded \$40 million in grants for 10 projects.

The Independent Budget partners also want to recognize NCA for their foresight in reducing the population threshold for the estab-

lishment of new cemeteries as well as understanding this policy needs to be flexible to take into account areas that do not easily fit into this model due to urban or geographical phenomena.

The Independent Budget requests an operating budget of \$274.5 million for NCA for fiscal year 2011. *The Independent Budget* is encouraged that \$25 million was set aside for the National Shrine commitment for fiscal year 2007 and 2008.

In 2006, only 67 percent of headstones and markers in national cemeteries were at a proper height and alignment. By 2009, proper alignment, height and alignment was increased to 76 percent.

NCA has also identified 153 historic monuments and memorials that need repair and/or restoration. With funding from the American Recovery and Reinvestment Act, NCA will make repairs to 32 percent of these monuments and memorials.

The Independent Budget supports the NCA's operational standards and measures outlined in the National Shrine commitment and in the past, *The Independent Budget* advocated for a 5-year, \$250 million National Shrine initiative to assist NCA in achieving those performance goals.

However, over the past few years, NCA has made marked improvements in the National Shrine commitment by earmarking a portion of its operations and maintenance budget for the commitment and pending receipts of funding from the ARRA.

Therefore, *The Independent Budget* no longer believes that it is necessary to implement the National Shrine Initiative Program at \$50 million a year for 5 years, but rather proposes an increase in NCA's operating and maintenance budget by \$25 million per year until the operational standards and measure goals are reached.

The State Cemeteries Grants Program faces the challenges of meeting a growing interest from States and provide burial services in areas that are not currently served by national cemeteries. Currently, there are 60 States and tribal government cemetery construction grant pre-applications, 36 of which have the required State matching funds totaling \$121 million.

The Independent Budget recommends that Congress appropriate \$51 million for the State Grant Program for fiscal year 2011. This funding level will allow the Grant Program to establish 13 new State cemeteries.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories, veterans who live inside the VA accessibility threshold model and those who live outside the threshold.

For those veterans who live outside the threshold, the service-connected burial benefit would be increased to \$6,160. Nonservice-connected veterans' burial benefits would increase to \$1,918. And the plot allowance would increase to \$1,150 to match the original value of the benefit.

For the veterans who live inside the threshold, the benefit for service-connected burial would be \$2,793. The amount provided for nonservice-connected burial would be \$854. And the plot allowance would be \$1,150.

This will provide a burial benefit at equal percentages, but based on the average cost for the VA funeral and not on the private fu-

neral cost that will be provided for those veterans who do not have access to a State or national cemetery.

The new model will provide a meaningful benefit for those veterans whose access to a State or national cemetery is restricted as well as provides an improved benefit for eligible veterans who opt for private burial.

Congress should also enact legislation to adjust these burial benefits for inflation annually.

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

[The prepared statement of Mr. Kelley appears on p. 73.]

The CHAIRMAN. We thank you very much for all the work you do each year on this *Independent Budget*. As you know, I use it as my Bible.

We have a lot of questions, but because of the votes that are present, we are going to submit them to you. We thank you so much.

I am going to recognize panel three. You have been sitting here all morning. If each of you could just stand up or take your microphone for 30 seconds and tell us what your first priority is? We are going to recess to go vote and I do not want to have to have you all waiting here again.

Steve Robertson, Director of the National Legislative Commission, the American Legion; Rick Weidman, Executive Director for Policy and Government Affairs for VVA; Paul Rieckhoff, Executive Director for the Iraq and Afghanistan Veterans of America (IAVA); and Paul Sullivan, Executive Director for Veterans for Common Sense. If you would just take a minute and state what is your top priority and what is missing from this budget that we ought to be correcting.

Mr. Robertson, I apologize for doing it this way. We have all of your statements for the record. We will start with you.

STATEMENTS OF STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION; RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA; PAUL RIECKHOFF, EXECUTIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND PAUL SULLIVAN, EXECUTIVE DIRECTOR, VETERANS FOR COMMON SENSE

STATEMENT OF STEVE A. ROBERTSON

Mr. ROBERTSON. Mr. Chairman, I just have one request that we be allowed to add additional comments as we had a very short window to review the budget and there are a lot of legislative proposals that we want to flush out before—

The CHAIRMAN. Yes. Of course, you will have that extra time, Mr. Robertson.

Mr. ROBERTSON. And we are very pleased with the budget. It is very rare that we get to come to a Congressional hearing where we do not have to beat up on somebody to make sure we get the benefits that we believe are earned benefits for America's veterans.

Thank you.

[The oral and prepared statements of Mr. Robertson appear on pp. 77 and 78.]

The CHAIRMAN. Where is your hat?

Mr. ROBERTSON. It is in my pocket.

The CHAIRMAN. I did not know you had hair.

Mr. Weidman.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. I have no hat, Mr. Chairman.

The CHAIRMAN. No hair either.

Mr. WEIDMAN. And no hair either. That is right.

The CHAIRMAN. The only order that we put you in is increasing baldness. You can see it goes from Robertson to Rieckhoff in a stepped up way.

Mr. WEIDMAN. Wow. I am trying to think about how to put this into one single thing. It is to let VA be VA. And what we mean by that is to start taking a military history. They are now exporting the Vista system to the private sector all over the country and it still does not have a military history in the damn medical record.

And what it says to people is it is unimportant for future health care risk where Tim Walz served in the Guard when he was on active duty during his 30 years in service. And that is a crock.

We need to be educating. Where 80 percent of American veterans get their health care is not at the VA and VA does nothing in terms of educating either its own people properly, never mind the rest of American medicine, and what are the wounds, maladies, and injuries of war that we need to start to address.

Part of that let VA be VA is \$590 million in set-aside for research. Of that, almost none of it is going to research in the wounds, maladies, and injuries of war.

Mr. Buyer talked about science. Well, you do not get science, if you do not put out money for research in order to get the science. And nobody is putting out the research for Agent Orange, for Gulf War I, never mind other conditions, and that is what we need to do in that regard.

And, last, but by no means least, has to do with the issue of transparency and partnership. And there was a lot of rhetoric about it, but the transparency at VA needs to go back to where it was prior to 2002, particularly at the Veterans Health Administration. They do too much stuff in secret. And, frankly, they screwed it up in secret because they did not consult with the veterans service organizations or the Hill properly before they headed off in the wrong direction.

So that is part and parcel of listen to the individual veterans and to the individual veteran and military service organizations and Members of Congress and then they will start to let VA be VA and get it right, sir.

[The prepared statement of Mr. Weidman appears on p. 91.]

The CHAIRMAN. Thank you. Thank you for your eloquence and your succinctness.

Mr. Sullivan.

STATEMENT OF PAUL SULLIVAN

Mr. SULLIVAN. Mr. Chairman, thank you.

In 30 seconds, Veterans for Common Sense urges Congress to require VA that they develop more accurate casualty estimates and implement a long-range strategic casualty plan.

Right now VA is treating a half million Iraq and Afghanistan veterans. They have almost as many claims. This is far above any worst case scenario we could have predicted.

For VA's 2012 budget, VA estimated less than 500,000 patients. That is low. That is wrong. A more realistic estimate of cumulative patients treated by 2012 would be closer to 800,000 new patients and claims from the two wars. And what is exacerbating that is the claims for PTSD and traumatic brain injury.

And, finally, Mr. Chairman, you mentioned in your conversations with the Secretary about a Department of Revolution that got some giggles in the back of the room among us bald people.

Disney set up Pixar and Mr. Cameron did Avatar. That is because they had new ideas and they thought outside of the box and they are very highly successful.

Mr. Chairman, VBA's Veterans Benefits Management System, you are right, is nothing more than putting a brand new logo on a broken down, rundown car.

In our view, we would ask that Congress fund a high priority task force independent of VA with one mission, overhaul VBA within 1 year and put them in a little box in a room somewhere and say here is the veteran, here is the check. Let us shorten the distance between the two and let us quit trying to improve on what we know is an absolutely totally broken model at VBA.

[The oral and prepared statements of Mr. Sullivan appear on pp. 98 and 99.]

The CHAIRMAN. Thank you, Mr. Sullivan.
Mr. Rieckhoff.

STATEMENT OF PAUL RIECKHOFF

Mr. RIECKHOFF. Thank you, Mr. Chairman. Thank you to the Committee.

I am from New York, so I will try to talk fast. We appreciate you having IAVA here to present our views. And we are an online-centric organization. So since I am cut for time, I would encourage you to go to our Web site, iava.org, where you can see my entire testimony.

We are pleased to see the budget submission for 2011 and 2012. It has all the right ingredients to transform VA and it is a message to our veterans that we really do have their back.

Our number one priority is modernizing the benefits delivery. The VA benefits system must be brought into the 21st century. Right now our veterans are receiving benefits under a system that was outdated years before most of them were born.

So facing this mountain of bureaucratic red tape and lengthy wait times, we join with the chorus of other veterans' groups in recommending that VA modernize their claims process system by digitizing records, holding processors accountable for the accuracy of the work, and by removing unnecessary steps in the evaluation process. It is cost effective. It will save the taxpayer money.

But disability reform is our number one priority for 2010. And we will be here all next week with dozens of veterans from around

the country for our annual Storm the Hill trip. We look forward to meeting with you and we strongly support this budget and appreciate your time. Check out the Web site.

[The prepared statement of Mr. Rieckhoff appears on p. 94.]

The CHAIRMAN. Thank you.

I apologize for having you rush. You all have very important things to say and we will read the testimony. If you want to augment it as Mr. Robertson said, try to do it within the next 5 days so we can get the record complete.

We thank all of you for your testimony and we must adjourn this meeting.

[Whereupon, at 1:03 p.m., the Committee was adjourned.]

A P P E N D I X

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

Welcome to the hearing on the Department of Veterans Affairs Budget Request for Fiscal Year 2011 and Fiscal Year 2012.

The President has requested a budget for VA of \$125 billion, including a total discretionary resource request of \$60.3 billion. VA medical care represents 86 percent of the total discretionary request. For fiscal year 2011, the Administration is requesting \$51.5 billion in resources for VA medical care. Appropriated resources for medical care for fiscal year 2011 have already been provided in last year's Consolidated Appropriations Act. This funding level is an increase of \$4.1 billion, or 8.6 percent over fiscal year 2010 levels.

In accordance with the Veterans Health Care Budget Reform and Transparency Act, enacted last year with the support of this Administration and the bipartisan support of this Congress, the VA has requested \$50.6 billion in appropriated dollars and a total resource level of \$54.3 billion, a \$2.8 billion, or 5.3 percent increase over fiscal year 2011 levels. We understand this level is consistent with the VA's actuarial model.

Rest assured that this Committee will be working closely with our counterparts in Congress and with the Administration as the process moves forward to ensure that veterans have the medical care resources they need when fiscal year 2012 begins on October 1, 2011.

The veterans' groups that co-author *The Independent Budget*, who will be testifying on our second panel today, have recommended for fiscal year 2011, a total resource level for VA medical care of \$52 billion, and an overall discretionary funding level of \$61.5 billion, \$1.2 billion above the Administration's requested increase of \$4.3 billion. We are looking forward to their testimony and the testimony of The American Legion, VVA, IAVA, and Veterans for Common Sense which are on our third panel.

Mr. Secretary, I am impressed by your robust budget request and your emphasis on funding many of the priorities of this Committee, including addressing the plague of homelessness, rural health care access, and the mental health care needs of our veterans. This budget addresses the problems faced by our newer veterans while not forgetting the sacrifices and service of veterans from previous conflicts.

I note that you are requesting additional funding for more claims processors and I am looking forward to you providing this Committee with a roadmap on how we reform the claims process. More money and more FTE will not solve this broken process and it won't provide us with a system that is fair to veterans and efficient.

We look forward to hearing about your successes this year, your frustrations, and how you plan to use the resources in this request to meet the needs of our veterans. We look forward to working with you to ensure that you have the money to do the job, and we look forward to working closely with you to assist you in your goal of creating a 21st Century VA.

Prepared Statement of Hon. Corrine Brown

Thank you, Mr. Chairman, for calling this hearing today. This will allow the Secretary to testify in support of his budget request for the 2011 and 2012 fiscal years.

Thank you, Mr. Secretary, for your decades of service defending the freedom of this Nation. Thank you for your commitment to the veterans who also served this Nation.

I am pleased with the budget you have submitted earlier this week.

Over the last few years, this Congress, and especially Chairman Filner has overseen the largest funding increase in the history of the VA.

That being said, I am pleased with the current increase in funding for health care and other priorities.

I applaud that you plan to bring more Priority 8 veterans back into the fold. These men and women have, by serving their country, paid their dues and earned their right to health care from the VA. However, maybe you could speed the timeline up further than just the 99,000 you estimate would additionally use the VA next year.

I am concerned about the increase in the wait times veterans are being subjected to, and I look forward to hearing how you plan on reducing the time our veterans have to wait for appointments.

I am pleased that so many contracts are being signed for the new VA Medical Center in Orlando. The VAMC should be fully funded and I want to hear about it ahead of time if the numbers are not matching up. We will fix it, if we know.

I believe the words of the first President of the United States, George Washington, are also worth repeating at this time:

“The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country.”

Prepared Statement of Hon. Harry E. Mitchell

Thank you Chairman Filner, and thanks to Secretary Shinseki and the Veterans Service Organizations (VSOs) for coming to participate in the hearing today.

Among the many important issues that this Congress and Administration must address in the 111th Congress, I wish to highlight two today.

First, I believe we need to do more to prevent veteran’s suicide.

As we all know, many of our newest generation of veterans, as well as those who served previously, bear wounds that cannot be seen and are hard to diagnose.

Proactively bringing the VA to our veterans, as opposed to waiting for veterans to find the VA, is a critical part of delivering the care they have earned in exchange for their brave service.

At my behest, Secretary Peake overturned VA’s self-imposed ban on television advertising as a method of outreach. Since then, the VA rolled out a public service announcement and outreach campaign to inform veterans and their families about the suicide prevention hotline.

What began as a limited DC area pilot program has been expanded nationally, and it has been effective. Since its inception in July of 2007, nearly 225,000 calls were received from veterans. And the hotline has been credited with saving 7,000 lives.

While I applaud the VA and Secretary Shinseki for expanding and extending outreach, I believe we need to do more. We need to expand and extend outreach efforts, including the use of twitter, facebook and new media, to let veterans know where they can get help.

Additionally, I believe the VA needs to aggressively reduce the claims backlog. The VA must deliver these earned benefits in a timely manner.

As many have noted, there is a backlog of disability claims that stretches hundreds of thousands of veterans long. I am pleased that the Administration has requested funding for more than 4,000 new claims processors in their FY 2011 request. However, I believe that the VA needs more than additional manpower to reduce the backlog.

The VA needs a long-term strategy and plan.

Doing so, I believe will provide better services to our veterans and increase their morale and confidence in the VA.

Finally, I want to say that I am encouraged by Secretary Shinseki’s commitment to reform the VA, and I look forward to working with him, with my colleagues in Congress, to bring the VA and its services to our veterans in an effective and efficient manner.

Thank you again to all of our witnesses. I look forward to hearing your perspective on the budget outlook for the VA in the coming fiscal year.

Prepared Statement of Hon. John Boozman

Thank you Mr. Chairman. I would agree with the remarks made by the Ranking Member. This is certainly a generous budget considering the economic crisis facing the Nation.

Mr. Secretary, I have one major budget concern and that is how VA proposes to allocate the over 4,000 new VBA employees among the various business lines. I believe that adding 3,919 FTE to C&P while cutting 9 employees from the Voc Rehab Service needs to be rethought.

The budget documents show a 10 percent increase in the total VR&E caseload so cutting counseling staffs when more resources are needed to bring the average caseload down does not reflect a focus on rehabilitating disabled veterans.

I hope you will revisit this staffing issue and consider shifting some of the new staffing resources to increase the VR&E staffing to reduce the average caseload to not more than 100.

I yield back.

**Prepared Statement of Hon. Eric K. Shinseki, Secretary,
U.S. Department of Veterans Affairs**

Chairman Filner, Ranking Member Buyer, Distinguished Members of the House Committee on Veterans' Affairs:

Thank you for this opportunity to present the President's Fiscal Year 2011 Budget and Fiscal Year 2012 Advance Appropriations Request for the Department of Veterans Affairs (VA). Our budget provides the resources necessary to continue our aggressive pursuit of the President's two overarching goals for the Department—to transform VA into a 21st Century organization and to ensure that we provide timely access to benefits and high quality care to our veterans over their lifetimes, from the day they first take their oaths of allegiance until the day they are laid to rest.

We recently completed development of a new strategic framework that is people-centric, results-driven, and forward-looking. The path we will follow to achieve the President's vision for VA will be presented in our new strategic plan, which is currently in the final stages of review. The strategic goals we have established in our plan are designed to produce better outcomes for all generations of veterans:

- Improve the quality and accessibility of health care, benefits, and memorial services while optimizing value;
- Increase veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services;
- Protect people and assets continuously and in time of crisis; and,
- Improve internal customer satisfaction with management systems and support services to achieve mission performance and make VA an employer of choice by investing in human capital.

The strategies in our plan will guide our workforce to ensure we remain focused on producing the outcomes veterans expect and have earned through their service to our country.

To support VA's efforts, the President's budget provides \$125 billion in 2011—almost \$60.3 billion in discretionary resources and nearly \$64.7 billion in mandatory funding. Our discretionary budget request represents an increase of \$4.3 billion, or 7.6 percent, over the 2010 enacted level.

VA's 2011 budget also focuses on three concerns that are of critical importance to our veterans—easier access to benefits and services; reducing the disability claims backlog and the time veterans wait before receiving earned benefits; and ending the downward spiral that results in veterans' homelessness.

This budget provides the resources required to enhance access in our health care system and our national cemeteries. We will expand access to health care through the activations of new or improved facilities, by expanding health care eligibility to more veterans, and by making greater investments in telehealth. Access to our national cemeteries will be increased through the implementation of new policy for the establishment of additional facilities.

We are requesting an unprecedented increase for staffing in the Veterans Benefits Administration (VBA) to address the dramatic increase in disability claim receipts while continuing our process-reengineering efforts, our development of a paperless claims processing system, and the creation of a Virtual Lifetime Electronic Record.

We are also requesting a substantial investment for our homelessness programs as part of our plan to ultimately eliminate veterans' homelessness through an aggressive approach that includes housing, education, jobs, and health care.

VA will be successful in resolving these three concerns by maintaining a clear focus on developing innovative business processes and delivery systems that will not only serve veterans and their families for many years to come, but will also dramatically improve the efficiency of our operations by better controlling long-term costs. By making appropriate investments today, we can ensure higher value and better outcomes for our veterans. The 2011 budget also supports many key investments in VA's six high priority performance goals (HPPGs).

HPPG I: Reducing the Claims Backlog

The volume of compensation and pension rating-related claims has been steadily increasing. In 2009, for the first time, we received over one million claims during the course of a single year. The volume of claims received has increased from 578,773 in 2000 to 1,013,712 in 2009 (a 75 percent increase). Original disability compensation claims with eight or more claimed issues have increased from 22,776 in 2001 to 67,175 in 2009 (nearly a 200 percent increase). Not only is VA receiving substantially more claims, but the claims have also increased in complexity. We expect this level of growth in the number of claims received to continue in 2010 and 2011 (increases of 13 percent and 11 percent were projected respectively even without claims expected under new presumptions related to Agent Orange exposure), which is driven by improved access to benefits through initiatives such as the Benefits Delivery at Discharge Program, increased demand as a result of nearly 10 years of war, and the impact of a difficult economy prompting America's Veterans to pursue access to the benefits they earned during their military service.

While the volume and complexity of claims has increased, so too has the productivity of our claims processing workforce. In 2009, the number of claims processed was 977,219, an increase of 8.6 percent over the 2008 level of 899,863. The average time to process a rating-related claim fell from 179 to 161 days in 2009, an improvement of 11 percent.

The progress made in 2009 is a step in the right direction, but it is not nearly enough. My goal for VA is an average time to process a claim of no more than 125 days. Reaching this goal will become even more challenging because of additional claims we expect to receive related to veterans' exposure to Agent Orange. Adding Parkinson's disease, ischemic heart disease, and B-cell leukemias to the list of presumptive disabilities is projected to significantly increase claims inventories in the near term, even while we make fundamental improvements to the way we process disability compensation claims.

We expect the number of compensation and pension claims received to increase from 1,013,712 in 2009 to 1,318,753 in 2011 (a 30 percent increase). Without the significant investment requested for staffing in this budget, the inventory of claims pending would grow from 416,335 to 1,018,343 and the average time to process a claim would increase from 161 to 250 days. If Congress provides the funding requested in our budget, these increases are projected to be 804,460 claims pending with an average processing time of 190 days. Through 2011, we expect over 228,000 claims related to the new presumptions and are dedicated to processing this near-term surge in claims as efficiently as possible.

This budget is based on our plan to improve claims processing by using a three-pronged approach involving improved business processes, expanded technology, and hiring staff to bridge the gap until we fully implement our long-range plan. We will explore process and policy simplification and contracted service support in addition to the traditional approach of hiring new employees to address this spike in demand. We expect these transformational approaches to begin yielding significant performance improvements in fiscal year 2012 and beyond; however, it is important to mitigate the impact of the increased workload until that time.

The largest increase in our 2011 budget request, in percentage terms, is directed to the Veterans Benefits Administration as part of our mitigation of the increased workload. The President's 2011 budget request for VBA is \$2.149 billion, an increase of \$460 million, or 27 percent, over the 2010 enacted level of \$1.689 billion. The 2011 budget supports an increase of 4,048 FTEs, including maintaining temporary FTE funded through ARRA. In addition, the budget also includes \$145.3 million in information technology (IT) funds in 2011 to support the ongoing development of a paperless claims processing system.

HPPG II: Eliminating Veteran Homelessness

Our Nation's veterans experience higher than average rates of homelessness, depression, substance abuse, and suicides; many also suffer from joblessness. On any given night, there are about 131,000 veterans who live on the streets, representing every war and generation, including those who served in Iraq and Afghanistan. VA's major homeless-specific programs constitute the largest integrated network of homeless treatment and assistance services in the country. These programs provide a continuum of care for homeless veterans, providing treatment, rehabilitation, and supportive services that assist homeless veterans in addressing health, mental health and psychosocial issues. VA also offers a full range of support necessary to end the cycle of homelessness by providing education, jobs, and health care, in addition to safe housing. We will increase the number and variety of housing options available to homeless veterans and those at risk of homelessness with permanent, transitional, contracted, community-operated, HUD-VASH provided, and VA-operated housing.

Homelessness is primarily a health care issue, heavily burdened with depression and substance abuse. VA's budget includes \$4.2 billion in 2011 to prevent and reduce homelessness among veterans—over \$3.4 billion for core medical services and \$799 million for specific homeless programs and expanded medical programs. Our budget includes an additional investment of \$294 million in programs and new initiatives to reduce the cycle of homelessness, which is almost 55 percent higher than the resources provided for homelessness programs in 2010.

VA's health care costs for homeless veterans can drop in the future as the Department emphasizes education, jobs, and prevention and treatment programs that can result in greater residential stability, gainful employment, and improved health status.

HPPG III: Automating the GI Bill Benefits System

The Post-9/11 GI Bill creates a robust enhancement of VA's education benefits, evoking the World War II Era GI Bill. Because of the significant opportunities the Act provides to veterans in recognition of their service, and the value of the program in the current economic environment, we must deliver the benefits in this Act effectively and efficiently, and with a client-centered approach. In August 2009, the new Post-9/11 GI Bill program was launched. We received more than 397,000 original and 219,000 supplemental applications since the inception of this program.

The 2011 budget provides \$44.1 million to complete the automated solution for processing Post-9/11 GI Bill claims and to begin the development and implementation of electronic systems to process claims associated with other education programs. The automated solution for the Post-9/11 GI Bill education program will be implemented by December 2010.

In 2011, we expect the total number of all types of education claims to grow by 32.3 percent over 2009, from 1.70 million to 2.25 million. To meet this increasing workload and complete education claims in a timely manner, VA has established a comprehensive strategy to develop an end-to-end solution that utilizes rules-based, industry-standard technologies to modernize the delivery of education benefits.

HPPG IV: Establishing a Virtual Lifetime Electronic Record

Each year, more than 150,000 active and reserve component servicemembers leave the military. Currently, this transition is heavily reliant on the transfer of paper-based administrative and medical records from the Department of Defense (DoD) to the veteran, the VA or other non-VA health care providers. A paper-based transfer carries risks of errors or oversights and delays the claim process.

In April 2009, the President charged me and Defense Secretary Gates with building a fully interoperable electronic records system that will provide each member of our armed forces a Virtual Lifetime Electronic Record (VLER). This virtual record will enhance the timely delivery of high-quality benefits and services by capturing key information from the day they put on the uniform, through their time as veterans, until the day they are laid to rest. The VLER is the centerpiece of our strategy to better coordinate the user-friendly transition of servicemembers from their service component into VA, and to produce better, more timely outcomes for veterans in providing their benefits and services.

In December 2009, VA successfully exchanged electronic health record (EHR) information in a pilot program between the VA Medical Center in San Diego and a local Kaiser Permanente hospital. We exchanged EHR information using the Nationwide Health Information Network (NHIN) created by the Department of Health and Human Services. Interoperability is key to sharing critical health information.

Utilizing the NHIN standards allows VA to partner with private sector health care providers and other Federal agencies to promote better, faster, and safer care for veterans. During the second quarter of 2010, the DoD will join this pilot and we will announce additional VLER health community sites.

VA has \$52 million in IT funds in 2011 to continue the development and implementation of this Presidential priority.

HPPG V: Improving Mental Health Care

The 2011 budget continues the Department's keen focus on improving the quality, access, and value of mental health care provided to veterans. VA's budget provides over \$5.2 billion for mental health, an increase of \$410 million, or 8.5 percent, over the 2010 enacted level. We will expand inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care.

Post-Traumatic Stress Disorder (PTSD) is the mental health condition most commonly associated with combat, and treating veterans who suffer from this debilitating disorder is central to VA's mission. Screening for PTSD is the first and most essential step. It is crucial that VA be proactive in identifying PTSD and intervening early in order to prevent chronic problems that could lead to more complex disorders and functional problems.

VA will also expand its screening program for other mental health conditions, most notably traumatic brain injury (TBI), depression, and substance use disorders. We will enhance our suicide prevention advertising campaign to raise awareness among veterans and their families of the services available to them.

More than one-fifth of the veterans seen last year had a mental health diagnosis. In order to address this challenge, VA has significantly invested in our mental health workforce, hiring more than 6,000 new workers since 2005.

In October 2009, VA and DoD held a mental health summit with mental health experts from both departments, and representatives from Congress and more than 57 non-government organizations. We convened the summit to discuss an innovative, wide-ranging public health model for enhancing mental health for returning servicemembers, veterans, and their families. VA will use the results to devise new innovative strategies for improving the health and quality of life for veterans suffering from mental health problems.

HPPG VI: Deploying a Veterans Relationship Management System

A key component of VA's transformation is to employ technology to dramatically improve service and outreach to veterans by adopting a comprehensive Veterans' Relationship Management System to serve as the primary interface between veterans and the Department. This system will include a framework that provides veterans with the ability to:

- Access VA through multiple methods;
- Uniformly find information about VA's benefits and services;
- Complete multiple business processes within VA without having to re-enter identifying information; and,
- Seamlessly access VA across multiple lines of business.

This system will allow veterans to access comprehensive online information anytime and anywhere via a single consistent entry point. Our goal is to deploy the Veterans Relationship Management System in 2011. Our budget provides \$51.6 million for this project.

In addition to resources supporting these high-priority performance goals, the President's budget enhances and improves services across the full spectrum of the Department. The following highlights funding requirements for selected programs along with the outcomes we will achieve for veterans and their families.

Delivering World-Class Medical Care

The Budget provides \$51.5 billion for medical care in 2011, an increase of \$4 billion, or 8.5 percent, over the 2010 level. This level will allow us to continue providing timely, high-quality care to all enrolled veterans. Our total medical care level is comprised of funding for medical services (\$37.1 billion), medical support and compliance (\$5.3 billion), medical facilities (\$5.7 billion), and resources from medical care collections (\$3.4 billion). In addition to reducing the number of homeless veterans and expanding access to mental health care, our 2011 budget will also achieve numerous other outcomes that improve veterans' quality of life, including:

- Providing extended care and rural health services in clinically appropriate settings;
- Expanding the use of home telehealth;
- Enhancing access to health care services by offering enrollment to more Priority Group 8 veterans and activating new facilities; and,
- Meeting the medical needs of women veterans.

During 2011, we expect to treat nearly 6.1 million unique patients, a 2.9 percent increase over 2010. Among this total are over 439,000 veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom, an increase of almost 57,000 (or 14.8 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for health care in 2010.

In 2011, the budget provides \$2.6 billion to meet the health care needs of veterans who served in Iraq and Afghanistan. This is an increase of \$597 million (or 30.2 percent) over our medical resource requirements to care for these veterans in 2010. This increase also reflects the impact of the recent decision to increase troop size in Afghanistan. The treatment of this newest generation of veterans has allowed us to focus on, and improve treatment for, PTSD as well as TBI, including new programs to reach veterans at the earliest stages of these conditions.

The FY 2011 Budget also includes funding for new patients resulting from the recent decision to add Parkinson's disease, ischemic heart disease, and B-cell leukemias to the list of presumptive conditions for veterans with service in Vietnam.

Extended Care and Rural Health

VA's budget for 2011 contains \$6.8 billion for long-term care, an increase of 858.8 million (or 14.4 percent) over the 2010 level. In addition, \$1.5 billion is included for non-institutional long-term care, an increase of \$276 million (or 22.9 percent) over 2010. By enhancing veterans' access to non-institutional long-term care, VA 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.

VA's 2011 budget also includes \$250 million to continue strengthening access to health care for 3.2 million enrolled veterans living in rural and highly rural areas through a variety of avenues. These include new rural health outreach and delivery initiatives and expanded use of home-based primary care, mental health, and telehealth services. VA intends to expand use of cutting edge telehealth technology to broaden access to care while at the same time improve the quality of our health care services.

Home Telehealth

Our increasing reliance on non-institutional long-term care includes an investment in 2011 of \$163 million in home telehealth. Taking greater advantage of the latest technological advancements in health care delivery will allow us to more closely monitor the health status of veterans and will greatly improve access to care for veterans in rural and highly rural areas. Telehealth will place specialized health care professionals in direct contact with patients using modern IT tools. VA's home telehealth program cares for 35,000 patients and is the largest of its kind in the world. A recent study found patients enrolled in home telehealth programs experienced a 25 percent reduction in the average number of days hospitalized and a 19 percent reduction in hospitalizations. Telehealth and telemedicine improve health care by increasing access, eliminating travel, reducing costs, and producing better patient outcomes.

Expanding Access to Health Care

In 2009 VA opened enrollment to Priority 8 veterans whose incomes exceed last year's geographic and VA means-test thresholds by no more than 10 percent. Our most recent estimate is that 193,000 more veterans will enroll for care by the end of 2010 due to this policy change.

In 2011 VA will further expand health care eligibility for Priority 8 veterans to those whose incomes exceed the geographic and VA means-test thresholds by no more than 15 percent compared to the levels in effect prior to expanding enrollment in 2009. This additional expansion of eligibility for care will result in an estimated 99,000 more enrollees in 2011 alone, bringing the total number of new enrollees from 2009 to the end of 2011 to 292,000.

Meeting the Medical Needs of Women Veterans

The 2011 budget provides \$217.6 million to meet the gender-specific health care needs of women veterans, an increase of \$18.6 million (or 9.4 percent) over the 2010 level. The delivery of enhanced primary care for women veterans remains one of the

Department's top priorities. The number of women veterans is growing rapidly and women are increasingly reliant upon VA for their health care.

Our investment in health care for women veterans will lead to higher quality of care, increased coordination of care, enhanced privacy and dignity, and a greater sense of security among our women patients. We will accomplish this through expanding health care services provided in our Vet Centers, increasing training for our health care providers to advance their knowledge and understanding of women's health issues, and implementing a peer call center and social networking site for women combat veterans. This call center will be open 24 hours a day, 7 days a week.

Advance Appropriations for Medical Care in 2012

VA is requesting advance appropriations in 2012 of \$50.6 billion for the three medical care appropriations to support the health care needs of 6.2 million patients. The total is comprised of \$39.6 billion for Medical Services, \$5.5 billion for Medical Support and Compliance, and \$5.4 billion for Medical Facilities. In addition, \$3.7 billion is estimated in medical care collections, resulting in a total resource level of \$54.3 billion. It does not include additional resources for any new initiatives that would begin in 2012.

Our 2012 advance appropriations request is based largely on our actuarial model using 2008 data as the base year. The request continues funding for programs that we will continue in 2012 but which are not accounted for in the actuarial model. These initiatives address homelessness and expanded access to non-institutional long-term care and rural health care services through telehealth. In addition, the 2012 advance appropriations request includes resources for several programs not captured by the actuarial model, including long-term care, the Civilian Health and Medical Program of the Department of Veterans Affairs, Vet Centers, and the state home per diem program. Overall, the 2012 requested level, based on the information available at this point in time, is sufficient to enable us to provide timely and high-quality care for the estimated patient population. We will continue to monitor cost and workload data throughout the year and, if needed, we will revise our request during the normal 2012 budget cycle.

After a cumulative increase of 26.4 percent in the medical care budget since 2009, we will be working to reduce the rate of increase in the cost of the provision of health care by focusing on areas such as better leveraging acquisitions and contracting, enhancing use of referral agreements, strengthening DoD/VA joint ventures, and expanding applications of medical technology (e.g. telehome health).

Investments in Medical Research

VA's budget request for 2011 includes \$590 million for medical and prosthetic research, an increase of \$9 million over the 2010 level. These research funds will help VA sustain its 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.

This budget contains funds to continue our aggressive research program aimed at improving the lives of veterans returning from service in Iraq and Afghanistan. This focuses on prevention, treatment, and rehabilitation research, including TBI and polytrauma, burn injury research, pain research, and post-deployment mental health research.

Sustaining High Quality Burial and Memorial Programs

VA remains steadfastly committed to providing access to a dignified and respectful burial for veterans choosing to be buried in a VA national cemetery. This promise to veterans and their families also requires that we maintain national cemeteries as shrines dedicated to the memory of those who honorably served this Nation in uniform. This budget implements new policy to expand access by lowering the veteran population threshold for establishing new national cemeteries and developing additional columbaria to better serve large urban areas.

VA expects to perform 114,300 interments in 2011 or 3.8 percent more than in 2010. The number of developed acres (8,441) that must be maintained in 2011 is 4.6 percent greater than the 2010 estimate, while the number of gravesites (3,147,000) that will be maintained is 2.6 percent higher. VA will also process more than 617,000 Presidential Memorial Certificates in recognition of veterans' honorable military service.

Our 2011 budget request includes \$251 million in operations and maintenance funding for the National Cemetery Administration. The 2011 budget request pro-

vides \$36.9 million for national shrine projects to raise, realign, and clean an estimated 668,000 headstones and markers, and repair 100,000 sunken graves. This is critical to maintaining our extremely high client satisfaction scores that set the national standard of excellence in government and private sector services as measured by the American Customer Satisfaction Index. The share of our clients who rate the quality of the memorial services we provide as excellent will rise to 98 percent in 2011. The proportion of clients who rate the appearance of our national cemeteries as excellent will grow to 99 percent. And we will mark 95 percent of graves within 60 days of interment.

The 2011 budget includes \$3 million for solar and wind power projects at three cemeteries to make greater use of renewable energy and to improve the efficiency of our program operations. It also provides \$1.25 million to conduct independent Facility Condition Assessments at national cemeteries and \$2 million for projects to correct safety and other deficiencies identified in those assessments.

Leveraging Information Technology

We cannot achieve the transformation of VA into a 21st Century organization capable of meeting veterans' needs today and in the years to come without leveraging the power of IT. The Department's IT program is absolutely integral to everything we do, and it is vital we continue the development of IT systems that will meet new service delivery demands and modernize or replace increasingly fragile systems that are no longer adequate in today's health care and benefits delivery environment. Simply put, IT is indispensable to achieving VA's mission.

The Department's IT operations and maintenance program supports 334,000 users, including VA employees, contractors, volunteers, and researchers situated in 1,400 health care facilities, 57 regional offices, and 158 national cemeteries around the country. Our IT program protects and maintains 8.5 million vital health and benefits records for veterans with the level of privacy and security mandated by both statutes and directives.

VA's 2011 budget provides \$3.3 billion for IT, the same level of funding provided in 2010. We have prioritized potential IT projects to ensure that the most mission-critical projects for improving service to veterans are funded. For example, the resources we are requesting will fund the development and implementation of an automated solution for processing education claims (\$44.1 million), the Financial and Logistics Integrated Technology Enterprise project to replace our outdated, non-compliant core accounting system (\$120.2 million), development and deployment of the paperless claims processing system (\$145.3 million), and continued development of HealthVet, VA's electronic health record system (\$346.2 million). In addition, the 2011 budget request includes \$52 million for the advancement of the Virtual Lifetime Electronic Record, a Presidential priority that involves our close collaboration with DoD.

Enhancing Our Management Infrastructure

A critical component of our transformation is to create a reliable management infrastructure that expands or enhances corporate transparency at VA, centralizes leadership and decentralizes execution, and invests in leadership training. This includes increasing investment in training and career development for our career civil service and employing a suitable financial management system to track expenditures. The Department's 2011 budget provides \$463 million in General Administration to support these vital corporate management activities. This includes \$23.6 million in support of the President's initiative to strengthen the acquisition workforce.

We will place particular emphasis on increasing our investment in training and career development—helping to ensure that VA's workforce remain leaders and standard-setters in their fields, skilled, motivated, and client-oriented. Training and development (including a leadership development program), communications and team building, and continuous learning will all be components of reaching this objective.

Capital Infrastructure

VA must provide timely, high-quality health care in medical infrastructure which is, on average, over 60 years old. In the 2011 budget, we are requesting \$1.6 billion to invest in our major and minor construction programs to accomplish projects that are crucial to right sizing and modernizing VA's health care infrastructure, providing greater access to benefits and services for more veterans, closer to where they live, and adequately addressing patient safety and other critical facility deficiencies.

Major Construction

The 2011 budget request for VA major construction is \$1.151 billion. This includes funding for five medical facility projects in New Orleans, Louisiana; Denver, Colorado; Palo Alto and Alameda, California; and Omaha, Nebraska.

This request provides \$106.9 million to support the Department's burial program, including gravesite expansion and cemetery improvement projects at three national cemeteries—Indiantown Gap, Pennsylvania; Los Angeles, California; and Tahoma, Washington.

Our major construction request includes \$51.4 million to begin implementation of a new policy to expand and improve access to burial in a national cemetery. Most significantly, this new policy lowers the veteran population threshold to build a new national cemetery from 170,000 to 80,000 veterans living within 75 miles of a cemetery. This will provide access to about 500,000 additional veterans. Moreover, it will increase our strategic target for the percent of veterans served by a burial option in a national or state veterans cemetery within 75 miles of their residence from 90 percent to 94 percent.

VA's major construction request also includes \$24 million for resident engineers that support medical facility and national cemetery projects. This represents a new source of funding for the resident engineer program, which was previously funded under General Operating Expenses.

Minor Construction

The \$467.7 million request for 2011 for 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 realign critical services; make seismic corrections; improve patient safety; enhance access to health care; increase capacity for dental care; enhance patient privacy; improve treatment of special emphasis programs; and expand our research capability. Minor construction funds are also used to improve the appearance of our national cemeteries. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

Summary

Our job at the VA is to serve veterans by increasing their access to VA benefits and services, to provide them the highest quality of health care available, and to control costs to the best of our ability. Doing so will make VA a model of good governance. The resources provided in the 2011 President's budget will permit us to fulfill our obligation to those who have bravely served our country.

The 298,000 employees of the VA are committed to providing the quality of service needed to serve our veterans and their families. They are our most valuable resource. I am especially proud of several VA employees that have been singled out for special recognition this year.

First, let me recognize Dr. Janet Kemp, who received the "2009 Federal Employee of the Year" award from the Partnership for Public Service. Under Dr. Kemp's leadership, VA created the Veterans National Suicide Prevention Hotline to help veterans in crisis. To date, the Hotline has received almost 225,000 calls and rescued about 6,800 people judged to be at imminent risk of suicide since its inception.

Second, we are also very proud of Nancy Fichtner, an employee at the Grand Junction Colorado Medical Center, for being the winner of the President's first-ever SAVE (Securing Americans Value and Efficiency) award. Ms. Fichtner's winning idea is for veterans leaving VA hospitals to be able to take medication they have been using home with them instead of it being discarded upon discharge.

And thirdly, we are proud of the VA employees at our Albuquerque, New Mexico Clinical Research Pharmacy Coordinating Center, including the Center Director, Mike R. Sather, for excellence in supporting clinical trials targeting current veteran health issues. Their exceptional and important work garnered the center's recognition as the 2009 Malcolm Baldrige National Quality Award Recipient in the non-profit category.

The VA is fortunate to have public servants that are not only creative thinkers, but also able to put good ideas into practice. With such a workforce, and the continuing support of Congress, I am confident we can achieve our shared goal of accessible, high-quality and timely care and benefits for veterans.

**Prepared Statement of Carl Blake, National Legislative
Director, Paralyzed Veterans of America**

Chairman Filner, Ranking Member Buyer, and Members of the Committee, as one of the four co-authors of *The Independent Budget* (IB), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) health care system for FY 2011.

When looking back on 2009, it is fair to say that the 111th Congress took an historic step toward providing sufficient, timely, and predictable funding, and yet it still failed to complete its appropriations work prior to the start of the new fiscal year on October 1. The actions of Congress last year generally reflected a commitment to maintain a viable VA health care system. More important, Congress showed real interest in reforming the budget process to ensure that the VA knows exactly how much funding it will receive in advance of the start of the new fiscal year.

As you know, for more than a decade, the Partnership for Veterans Health Care Budget Reform (hereinafter "Partnership"), made up of nine veterans service organizations, including the four co-authors of *The Independent Budget*, advocated for reform in the VA health care budget formulation process. By working with the leadership of the House and Senate Committees on Veterans' Affairs, the Military Construction and Veterans Affairs Appropriations Subcommittees, and key members of both parties, we were able to move advance appropriations legislation forward. Congress ultimately approved and the President signed into law P.L. 111-81, the "Veterans Health Care Budget Reform and Transparency Act." A review of recent budget cycles made it evident that even when there was strong support for providing sufficient funding for veterans medical care programs, the systemic flaws in the budget and appropriations process continued to hamper access to and threaten the quality of the VA health care system. Now, with enactment of advance appropriations the VA can properly plan to meet the health care needs of the men and women who have served this Nation in uniform.

In February 2009, the President released a preliminary budget submission for the Department of Veterans Affairs for FY 2010. This submission only projected funding levels for the overall VA budget. The Administration recommended an overall funding authority of \$55.9 billion for the VA, approximately \$5.8 billion above the FY 2009 appropriated level and nearly \$1.3 billion more than *The Independent Budget* had recommended.

In May, the Administration released its detailed budget blueprint that included approximately \$47.4 billion for medical care programs, an increase of \$4.4 billion over the FY 2009 appropriated level and approximately \$800 million more than the recommendations of *The Independent Budget*. The budget also included \$580 million in funding for Medical and Prosthetic Research, an increase of \$70 million over the FY 2009 appropriated level. By the end of the year, Congress enacted P.L. 111-117, the "Consolidated Appropriations Act for FY 2010," that provided funding for the VA to virtually match the recommendations of the Administration. While the importance of these historic funding levels coupled with the enactment of advance appropriations legislation cannot be overstated, it is important for Congress and the Administration to continue this commitment to the men and women who have served and sacrificed for this country.

Funding for FY 2011

Despite the fact that Congress has already provided advance appropriations for FY 2011, *The Independent Budget* has chosen to still present budget recommendations for the medical care accounts specifically for FY 2011. Included in P.L. 111-117 was advance appropriations for FY 2011. Congress provided approximately \$48.2 billion in discretionary funding for VA medical care. When combined with the \$3.3 billion Administration projection for medical care collections in 2010, the total available operating budget provided by the appropriations bill is approximately \$51.5 billion. Accordingly for FY 2011, *The Independent Budget* recommends approximately \$52.0 billion for total medical care, an increase of \$4.5 billion over the FY 2010 operating budget level established by P.L. 111-117, the "Consolidated Appropriations Act for FY 2010." We believe that this estimation validates the advance projections that the Administration developed last year and has carried forward into this year. Furthermore, we remain confident that the Administration is headed in a positive direction that will ultimately benefit the veterans who rely on the VA health care system to receive their care.

The medical care appropriation includes three separate accounts—Medical Services, Medical Support and Compliance, and Medical Facilities—that comprise the total VA health care funding level. For FY 2011, *The Independent Budget* rec-

ommends approximately \$40.9 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	\$38,988,080,000
Increase in Patient Workload	\$1,302,874,000
Policy Initiatives	\$650,000,000
Total FY 2011 Medical Services	\$40,940,954,000

Our growth in patient workload is based on a projected increase of approximately 117,000 new unique patients—Priority Group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately \$926 million. The increase in patient workload also includes a projected increase of 75,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately \$252 million.

Finally, our increase in workload includes the projected enrollment of new Priority Group 8 veterans who will use the VA health care system as a result of the Administration's plan to incrementally increase the enrollment of Priority Group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new Priority Group 8 veterans who will enroll in the VA will increase by 125,000 in each of the next four years. Based on the Priority Group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately \$125 million.

As we have emphasized in the past, the VA must have a clear plan for incrementally increasing this enrollment. Otherwise, the VA risks being overwhelmed by significant new workload. *The Independent Budget* is committed to working with the VA and Congress to implement a workable solution to allow all eligible Priority Group 8 veterans who desire to do so to begin enrolling in the system.

Our policy initiatives have been streamlined to include immediately actionable items with direct funding needs. Specifically, we have limited our policy initiatives recommendations to restoring long-term care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of the VA) and centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to restore the VA's long-term care average daily census (ADC) to the level mandated by P.L. 106–117, the "Veterans Millennium Health Care Act," we recommend \$375 million. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional \$275 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2009 to FY 2010 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2011. The funding for prosthetics is particularly important because it reflects current services and represents a demonstrated need now; whereas, our funding recommendations for long-term care reflect our desire to see this capacity expanded beyond the current services level.

For Medical Support and Compliance, *The Independent Budget* recommends approximately \$5.3 billion. Finally, for Medical Facilities, *The Independent Budget* recommends approximately \$5.7 billion. Our recommendation once again includes an additional \$250 million for non-recurring maintenance (NRM) provided under the Medical Facilities account. This would bring our overall NRM recommendation to approximately \$1.26 billion for FY 2011. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. Based on that logic, the VA should actually be receiving at least \$1.7 billion annually for NRM (Refer to Construction section article "Increase Spending on Nonrecurring Maintenance").

For Medical and Prosthetic Research, *The Independent Budget* recommends \$700 million. This represents a \$119 million increase over the FY 2010 appropriated level, and approximately \$110 million above the Administration's request. We are particularly pleased that Congress has recognized the critical need for funding in the Medical and Prosthetic Research account in the last couple of years. Research is a vital part of veterans' health care, and an essential mission for our national health care system. We are extremely disappointed in the Administration's decision to virtually flat line the research budget. VA research has been grossly underfunded in contrast to the growth rate of other federal research initiatives. At a time of war,

the government should be investing more, not less, in veterans' biomedical research programs.

The Independent Budget recommendation also includes a significant increase in funding for Information Technology (IT). For FY 2011, we recommend that the VA IT account be funded at approximately \$3.553 billion. This amount includes approximately \$130 million for an Information Systems Initiative to be carried out by the Veterans Benefits Administration. This initiative is explained in greater detail in the policy portion of *The Independent Budget*.

This represents an increase of \$246 million over the FY 2010 appropriated level as well as the Administrations request. We are greatly concerned that the Administration is shortchanging this account in a budget in which the VA and the Department of Defense are called on to jointly implement the Virtual Lifetime Electronic Record, and in which the Administration proposes to automate claims processing to improve the accuracy and timeliness of veterans' benefits, particularly disability compensation and the new Post-9/11 GI Bill.

As explained in *The Independent Budget*, there is a significant backlog of major and minor construction projects awaiting action by the VA and funding from Congress. We have been disappointed that there has been inadequate follow-through on issues identified by the Capital Asset Realignment for Enhanced Services (CARES) process. In fact, we believe it may be time to revisit the CARES process all together. For FY 2011, *The Independent Budget* recommends approximately \$1.295 billion for Major Construction and \$785 million for Minor Construction. The Major Construction recommendation includes approximately \$100 million for research infrastructure and the Minor Construction recommendation includes approximately \$200 million for research facility construction needs.

We note that the Budget Request reduces funding for Major Construction and slashes funding for Minor Construction. Despite additional funding that has been provided in recent years to address the construction backlog and maintenance needs facing VA, a great deal remains to be done. We cannot comprehend what policy decisions could justify such a steep decrease in funding for Minor Construction and we look forward to reviewing the detailed explanation in the President's Budget Request.

Advance Appropriations for FY 2012

Public Law 111-81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and the VA Secretary to provide detailed estimates of the funds necessary for these medical care accounts in his budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget*, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the Government Accountability Office (GAO) to determine if that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

We are pleased to see that the Administration has followed through on its responsibility to provide an estimate for the Medical Care accounts of the VA for FY 2012. It is important to note that this is the first year the budget documents have included advance appropriations estimates. This will also be the first time that the GAO examines the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model, and what recommendations or other information the GAO report will include. *The Independent Budget* looks forward to examining all of this new information and incorporating it into future budget estimates.

In the end, it is easy to forget, that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

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

Prepared Statement of John L. Wilson, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to appear before you on behalf of the Disabled American Veterans (DAV), one of four national veterans' organizations that

create the annual *Independent Budget* (IB) for veterans programs, to summarize our recommendations for fiscal year (FY) 2011.

As you know Mr. Chairman, the IB is a budget and policy document that sets forth the collective views of DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW). Each organization accepts principal responsibility for production of a major component of our IB—a budget and policy document on which we all agree. Reflecting that division of responsibility, my testimony focuses primarily on the variety of Department of Veterans Affairs (VA) benefits programs available to veterans.

In preparing this 24th IB, the IB Veterans Service Organizations (IBVSOs) draw upon our extensive experience with veterans' programs, our firsthand knowledge of the needs of America's veterans, and the information gained from continuous monitoring of workloads and demands upon, as well as the performance of, the veterans benefits and services system. This Committee has acted favorably on many of our recommendations to improve services to veterans and their families. We ask that you give our recommendations serious consideration again this year. My testimony today will focus on three areas: Benefits; General Operating Expenses; and Judicial Review.

Within the Benefits arena, the first area to address is concurrent receipt of compensation and military longevity retired pay. It has been and continues to be the perspective of the IBVSOs that all military retirees should be permitted to receive military longevity retired pay and VA disability compensation concurrently, regardless of the level of their disability rating.

Many veterans, retired from the armed forces based on longevity of service, must forfeit a portion of their retired pay earned through faithful performance of military service before they receive VA compensation for service-connected disabilities. This is inequitable. Military retired pay is earned by virtue of a veteran's career of service on behalf of the Nation, careers of no less than 20 years.

Entitlement to disability compensation, on the other hand, is paid solely because of disabilities resulting from military service, regardless of the length of service. Most nondisabled military retirees pursue second careers after serving in order to supplement their income, thereby justly enjoying a full reward for completion of a military career with the added reward of full civilian employment income. In contrast, service-connected disabled military longevity retirees do not enjoy the same full earning potential. Instead their earning potential is reduced commensurate with the degree of service-connected disability.

While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent who retire from the Armed Forces on length of service will not receive both their VA disability compensation and full military retired pay.

The IBVSOs recommend Congress enact legislation to repeal the inequitable requirement that veterans' military retired pay be offset by an amount equal to their rightfully earned VA disability compensation.

The next area to address is repeal of the current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of and by an amount equal to Dependency and Indemnity Compensation (DIC).

Career members of the armed forces earn entitlement to retired pay after 20 or more years' service. Unlike many retirement plans in the private sector, survivors have no entitlement to any portion of the member's retired pay after his or her death. Under the SBP, deductions are made from the member's retired pay to purchase a survivors' annuity. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died of other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was due to service or followed from the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. If the monthly DIC rate is equal to or greater than the monthly SBP annuity, then beneficiaries lose all entitlement to the SBP annuity.

This offset is inequitable because no duplication of benefits is involved. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay.

It is the recommendation of the IBVSOs that Congress repeal the offset between DIC and SBP.

The last area to address within the Benefits section of the IB is the topic of automobile grants and adaptive equipment. The automobile and adaptive equipment

grants need to be increased and automatically adjusted annually to cover increases in costs.

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

Congress initially fixed the amount of the automobile grant to cover the full cost of the automobile. However, because sporadic adjustments have not kept pace with increasing costs, over the past 53 years the value of the automobile allowance has been substantially eroded. In 1946 the \$1,600 allowance represented 85 percent of the average retail cost and was sufficient to pay the full cost of automobiles in the "low-price field."

The Federal Trade Commission cites National Automobile Dealers Association data that indicate that the average price of a new car in 2009 was \$28,400. The current \$11,000 automobile allowance represents 62 percent of the 1946 benefit when adjusted for inflation by the CPI; however, it is only 39 percent of the average cost of a new automobile. To restore equity between the cost of an automobile and the allowance, the allowance, based on 80 percent of the average new vehicle cost, would be \$22,800.

It is the recommendation of the IBVSOs that Congress enact legislation to increase the automobile allowance to 80 percent of the average cost of a new automobile in 2009 and then provide for automatic annual adjustments based on the rise in the cost of living. Congress should also consider increasing the automobile allowance to cover 100 percent of the average cost of a new vehicle and provide for automatic annual adjustments based on the actual cost of a new vehicle, not the CPI.

Within the General Operating Expenses arena, the IBVSOs offer Congress and the Administration many opportunities for improvement. The first topic of consideration has to do with the Veterans Benefits Administration (VBA) disability claims process.

While simultaneously enhancing training and increasing individual and managerial accountability, Congress and the VA must take definitive steps to reduce delays in the disability claims process caused by policies and practices that were developed in a disjointed and haphazard manner.

The adjudication of compensation claims is complex and time consuming. Failure to develop evidence correctly requires serial redevelopment, which delays claims resolution and increases opportunities for mistakes. Further, inadequately trained employees may fail to recognize when claims development is inadequate for rating purposes. The lack of effective on-the-job training, as well as the failure to involve program expertise of senior Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) earlier in the process are critical failures. As a consequence, VA routinely continues to develop many claims rather than making timely rating decisions.

Processing policy should be changed to get claims into the hands of experienced technicians (Journey-level VSRs/RVSRs) earlier in the process. This way, issues with sufficient evidence can be evaluated, while development of other outstanding issues continues as directed by those more experienced technicians.

It is understandable that VA wants to be deliberative as it determines the next best course of action to address how to improve the claims process. After all, the VA estimates it will manage as many as 946,000 total claims this fiscal year and provide more than \$30 billion in compensation and pension benefits. The IBVSOs recognize that VA has a responsibility to administer these programs according to the law.

There is virtually no in-process quality control that could detect errors before they create undue delays, and provide real-time feedback to technicians. The claims process is a series of steps VA goes through to identify necessary evidence, obtain that evidence, and then make decisions based on the law and the evidence gathered. What fails here is the execution. While the rules are fairly clear, it is the overwhelming quantity of the work, inadequate training, lack of adequate accountability, and pressure to cut corners to produce numbers that result in an 18 percent substantive error rate (by VA's own admission). It is difficult to maintain quality control when individual performance reviews are limited to 5 cases per month, and when there is virtually no oversight on the propriety of end product closures.

There is ample room to improve the law in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assist-

ance Act (VCAA) notice letter. These notice letters, in their current form, do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes.

In FY 2007, the Board of Veterans' Appeals (BVA) remanded more than 12,000 cases to obtain a medical opinion. In 2008, that number climbed to more than 16,000. In the view of the IBVSOs, many of these remands could have been avoided if VA had accepted sufficient medical opinions already provided by veterans. While recent court decisions have indicated that VA should accept private medical opinions that are credible and acceptable for rating purposes, we have seen no evident reduction in remands to obtain medical opinions.

To correct this deficiency, we recommend that when VA issues proposed regulations to implement the recent amendment of title 38, United States Code §5103, its proposed regulations contain a provision that will require it to inform a claimant, in a VCAA notice letter, of the basic elements that make medical opinions adequate for rating purposes.

Congress should also consider amending title 38, United States Code §5103A(d)(1), to provide that when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request such evidence from a VA health care facility. The language we suggest adding to section 5103A(d)(1), would not, however, require VA to accept private medical evidence if, for example, VA finds that the evidence is not credible and therefore not adequate for VA rating purposes.

Modifying regional office jurisdiction regarding supplemental statements of the case (SSOCs) will improve the timeliness of the appeals process. This proposal is addressed in H.R. 4121, which seeks to amend title 38, United States Code, to improve the appeals process of the VA and was introduced by Representative John Hall on November 19, 2009.

In the current process, when an appeal is not resolved, the VA regional office will issue a statement of the case (SOC) along with a VA Form 9, to the claimant, who concludes, based on the title of the Form 9 (Appeal to the BVA) that the case is now going to the VA. Consequently, the veteran may feel compelled to submit additional or repetitive evidence in the mistaken belief that his or her appeal will be reviewed immediately by BVA. But the VARO issues another SSOC each time new evidence is submitted. This continues until VA finally issues a VAF-8, Certification of Appeal, which actually transfers the case to the BVA.

H.R. 4121 would amend this process so that evidence submitted after the appeal has been certified to the BVA will be forwarded directly to the BVA and not considered by the regional office unless the appellant or his or her representative elects to have additional evidence considered by the regional office. This opt-out clause merely reverses the standard process without removing any rights from an appellant. The IBVSOs believe this change should result in reduced appellant lengths, much less appellant confusion, and nearly 100,000 reduced VA work hours by eliminating in many cases the requirement to issue SSOCs.

It is the IBVSOs' recommendation that:

Congress should modify current "duty to assist" requirements that VA undertake independent development of the case, including gathering new medical evidence, when VA determines the claim already includes sufficient evidence to award all benefits sought by the veteran.

Congress should allow the BVA to directly hear new evidence in cases certified to it, rather than require VA's regional offices to hear the evidence and submit SSOCs.

Congress pass H.R. 4121 to amend the process so that evidence submitted after the appeal and certified to the BVA be forwarded directly to the BVA and not considered by the regional office unless the appellant or his or her representative elects to have additional evidence considered by the regional office.

The next area to address is VBA training. Although the VA has improved its training programs to some extent, more needs to be done to ensure decision makers and adjudicators are held accountable to training standards.

The IBVSOs have consistently maintained that VA must invest more in training adjudicators in order to hold them accountable for accuracy. VA has made improvements to its training programs in the past few years; nonetheless, much more improvement is required in order to meet quality standards that disabled veterans and their families deserve.

Training, informal instruction as well as on-the-job training, has not been a high enough priority in VA. The IBVSOs have consistently asserted that proper training leads to better quality decisions, and that quality is the key to timeliness of VA decision-making. VA will achieve such quality only if it devotes adequate resources to perform comprehensive and ongoing training and imposes and enforces quality standards through effective quality assurance methods and accountability mechanisms. The Administration and Congress should require mandatory and comprehensive testing designed to hold trainees accountable. This requirement should be the first priority in any plan to improve training. VA should not advance trainees to subsequent stages of training until they have successfully demonstrated that they have mastered the material.

One of the most essential resources is experienced and knowledgeable personnel devoted to training. More management devotion to training and quality requires a break from the status quo of production goals above all else. In a 2005 report from the VA Office of Inspector General, VBA employees were quoted as stating: "Although management wants to meet quality goals, they are much more concerned with quantity. An RVSR is much more likely to be disciplined for failure to meet production standards than for failing to meet quality standards," and "there is a lot of pressure to make your production standard. In fact, your performance standard centers around production and a lot of awards are based on it. Those who don't produce could miss out on individual bonuses, etc."¹ Little if anything has changed since the Inspector General issued this report.² VBA employees continue to report that they receive minimal time for training, whether it is self-study, training broadcasts, or classroom training. They report that management remains focused on production over quality.

The Veterans' Benefits Improvement Act of 2008 mandated some testing for claims processors and VBA managers, which is an improvement; however, it does not mandate the type of testing during the training process as explained herein. Measurable improvement in the quality of and accountability for training will not occur until such mandates exist.

Training will only be effective if the VBA training board, or a more robust oversight entity, can ensure communication and coordination between the Office of Employee Development and Training, Technical Training and Evaluation, Veterans Benefits Academy and the five business lines. Feedback should be collected from ROs to assess the effectiveness of their training, which can be incorporated into revised lesson plans as necessary. Communication and close, continued coordination by each of these offices is essential to the establishment of a comprehensive, responsive training program.

For a culture of quality to thrive in the VBA, VA leaders must be the change agents to achieve this important goal. Training is an essential component to transforming the organization from a production-at-all-costs focus to one of decisions based quality products which are delivered in a timely manner.

It is the IBVSOs' recommendation that:

VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence and require mandatory and comprehensive testing of the claims process and appellate staff. To the extent that VA fails to provide adequate training and testing, Congress should require mandatory and comprehensive testing, under which VA will hold trainees accountable.

VA should hold managers accountable to ensure that the necessary training and time is provided to ensure all personnel are adequately trained. Feedback should be collected from ROs on the effectiveness of the training. The Office of Employee Development and Training, Technical Training and Evaluation, Veterans Benefits Academy and the five business lines should incorporate any emerging trends into revised training plans.

The next topic of consideration is VBA's current accountability and quality mechanisms. It is the IBVSOs' position that VBA must overhaul these outdated and ineffective mechanisms.

This can be accomplished through the development and deployment of a robust new electronic document management system, capable of converting all claims-re-

¹Department of Veterans Affairs Office of Inspector General, Rep. No. 05-00765-137, Review of State Variances in VA Disability Compensation Payments 61 (May 19, 2005).

²A survey conducted by the Center for Naval Analysis Corporation for the Veterans' Disability Benefits Commission found that "some raters felt that they were not adequately trained or that they lacked enough experience." Veterans' Disability Benefits Commission, October 2007, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century. p. 12.

lated paperwork into secure, official electronic documentation that is easily accessible and searchable by all official personnel involved in the process and has built-in accountability and quality management process management tools.

“Sixty Minutes” ran a story on January 3, 2010, entitled “Delay, Deny and Hope I Die,” which addressed the issue of the VA’s claims backlog and veterans’ frustrations. The VA Deputy Under Secretary for Benefits, Michael Walcoff, was interviewed for the story. When asked if VA had a focus on quantity over quality, he stated, “I don’t believe that they’re being pressured to produce claims at the expense of quality. We stress over and over again to our employees that quality is our number one indicator, that that’s absolutely a requirement for successful performance.”

While he and others in leadership positions may stress quality, what employees are compensated for is quantity based on a work credit system.

In March 2009, the VA’s Inspector General discovered that the VA was making more mistakes than it reported. The internal investigation found that nearly one out of four files had errors. That is 200,000 claims that “may be incorrect.”

Although quality may be emphasized and measured in limited ways, as it currently stands, almost everything in the VBA is production driven. Employees naturally will work towards those things that enhance compensation and currently that is production. Performance awards are based on production alone. They should also be based on demonstrated quality. However, in order for this to occur, the VBA must implement stronger accountability quality assurance measures.

What does VBA do to assess the quality of the product it delivers? The quality assurance tool used by the VA for compensation and pension claims is the Systematic Technical Accuracy Review (STAR) program. Under the STAR program, VA reviews a sampling of decisions from regional offices and bases its national accuracy measures on the percentage with errors that affect entitlement, benefit amount, and effective date. However, samples as small as 20 cases per month per office are inadequate to determine individual quality.

With STAR samples far too small to allow any conclusions concerning individual quality, rating team coaches who are charged with reviewing a sample of ratings for each RVSR each month. This review, if conducted properly, should identify those employees with the greatest success as well as those with problems. In practice, however, most rating team coaches have insufficient time to review what could be 100 or more cases each month. As a result, individual quality is often undervalued and employees performing successfully may not receive the recognition they deserve and those employees in need of extra training and individualized mentoring may not get the attention they need to become more effective.

The problems related to the quality of decisions, the timeliness of decisions, workload management, and safeguarding case files can be significantly improved by incorporating a robust IT solution. VA should establish systems that rapidly and securely convert paper documents into electronic formats, and establish new electronic information delivery systems that provide universal searchability and connectivity. This would increase the ability of veterans who have the means and familiarity with digital approaches to file electronic claims using VONAPP (Veterans On Line Application) or other future digital claims filing options. Lost or incorrectly destroyed records must become a problem of the past, as should the need to transfer thousands of case files from one location to the next.

The Veterans’ Benefits Improvement Act of 2008 (section 226) required VA to conduct a study on the effectiveness of the current employee work-credit system and work-management system. In carrying out the study, VA is required to consider, among other things:

1. Measures to improve the accountability, quality, and accuracy for processing claims for compensation and pension benefits;
2. Accountability for claims adjudication outcomes; and
3. The quality of claims adjudicated. The legislation requires VA to submit the report to Congress, which must include the components required to implement the updated system for evaluating VBA employees, no later than October 31, 2009. This report was not delivered on time.

This study is a historic opportunity for VA to implement a new methodology—a new philosophy—by developing a new system with a primary focus of quality through accountability. Properly undertaken, the outcome would result in a new institutional mind-set across the VBA—one that focuses on the achievement of excellence—and change a mind-set focused mostly on quantity-for-quantity’s sake to a focus of quality and excellence. Those who produce quality work are rewarded and those who do not are finally held accountable.

It is the recommendation of the IBVSOs that:

The VA Secretary's upcoming report focus on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those VA employees who commit errors while simultaneously providing employee motivation for the achievement of excellence.

VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

The performance management system for claims processors should be adjusted to allow managers to greater flexibility and enhanced tools to acknowledge and reward staff for higher levels of performance.

The IBVSOs urge VA to identify new funding for the purposes enumerated in this section and to ensure that new VBA personnel are properly supported with necessary IT resources. With restored investments in these initiatives, the VBA could complement staffing adjustments for increased workloads with a supportive infrastructure to improve operational effectiveness. The VBA could resume an adequate pace in its development and deployment of IT solutions, as well as to upgrade and enhance training systems for staff to improve operations and service delivery to veterans. It is vital to the VBA that many of their unique needs are met in a timely manner, including the following: expansion of web-based technology and deliverables, such as a web portal and Training and Performance Support System (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service access to benefit application, status, and delivery; data integration across business lines; use of the corporate database; information exchange; quality assurance programs and controls; and employee skills certification and training.

It is imperative that TEES and WINRS develop common architecture designs that maximize data sharing between the new GI Bill and the Vocational Rehabilitation programs. These programs share common information about programs of education, school approvals, tuition & fees, and other similar data which their processing systems should share more effectively. TEES provides for electronic transmission of applications and enrollment documentation along with automated expert processing.

Also, the IBVSOs believe the VBA should continue to develop and enhance data-centric benefits integration with "Virtual VA" and modification of The Imaging Management System (TIMS). All these systems serve to replace paper-based records with electronic files for acquiring, storing, and processing claims data.

Virtual VA supports pension maintenance activities at three VBA pension maintenance centers. Further enhancement would allow for the entire claims and award process to be accomplished electronically. TIMS is the Education Service system for electronic education claims files, storage of imaged documents, and workflow management. The current VBA initiative is to modify and enhance TIMS to make it fully interactive and allow for fully automated claims and award processing by the Education Service and VR&E nationwide.

VA's TPSS is a multimedia, multimethod training tool that applies the instructional systems development methodology to train and support employee performance of job tasks. These TPSS applications require technical updating to incorporate changes in laws, regulations, procedures, and benefit programs. In addition to regular software upgrades, a help desk for users is needed to make TPSS work effectively.

VBA initiated its skills certification instrument in 2004. This tool helps the VBA assess the knowledge base of veterans' service representatives. VBA intends to develop additional skills certification modules to test rating veteran service representatives, decision review officers, field examiners, pension maintenance center employees, and veterans' claims examiners in the Education Service.

By providing veterans regionalized telephone contact access from multiple offices within specified geographic locations, VA could achieve greater efficiency and improved customer service. Accelerated deployment of virtual information centers will more timely accomplish this beneficial effect.

It is the IBVSOs' recommendation that:

VA complete the replacement of the antiquated and inadequate Benefits Delivery Network (BDN) with the Veterans Service Network (VETSNET), or a successor system, that creates a comprehensive nationwide information system for claims development, adjudication, and payment administration.

VA enhance the Education Expert System (TEES) for the Education Service to support the new GI Bill recently enacted by Congress in Public Law 110-181.

VA update the corporate WINRS (CWINRS) to support programs of the Vocational Rehabilitation and Employment (VR&E) Service. CWINRS is a case management and information system allowing for more efficient award processing and sharing of information nationwide.

Congress provide VBA adequate funding for its information technology initiatives to improve multiple information and information-processing systems and to advance ongoing, approved, and planned initiatives such as those enumerated in this section. These IT programs should be increased annually by a minimum of 5 percent or more.

VBA revise its training programs to stay abreast of IT program changes and modern business practices.

VA ensure that recent funding specifically designated by Congress to support the IT needs of the VBA, and of new VBA staff authorized in FY 2009, are provided to VBA as intended, and on an expedited basis.

The Chief Information Officer and Under Secretary for Benefits should give high priority to the review and report required by Public Law 110-389 and redouble their efforts to ensure these ongoing VBA initiatives are fully funded and accomplish their stated intentions.

The VA Secretary examine the impact of the current level of IT centralization under the chief information officer on these key VBA programs and, if warranted, shift appropriate responsibility for their management, planning, and budgeting from the chief information officer to the Under Secretary for Benefits.

Congress require the Secretary to establish a quality assurance and accountability program that will detect, track, correct and prevent future errors and, by creating a work environment that properly aligns incentives with goals, holds both VBA employees and management accountable for their performance.

The next topic to address in the area of General Operating Expenses is staffing. It is the IBVSOs' position that recent staffing increases in the VBA may now be sufficient to reduce the backlog of pending claims, once new hires complete training. However, any move by Congress to reduce VBA staffing in the foreseeable future will guarantee a return to unacceptably high backlogs.

VA began making some progress in reducing pending rating claims in FY 2008. At the end of FY 2009, over 940,000 claims had been processed, well above the 940,000 that had been projected. Over 388,000 compensation claims were pending rating decisions, which is above the 386,000 of FY 2008.³

During FY 2008, VA hired nearly 2,000 staff authorized by Congress. The total number of new hires since 2007 now stands at over 4,200. Historically, it takes at least two years for new nonrating claims processors to acquire sufficient knowledge and experience to be able to work independently with both speed and quality. Those selected to make rating decisions require a separate period of at least two years of training before they have the skills to accurately complete most rating claims.

It would be interesting to know the attrition rate of these 4,200 new hires. How many have successfully completed training? How many current employees have retired or terminated employment in comparison? Answers to these questions and other questions would be useful in discussions on the adequacy of the number of new hires and their current and future ability to substantially affect the claims backlog.

Once everyone is fully trained and reductions in the backlog are seriously under way, it would be a mistake of monumental proportions if Congress were to allow staffing levels to decline. The IBVSOs do not suggest that VBA staffing remain off limits to Congressional budget considerations. What we believe, however, is that staffing reductions should occur only after the VBA has demonstrated, through technological innovation and major management and leadership reforms, that it has the right people and the right tools in place to ensure that claims can be processed both timely and correctly. As with backlog reductions, these changes will also not occur overnight. Congressional oversight, therefore, is critical to buttress any real improvements in claims processing and quality decisions.

It is the recommendation of the IBVSOs that:

Congress require the VA to report the attrition rate for the 4,200 new hires; how many successfully completed training; how many current employees have retired or terminated employment in comparison.

³Monday Morning Workload Report, October 3, 2009, pg. 1.

Congress continue to monitor current staffing levels and ensure that they remain in place until such time as the backlog is eliminated.

Once the backlog is eliminated, Congress consider staffing reductions in the VBA but only after ensuring that quality problems are fully and adequately addressed.

Congress ensure through oversight that management and leadership reforms in the VBA are completed and permanent.

The next topic of consideration is Vocational Rehabilitation and Employment, a program that continues to provide critical resources to service-connected disabled veterans despite inadequate staffing levels. To meet its ongoing workload demands and to implement new initiatives recommended by the Secretary's Vocational Rehabilitation and Employment (VR&E) Task Force, VR&E needs to increase its staffing.

The cornerstone among several new initiatives is VR&E's Five-Track Employment Process, which aims to advance employment opportunities for disabled veterans. Integral to attaining and maintaining employment through this process, the employment specialist position was changed to employment coordinator and was expanded to incorporate employment readiness, marketing, and placement responsibilities. In addition, increasing numbers of severely disabled veterans from Operations Enduring and Iraqi Freedom (OEF/OIF) benefit from VR&E's Independent Living Program, which empowers such veterans to live independently in the community to the maximum extent possible. Independent living specialists provide the services required for the success of severely disabled veterans participating in this program. VR&E needs approximately 200 additional full-time employees (FTEs) to offer these services nationally.

Given its increased reliance on contract services, VR&E needs approximately 50 additional FTEs dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. As a part of its strategy to enhance accountability and efficiency, the VA VR&E Task Force recommended creation and training of new staff positions for this purpose. Other new initiatives recommended by the task force also require an investment of personnel resources.

Finally, VA has a pilot program at the University of Southern Florida entitled "Veteran Success on Campus" that places a qualified Vocational Rehabilitation Counselor on the campus to assist veterans in Vocational Rehabilitation as well as veterans enrolled in the Post-9/11 or other VA educational programs. The pilot has garnered high praise from the University, the American Council on Education, and the press. VA should be authorized to expand the program significantly in the next fiscal year.

In FY 2009, VR&E was authorized 1,105 FTEs. The IBVSOs have been informed that this number has been "frozen" due to the unknown impact the implementation of chapter 33 benefits will have on the VR&E program. Last year, we recommended that total staffing be increased to manage the current and anticipated workload as stated in the Secretary's VR&E Task Force. We believe that this increase is still warranted. VA currently has approximately 106,000 enrollees in Chapter 31. The IBVSOs believe that a ratio of 1:96 (which includes administrative support) is inadequate to provide the level of counseling and support that our wounded and disabled veterans need to achieve success in their employment goals.

It is the recommendation of the IBVSOs that Congress should authorize 1,375 total FTEs for the Vocational Rehabilitation and Employment Service for FY 2010.

The last area of the IB that I wish to address is Judicial Review. From its creation in 1930, decisions of the Veterans Administration, now the Department of Veterans Affairs, could not be appealed outside VA except on rare Constitutional grounds. This was thought to be in the best interests of veterans, in that their claims for benefits would be decided solely by an agency established to administer veteran friendly laws in a paternalistic and sympathetic manner. At the time, Congress also recognized that litigation could be very costly and sought to protect veterans from such expense.

For the most part, VA worked well. Over the course of the next 50 years, VA made benefit decisions in millions of claims, providing monetary benefits and medical care to millions of veterans. Most veterans received the benefits to which they were entitled.

Congress eventually came to realize that without judicial review, the only remedy available to correct VA's misinterpretation of laws, or the misapplication of laws to veterans claims, was through the unwieldy hammer of new legislation.

In 1988, Congress thus enacted legislation to authorize judicial review and created the United States Court of Appeals for Veterans Claims (CAVC) to hear appeals from BVA.

Today, the VA's decisions on claims are subject to judicial review in much the same way as a trial court's decisions are subject to review on appeal. This review process allows an individual to challenge not only the application of law and regulations to an individual claim, but more importantly, contest whether VA regulations accurately reflect the meaning and intent of the law. When Congress established the CAVC, it added another beneficial element to appellate review by creating oversight of VA decision-making by an independent, impartial tribunal from a different branch of government. Veterans are no longer without a remedy for erroneous BVA decisions.

Judicial review of VA decisions has, in large part, lived up to the positive expectations of its proponents. Nevertheless, based on past recommendations in the IB, Congress has made some important adjustments to the judicial review process based on lessons learned over time. More precise adjustments are still needed to conform judicial review to Congressional intent. Accordingly, IBVSOs make the following recommendations to improve the processes of judicial review in veterans' benefits matters.

In the area of scope of review, the IBVSOs believe that to achieve the law's intent that the CAVC enforce the benefit-of-the-doubt rule on appellate review, Congress must enact more precise and effective amendments to the statute setting forth the Court's scope of review.

Title 38, United States Code, section 5107(b) grants VA claimants a statutory right to the "benefit of the doubt" with respect to any benefit under laws administered by the Secretary of Veterans Affairs when there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter. Yet, the CAVC has affirmed many BVA findings of fact when the record contains only minimal evidence necessary to show a "plausible basis" for such finding. The CAVC upholds VA findings of "material fact" unless they are clearly erroneous and has repeatedly held that when there is a "plausible basis" for the BVA factual finding, it is not clearly erroneous.

This makes a claimant's statutory right to the "benefit of the doubt" meaningless because claims can be denied and the denial upheld when supported by far less than a preponderance of evidence. These actions render Congressional intent under section 5107(b) meaningless.

To correct this situation, Congress amended the law with the enactment of the Veterans Benefits Improvement Act of 2008 to expressly require the CAVC to consider whether a finding of fact is consistent with the benefit-of-the-doubt rule; however this intended effect of section 401 of the Veterans Benefits Act of 2008 has not been used in subsequent Court decisions.

Prior to the Veterans Benefits Act, the Court's case law provided (1) that the Court was authorized to reverse a BVA finding of fact when the only permissible view of the evidence of record was contrary to that found by the BVA and (2) that a BVA finding of fact must be affirmed where there was a plausible basis in the record for the Board's determination.

As a result of Veterans Benefits Act section 401 amendments to section 7261(a)(4), the CAVC is now directed to "hold unlawful and set aside or reverse" any "finding of material fact adverse to the claimant... if the finding is clearly erroneous."⁴ Furthermore, Congress added entirely new language to section 7261(b)(1) that mandates the CAVC to review the record of proceedings before the Secretary and the BVA pursuant to section 7252(b) of title 38 and "take due account of the Secretary's application of section 5107(b) of this title..."⁵

The Secretary's obligation under section 5107(b), as referred to in section 7261(b)(1), is as follows:

- (b) **BENEFIT OF THE DOUBT**—The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.⁶

Congress wanted for the Court to take a more proactive and less deferential role in its BVA fact-finding review, as detailed in a joint explanatory statement of the compromise agreement contained in the legislation:⁷

⁴38 U.S.C. § 7261(a)(4). See also 38 U.S.C. § 7261(b)(1).

⁵38 U.S.C. § 7261(b)(1).

⁶38 U.S.C. § 5107(b).

⁷148 *Congressional Record* S11337, H9007.

[T]he Committees expect the Court to reverse clearly erroneous findings when appropriate, rather than remand the case. The new subsection (b) [of section 7261] would maintain language from the Senate bill that would require the Court to examine the record of proceedings before the Secretary and BVA and the special emphasis during the judicial process on the benefit-of-doubt provisions of section 5107(b) as it makes findings of fact in reviewing BVA decisions... The combination of these changes is intended to provide for more searching appellate review of BVA decisions, and thus give full force to the “benefit-of-doubt” provision.⁸

With the foregoing statutory requirements, the Court should no longer uphold a factual finding by the Board solely because it has a plausible basis, inasmuch as that would clearly contradict the requirement that the CAVC’s decision must take due account whether the factual finding adheres to the benefit-of-the-doubt rule. Yet such CAVC decisions upholding BVA denials because of the “plausible bases” standard continue as if Congress never acted.

It is the IBVSOs’ recommendation that:

Congress clearly intended a less deferential standard of review of the Board’s application of the benefit-of-the-doubt rule when it amended title 38, United States Code, section 7261 in 2002, yet there has been no substantive change in the Court’s practices. Therefore, to clarify the less deferential level of review that the Court should employ, Congress should amend title 38, United States Code, section 7261(a) by adding a new section, (a)(5), that states: “(5) In conducting review of adverse findings under (a)(4), the Court must agree with adverse factual findings in order to affirm a decision.”

Congress should also require the Court to consider and expressly state its determinations with respect to the application of the benefit-of-the-doubt doctrine under title 38, United States Code, section 7261(b)(1), when applicable.

The next topic to address is the appointment of judges to the CAVC. The CAVC received well over 4,000 cases during FY 2008. According to the Court’s annual report, the average number of days it took to dispose of cases was nearly 450. This period has steadily increased each year over the past four years, despite the Court having recalled retired judges numerous times over the past two years specifically because of the backlog.

Veterans’ law is an extremely specialized area of the law that currently has fewer than 500 attorneys nationwide whose practices are primarily in veterans law. Significant knowledge and experience in this practice area would reduce the amount of time necessary to acclimate a new judge to the Court’s practice, procedures, and body of law.

A reduction in the time to acclimate would allow a new judge to begin a full caseload in a shorter period, thereby benefiting the veteran population. The Administration should therefore consider appointing new judges to the Court from the selection pool of current veterans law practitioners.

The IBVSOs urge the Administration to consider that any new judges appointed to the CAVC be selected from the knowledgeable pool of current veterans law practitioners.

The last topic to address in this area is in reference to Court facilities. During the 21 years since the CAVC was formed in accordance with legislation enacted in 1988, it has been housed in commercial office buildings. It is the only Article I court that does not have its own courthouse.

The “Veterans Court” should be accorded at least the same degree of respect enjoyed by other appellate courts of the United States. Congress has finally responded by allocating \$7 million in FY 2008 for preliminary work on site acquisition, site evaluation, preplanning for construction, architectural work, and associated other studies and evaluations. The issue of providing the proper court facility is now moving forward.

It is the recommendation of the IBVSOs that Congress should provide all funding as necessary to construct a courthouse and justice center in a location befitting the CAVC.

We hope the Committee will review these recommendations and give them consideration for inclusion in your legislative plans for FY 2011. Mr. Chairman, thank you

⁸ 148 *Congressional Record* S11337, H9003 (daily ed. November 18, 2002) (emphasis added). (Explanatory statement printed in *Congressional Record* as part of debate in each body immediately prior to final passage of compromise agreement.)

for inviting the DAV and other member organizations of the IB to testify before you today.

**Prepared Statement of Eric A. Hilleman, Director, National
Legislative Service, Veterans of Foreign Wars of the United States**

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for the opportunity to testify today. The VFW works alongside the other members of *The Independent Budget* (IB)—AMVETS, Disabled American Veterans and Paralyzed Veterans of America—to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America’s veterans. The VFW is responsible for the construction portion of the IB, so I will limit my remarks to that portion of the budget.

VA’s infrastructure—particularly within its health-care system—is at a crossroads. The system is facing many challenges, including the average age of buildings (60 years) and significant funding needs for routine maintenance, upgrades, modernization and construction. VA is beginning a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on needs of sick and disabled veterans in the 21st Century. Regardless of what the VA health care system of the future looks like, our focus must remain on a lasting and accessible VA health-care system that is dedicated to their unique needs and one that can provide high quality, timely care when and where they need it.

VA manages a wide portfolio of capital assets throughout the Nation. According to its latest Capital Asset Plan, VA is responsible for 5,500 buildings and almost 34,000 acres of land. It is a vast network of facilities that requires significant time and attention from VA’s capital asset managers.

CARES—VA’s data-driven assessment of VA’s current and future construction needs gave VA a long-term roadmap and has helped guide its capital planning process over the past few fiscal years. CARES showed a large number of significant construction priorities that would be necessary for VA to fulfill its obligation to this Nation’s veterans and over the last several fiscal years, the administration and Congress have made significant inroads in funding these priorities. Since FY 2004, \$4.9 billion has been allocated for these projects. Of these CARES-identified projects, VA has completely five and another 27 are currently under construction. It has been a huge, but necessary undertaking and VA has made slow, but steady progress on these critical projects.

The challenge for VA in the post-CARES era is that there are still numerous projects that need to be carried out, and the current backlog of partially funded projects that CARES has identified is large, too. This means that VA is going to continue to require significant appropriations for the major and minor construction accounts to live up to the promise of CARES.

VA’s most recent Asset Management Plan provides an update of the state of CARES projects—including those only in the planning of acquisition process. Table 4–5: (page 7.4–49) shows a need of future appropriations to complete these projects of \$3.25 billion.

Project	Future Funding Needed (\$ In Thousands)
Denver	492,700
San Juan	122,920
New Orleans	370,000
St. Louis	364,700
Palo Alto	478,023
Bay Pines	80,170
Seattle	38,700

Project	Future Funding Needed (\$ In Thousands)
Seattle	193,830
Dallas	80,100
*Louisville	1,100,000
TOTAL	3,246,143

This amount represents just the backlog of current construction projects. It does not reflect the administration's FY 2011 proposed appropriation toward Denver, New Orleans, and Palo Alto. (*Louisville's cost estimate is found on table 5-6, on Page 7.5-93).

Meanwhile, VA continues to identify and reprioritize potential major construction projects. These priorities, which are assessed using the rigorous methodology that guided the CARES decisions are released in the Department's annual Five Year Capital Asset Plan, which is included in the Department's budget submission. The most recent one was included in Volume IV and is available on VA's Web site: http://www4.va.gov/budget/docs/summary/Fy2011_Volume_4-Construction_and_5_Year_Cap_Plan.pdf.

Table 4-5 shows a long list of partially funded major construction projects. These 82 ongoing projects demonstrate the continued need for VA to upgrade and repair its aging infrastructure, and that continuous funding is necessary for not just the backlog of projects, but to keep VA viable for today's and future veterans.

In a November 17, 2008 letter to the Senate Veterans Affairs Committee, Secretary Peake said that "the Department estimates that the total funding requirement for major medical facility projects over the next 5 years would be in excess of \$6.5 billion."

It is clear that VA needs a significant infusion of cash for its construction priorities. VA's own words and studies show this.

Major Construction Account Recommendations	
Category	Recommendation (\$ in Thousands)
VHA Facility Construction	\$1,000,000
NCA Construction	\$60,000
Advance Planning	\$40,000
Master Planning	\$15,000
Historic Preservation	\$20,000
Medical Research Infrastructure	\$100,000
Miscellaneous Accounts	\$58,000
TOTAL	\$1,295,000

- VHA Facility Construction—this amount would allow VA to continue digging into the \$3.25 billion backlog of partially funded construction projects. Depending on the stages and ability to complete portions of the projects, any additional money could be used to fund new projects identified by VA as part of its prioritization methodology in the Five-Year Capital Plan.
- NCA Construction's Five-Year Capital Plan details numerous potential major construction projects for the National Cemetery Association throughout the country. This level of funding would allow VA to begin construction on at least three of its scored priority projects.
- Advance Planning—helps develop the scope of the major construction projects as well as identifying proper requirements for their construction. It allows VA to conduct necessary studies and research similar to planning processes in the private sector.
- Master Planning—a description of our request follows later in the text.

- Historic Preservation—a description of our request follows later in the text.
- Miscellaneous Accounts—these include the individual line items for accounts such as asbestos abatement, the judgment fund and hazardous waste disposal. Our recommendation is based upon the historic level for each of these accounts.

Minor Construction Account Recommendations	
Category	Funding (\$ in Thousands)
Veterans Health Administration	\$450,000
Medical Research Infrastructure	\$200,000
National Cemetery Administration	\$100,000
Veterans Benefits Administration	\$20,000
Staff Offices	\$15,000
TOTAL	\$785,000

- Veterans Health Administration—Page 7.8–138 of VA’s Capital Plan reveals hundreds of already identified minor construction projects. These projects update and modernize VA’s aging physical plant ensuring the health and safety of veterans and VA employees. Additionally, a great number of minor construction projects address FCA-identified maintenance deficiencies; the backlog of 216 projects in FY 2010 with over \$1 billion that has yet to be funded.
- Medical Research Infrastructure—a description of our request follows later in the text.
- National Cemetery Administration of the Capital Plan identifies numerous minor construction projects throughout the country including the construction of several columbaria, installation of crypts and landscaping and maintenance improvements. Some of these projects could be combined with VA’s new NCA nonrecurring maintenance efforts.
- Veterans Benefits Administration—Page 7.6–106 of the Capital Plan lists several minor construction projects in addition to the leasing requirements VBA needs.
- Staff Offices—Page 7.8–134 lists numerous potential minor construction projects related to staff offices.

Increase Spending on Nonrecurring Maintenance

The deterioration of many VA properties requires increased spending on nonrecurring maintenance

For years, *The Independent Budget* Veteran Service Organizations (IBVSOs) have highlighted the need for increased funding for the nonrecurring maintenance (NRM) account. NRM consists of small projects that are essential to the proper maintenance of and preservation of the lifespan of VA’s facilities. NRM projects are one-time repairs such as maintenance to roofs, repair and replacement of windows and flooring or minor upgrades to the mechanical or electrical systems. They are a necessary component of the care and stewardship of a facility.

These projects are so essential because if left unrepaired, they can really take their toll on a facility, leading to more costly repairs in the future, and the potential of a need for a minor construction project. Beyond the fiscal aspects, facilities that fall into disrepair can create access difficulties and impair patient and staff health and safety, and if things do develop into a larger construction projection because early repairs were not done, it creates an even larger inconvenience for veterans and staff.

The industry standard for medical facilities is for managers to spend from 2 percent–4 percent of plant replacement value (PRV) on upkeep and maintenance. The 1998 PriceWaterhouseCoopers study of VA’s facilities management practices argued for this level of funding and previous versions of VA’s own Asset Management Plan have agreed that this level of funding would be adequate.

The most recent estimate of VA’s PRV is from the FY 08 Asset Management Plan. Using the standards of the Federal Government’s Federal Real Property Council (FRPC), VA’s PRV is just over \$85 billion (page 26).

Accordingly, to fully maintain its facilities, VA needs a NRM budget of at least \$1.7 billion. This number would represent a doubling of VA's budget request from FY 2009, but is in line with the total NRM budget when factoring in the increases Congress gave in the appropriations bill and the targeted funding included in the supplemental appropriations bills.

Increased funding is required not to just to fill current maintenance needs and levels, but also to dip into the extensive backlog of maintenance requirements VA has. VA monitors the condition of its structures and systems through the Facility Condition Assessment (FCA) reports. VA surveys each medical center periodically, giving each building a thorough assessment of all essential systems. Systems are assigned a letter grade based upon the age and condition of various systems, and VA gives each component a cost for repair or replacement.

The bulk of these repairs and replacements are conducted through the NRM program, although the large increases in minor construction over the last few years have helped VA to address some of these deficiencies.

VA's 5-Year Capital Plan discusses FCAs and acknowledges the significant backlog the number of high priority deficiencies—those with ratings of D or F—had replacement and repair costs of over \$9.4 billion, found on page 7.1–18. VA estimates that 52 percent of NRM dollars are obligated to toward this cost.

VA uses the FCA reports as part of its Federal Real Property Council (FRPC) metrics. The department calculates a Facility Condition Index, which is the ratio of the cost of FCA repairs to the cost of replacement. According to the FY 08 Asset Management Plan, this metric has gone backwards from 82 percent in 2006 to just 68 percent in 2008. VA's strategic goal is 87 percent, and for it to meet that, it would require a sizeable investment in NRM and minor construction.

Given the low level of funding the NRM account has historically received, the IBVSOs are not surprised at the metrics or the dollar cost of the FCA deficiencies. The 2007 "National Roll Up of Environment of Care Report," which was conducted in light of the shameful maintenance deficiencies at Walter Reed further prove the need for increased spending on this account. Maintenance has been neglected for far too long, and for VA to provide safe, high-quality health care in its aging facilities, it is essential that more money be allocated for this account.

We also have concerns with how NRM funding is actually apportioned. Since it falls under the Medical Care account, NRM funding has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This model works when divvying up health-care dollars, targeting money to those areas with the greatest demand for health care. When dealing with maintenance needs, though, this same formula may actually intensify the problem, moving money away from older hospitals, such as in the northeast, to newer facilities where patient demand is greater, even if the maintenance needs are not as high. We were happy to see that the conference reports to the VA appropriations bills required NRM funding to be apportioned outside the VERA formula, and we would hope that this continues into the future.

Another issue related to apportionment of funding came to light in a May 2007 Government Accountability Office (GAO) report. They found that the bulk of NRM funding is not actually apportioned until September, the final month of the fiscal year. In September 2006, GAO found that VA allocated 60 percent of that year's NRM funding. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and since NRM funding is year-to-year, it means that it could lead to wasteful or unnecessary spending as hospital managers rushed in a flurry to spend their apportionment before forfeiting it back. We cannot expect VA to perform a year's worth of maintenance in a month. It is clearly poor policy and not in the best interest of veterans. The IBVSOs believe that Congress should consider allowing some NRM money to be carried over from one fiscal year to another. While we would hope that this would not resort to hospital managers hoarding money, it could result in more efficient spending and better planning, rather than the current situation where hospital managers sometimes have to spend through a large portion of maintenance funding before losing it at the end of the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance in line with the 2 percent–4 percent total that is the industry standard so as to maintain clean, safe and efficient facilities. VA also requires additional maintenance funding to allow the department to begin addressing the substantial maintenance backlog of FCA-identified projects.

Portions of the NRM account should be continued to be funded outside of the VERA formula so that funding is allocated to the facilities that actually have the greatest maintenance needs.

Congress should consider the strengths of allowing VA to carry over some maintenance funding from one fiscal year to another so as to reduce the temptation some VA hospital managers have of inefficiently spending their NRM money at the end of a fiscal year for fear of losing it.

Inadequate Funding and Declining Capital Asset Value

VA must protect against deterioration of its infrastructure and a declining capital asset value

The last decade of underfunded construction budgets has meant that VA has not adequately recapitalized its facilities. Recapitalization is necessary to protect the value of VA's capital assets through the renewal of the physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age approaching 60 years, and it is essential that funding be increased to renovate, repair and replace these aging structures and physical systems.

As in past years, the IBVSOs cite the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). It found that from 1996–2001, VA's recapitalization rate was just 0.64 percent. At this rate, VA's structures would have an assumed life of 155 years.

The PTF cited a PriceWaterhouseCoopers study of VA's facilities management programs that found that to keep up with industry standards in the private sector and to maintain patient and employee safety and optimal health care delivery, VA should spend a minimum of 5 to 8 percent of plant replacement value (PRV) on its total capital budget.

The FY 08 VA Asset Management Plan provides the most recent estimate of VA's PRV. Using the guidance of the Federal Government's Federal Real Property Council (FRPC), VA's PRV is just over \$85 billion (page 26).

Accordingly, using that 5 to 8 percent standard, VA's capital budget should be between \$4.25 and \$6.8 billion per year in order to maintain its infrastructure.

VA's capital budget request for FY 2009—which includes major and minor construction, maintenance, leases and equipment—was just \$3.6 billion. We greatly appreciate that Congress increased funding above that level with an increase over the administration request of \$750 million in major and minor construction alone. That increased amount brought the total capital budget in line with industry standards, and we strongly urge that these targets continue to be met and we would hope that future VA requests use these guidelines as a starting point without requiring Congress to push them past the target.

Recommendation:

Congress and the Administration must ensure that there are adequate funds for VA's capital budget so that VA can properly invest in its physical assets to protect their value and to ensure that the Department can continue to provide health care in safe and functional facilities long into the future.

Maintain VA's Critical Infrastructure

The IBVSOs are concerned with VA's recent attempts to back away from the capital infrastructure blueprint laid out by CARES and we are worried that its plan to begin widespread leasing and contracting for inpatient services might not meet the needs of veterans.

VA acknowledges three main challenges with its capital infrastructure projects. First, they are costly. According to a March 2008 briefing given to the VSO community, over the next five years, VA would need \$2 billion per year for its capital budget. Second, there is a large backlog of partially funded construction projects. That same briefing claimed that the difference in major construction requests given to OMB was \$8.6 billion from FY 03 through FY 09, and that they have received slightly less than half that total. Additionally, there is a \$2 billion funding backlog for projects that are partially but not completely funded. Third, VA is concerned about the timeliness of construction projects, noting that it can take the better part of a decade from the time VA initially proposes a project until the doors actually open for veterans.

Given these challenges, VA has floated the idea of a new model for health care delivery, the Health Care Center Facility (HCCF) leasing program. Under the HCCF, VA would begin leasing large outpatient clinics in lieu of major construction. These large clinics would provide a broad range of outpatient services including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

On the face of it, this sounds like a good initiative. Leasing has the advantage of being able to be completed quickly, as well as being adaptable, especially when compared to the major construction process. Leasing has been particularly valuable for VA as evidenced by the success of the Community Based Outpatient Clinics (CBOCs) and Vet Centers.

Our concern rests, however, with VA's plan for inpatient services. VA aims to contract for these essential services with affiliates or community hospitals. This program would privatize many services that the IBVSOs believe VA should continue to provide. We lay out our objections to privatization and widespread contracting for care elsewhere in *The Independent Budget*.

Beyond those objections, though, is the example of Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for those services. Recently, the contract between the local facility and VA was canceled, meaning veterans in that area can no longer receive inpatient services locally. They must travel great distances to other VA facilities such as the Omaha VA Medical Center. In some cases, when Omaha is unable to provide specialized care, VA is flying patients at its expense to faraway VA medical centers, including those in St. Louis and Minneapolis.

Further, with the canceling of that contract, St. Francis no longer provides the same level of emergency services that a full VA Medical Center would provide. With VA's restrictions on paying for emergency services in non-VA facilities, especially for those who may have some form of private insurance, this amounts to a cut in essential services to veterans. Given the expenses of air travel and medevac services, the current arrangement in Grand Island has likely not resulted in any cost savings for VA. Ferrying sick and disabled veterans great distances for inpatient care also raises patient safety and quality concerns.

The HCCF program raises many concerns for the IBVSOs that VA must address before we can support the program. Among these questions, we wonder how VA would handle governance, especially with respect to the large numbers of non-VA employees who would be treating veterans. How would the non-VA facility deal with VA directives and rule changes that govern health-care delivery and that ensure safety and uniformity of the quality of care? Will VA apply its space planning criteria and design guides to non-VA facilities? How will VA's critical research activities, most of which improve the lives of all Americans and not only veterans, be affected if they are being conducted in shared facilities, and not a traditional part of VA's first-class research programs? What would this change mean for VA's electronic health record, which many have rightly lauded as the standard that other health-care systems should aim to achieve? Without the electronic health record, how would VA maintain continuity of care for a veteran who moves to another area?

But most importantly, CARES required years to complete and consumed thousands of hours of effort and millions of dollars of study. We believe it to be a comprehensive and fully justified roadmap for VA's infrastructure as well as a model that VA can apply periodically to assess and adjust those priorities. Given the strengths of the CARES process and the lessons VA learned and has applied from it, why is the HCCF model, which to our knowledge has not been based on any sort of model or study of the long-term needs of veterans, the superior one? We have yet to see evidence that it is and until we see more convincing evidence that it will truly serve the best needs of veterans, the IBVSOs will have a difficult time supporting it.

Recommendation:

VA must resist implementing the HCCF model without fully addressing the many questions the IBVSOs have and VA must explain how the program would meet the needs of veterans, particularly as compared to the roadmap CARES has laid out.

Research Infrastructure Funding

The Department of Veterans Affairs must have increased funding for its research infrastructure to provide a state-of-the-art research and laboratory environment for its excellent programs, but also to ensure that VA hires and retains the top scientists and researchers.

VA Research Is a National Asset

Research conducted in the Department of Veterans Affairs has led to such innovations and advances as the cardiac pacemaker, nuclear scanning technologies, radioisotope diagnostic techniques, liver and other organ transplantation, the nicotine patch, and vast improvements in a variety of prosthetic and sensory aids. A state-of-the-art physical environment for conducting VA research promotes excellence in health professions education and VA patient care as well as the advancement of bio-

medical science. Adequate and up-to-date research facilities also help VA recruit and retain the best and brightest clinician scientists to care for enrolled veterans.

VA Research Infrastructure Funding Shortfalls

In recent years, funding for the VA Medical and Prosthetics Research Program has failed to provide the resources needed to maintain, upgrade, and replace VA's aging research facilities. Many VA facilities have exhausted their available research space. Along with space reconfiguration, ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades in VA's academic health centers. In the 2003 Draft National Capital Asset Realignment for Enhanced Services (CARES) plan, VA included \$142 million designated for renovation of existing research space and build-out costs for leased researched facilities. However, these capital improvement costs were omitted from the Secretary's final report. Over the past decade, only \$50 million has been spent on VA research construction or renovation nationwide, and only 24 of the 97 major VA research sites across the Nation have benefited.

In House Report 109–95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee directed VA to conduct “a comprehensive review of its research facilities and report to the Congress on the deficiencies found and suggestions for correction of the identified deficiencies.” In FY 2008, the VA Office of Research and Development initiated a multiyear examination of all VA research infrastructure for physical condition and capacity for current research, as well as program growth and sustainability of the space needed to conduct research.

Lack of a Mechanism to Ensure VA's Research Facilities Remain Competitive

In House Report 109–95 accompanying the FY 2006 VA appropriations, the House Appropriations Committee expressed 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.” A significant cause of research infrastructure's neglect is that there is no direct funding line for research facilities.

The VA Medical and Prosthetic Research appropriation does not include funding for construction, renovation, or maintenance of research facilities. VA researchers must rely on their local facility managements to repair, upgrade, and replace research facilities and capital equipment associated with VA's research laboratories. As a result, VA research competes with other medical facilities' direct patient care needs—such as medical services infrastructure, capital equipment upgrades and replacements, and other maintenance needs—for funds provided under either the VA Medical Facilities appropriation account or the VA Major or Minor Medical Construction appropriations accounts.

Recommendations:

The Independent Budget veterans service organizations anticipate VA's analysis will find a need for funding significantly greater than VA had identified in the 2004 Capital Asset Realignment for Enhanced Services report. As VA moves forward with its research facilities assessment, the IBVSOs urge Congress to require the VA to submit the resulting report to the House and Senate Committees on Veterans' Affairs no later than October 1, 2009. This report will ensure that the Administration and Congress are well informed of VA's funding needs for research infrastructure so they may be fully considered at each stage of the FY 2011 budget process.

To address the current shortfalls, the IBVSOs recommend an appropriation in FY 2010 of \$142 million, dedicated to renovating existing VA research facilities in line with the 2004 CARES findings.

To address the VA research infrastructure's defective funding mechanism, the IBVSOs encourage the Administration and Congress to support a new appropriations account in FY 2010 and thereafter to independently define and separate VA research infrastructure funding needs from those related to direct VA medical care. This division of appropriations accounts will empower VA to address research facility needs without interfering with the renovation and construction of VA direct health-care infrastructure.

Program for Architectural Master Plans:

Each VA medical facility must develop a detailed master plan.

The delivery models for quality health care are in a constant state of change. This is due to many factors including advances in research, changing patient demographics, and new technology.

The VA must design their facilities with a high level of flexibility in order to accommodate these new methods of patient care. The department must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in already existing programs.

A facility master plan is a comprehensive tool to look at potential new patient care programs and how they might affect the existing health care facility. It also provides insight with respect to possible growth, current space deficiencies, and other facility needs for existing programs and how VA might accommodate these in the future.

In some cases in the past, VA has planned construction in a reactive manner. After funding, VA would place projects in the facility in the most expedient manner—often not considering other projects and facility needs. This would result in shortsighted construction that restricts, rather than expands options for the future.

The IBVSOs believe that each VA medical Center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility. Short and long-term CARES objectives should be the basis of the master plan.

Four critical programs were not included in the CARES initiative. They are long-term care, severe mental illness, domiciliary care, and Polytrauma. VA must develop a comprehensive plan addressing these needs and its facility master plans must account for these services.

VA has undertaken master planning for several VA facilities; most recently Tampa, Florida. This is a good start, but VA must ensure that all facilities develop a master plan strategy to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendation:

Congress must appropriate \$20 million to provide funding for each medical facility to develop a master plan.

Each facility master plan should include the areas left out of CARES; long-term care, severe mental illness, domiciliary care, and Polytrauma programs as it relates to the particular facility.

VACO must develop a standard format for these master plans to ensure consistency throughout the VA health care system.

Empty or Underutilized Space

VA must not use empty space inappropriately and must continue disposing of unnecessary property where appropriate. Studies have suggested that the VA medical system has extensive amounts of empty space that the Department can reuse for medical services. Others have suggested that unused space at one medical center may help address a deficiency that exists at another location. Although the space inventories are accurate, the assumption regarding the feasibility of using this space is not.

Medical facility planning is complex. It requires intricate design relationships for function, but also because of the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. For example, VA cannot use unoccupied rooms on the eighth floor to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and intra- departmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect of everything around it. These secondary impacts greatly increase construction expense, and they can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot be altered. Different aspects of medical care have different requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the needs of different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Labs should have long structural bays and function best without windows. When renovating empty space, if the area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient.

Renovating old space rather than constructing new space creates only a marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would. When you factor in the aforementioned domino or secondary

costs, the renovation can end up costing more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies, but it is rarely economical.

Many older VA Medical Centers that were rapidly built in the 1940s and 1950s to treat a growing veteran population are simply unable to be renovated for modern needs. Most of these Bradley-style buildings were designed before the widespread use of air conditioning and the floor-to-floor heights are very low. Accordingly, it is impossible to retrofit them for modern mechanical systems. They also have long, narrow wings radiating from a small central core, which is an inefficient way of laying out rooms for modern use. This central core, too, has only a few small elevator shafts, complicating the vertical distribution of modern services.

Another important problem with this unused space is its location. Much of it is not located in a prime location; otherwise, VA would have previously renovated or demolished this space for new construction. This space is typically located in outlying buildings or on upper floor levels, and is unsuitable for modern use.

VA Space Planning Criteria/Design Guides:

VA must continue to maintain and update the Space Planning Criteria and Design Guides to reflect state-of-the-art methods of health care delivery.

VA has developed space-planning criteria it uses to allocate space for all VA health care projects. These criteria are organized into sixty chapters; one for each health care service provided by VA as well as their associated support services. VA updates these criteria to reflect current methods of health care delivery.

In addition to updating these criteria, VA has utilized a computer program called VA SEPS (Space and Equipment Planning System) it uses as a tool to develop space and equipment allocation for all VA health care projects. This tool is operational and VA currently uses it on all VA health care projects.

The third component used in the design of VA health care projects is the design guides. Each of the sixty space planning criteria chapters has an associated design guide. These design guides go beyond the allocation of physical space and outline how this space is organized within each individual department, as well as how the department relates to the entire medical facility.

VA has updated several of the design guides to reflect current patient delivery models. These include those guides that cover Spinal Cord Injury/Disorders Center, Imaging, Polytrauma Centers, as well as several other services.

Recommendation:

The VA must continue to maintain and update the Space Planning Criteria and the VA SEPS space-planning tool. It also must continue the process of updating the Design Guides to reflect current delivery models for patient care. VA must regularly review and update all of these space-planning tools as needed, to reflect the highest level of patient care delivery.

Design-build Construction Delivery System

The VA must evaluate use of the Design-build construction delivery system.

For the past 10 years, VA has embraced the design-build construction delivery system as a method of project delivery for many health care projects. Design-build attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to the owner and reduce the project delivery schedule. Design-build, as used by VA, places the contractor as the design builder.

Under the contractor-led design build process, VA gives the contractor a great deal of control over how he or she designs and completes the project. In this method, the contractor hires the architect and design professionals. With the architect as a subordinate, a contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of the owner.

Use of design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition, the construction documents may not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, which often compromises VA's design standards.

Design-build forces the owner to rely on the contractor to properly design a facility that meets the owner's needs. In the event that the finished project is not satisfactory to the owner, the owner may have no means to insist on correction of work

done improperly unless the contractor agrees with the owner's assessment. This may force the owner to go to some form of formal dispute resolution such as litigation or arbitration.

Recommendation:

VA must evaluate the use of Design-build as a method of construction delivery to determine if design-build is an appropriate method of project delivery for VA health care projects.

The VA must institute a program of "lessons learned". This would involve revisiting past projects and determining what worked, what could be improved, and what did not work. VA should compile and use this information as a guide to future projects. VA must regularly update this document to include projects as they are completed.

Preservation of VA's Historic Structures:

The VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The VA has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, and who helped to develop this great Nation. Of the approximately 2,000 historic structures, many are neglected and deteriorate year after year because of a lack of funding. These structures should be stabilized, protected and preserved because they are an integral part our Nation's history.

Most of these historic facilities are not suitable for modern patient care. As a result, a preservation strategy was not included in the CARES process. For the past six years, the IBVSOs have recommended that VA conduct an inventory of these properties; classifying their physical condition and their potential for adaptive reuse. VA has been moving in that direction and historic properties are identified on their Web site. VA has placed many of these buildings in an "Oldest and Most Historic" list and these buildings require immediate attention.

At least one project has received funding. The VA has invested over \$100,000 in the last year to address structural issues at a unique round structure in Hampton, VA. Built in 1860, it was originally a latrine and the funding is allowing VA to convert it into office space.

The cost for saving some of these buildings is not very high considering that they represent a part of history that enriches the texture of our landscape that once gone cannot be recaptured. For example, VA can restore the Greek Revival Mansion in Perry Point, MD, which was built in the 1750's, to use as a training space for about \$1.2 million. VA could restore the 1881 Milwaukee Ward Memorial Theater for use as a multi-purpose facility at a cost of \$6 million. This is much less than the cost of a new facility.

As part of its adaptive reuse program, VA must ensure that the facilities that it leases or sells are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

We encourage the use of P.L. 108-422, the Veterans Health Programs Improvement Act, which authorized historic preservation as one of the uses of a new capital assets fund that receives funding from the sale or lease of VA property.

Recommendation:

VA must further develop a comprehensive program to preserve and protect its inventory of historic properties.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or the Members of the Committee may have.

Prepared Statement of Raymond C. Kelley, National Legislative Director, American Veterans (AMVETS)

Chairman Filner, Ranking Member Buyer, and Members of the Committee:

AMVETS is honored to join our fellow veterans service organizations and partners at this important hearing on the Department of Veterans Affairs budget request for fiscal year 2011. My name is Raymond C. Kelley, National Legislative Director of AMVETS, and I am pleased to provide you with our best estimates on the resources necessary to carry out a responsible budget for VA.

AMVETS testifies before you as a co-author of *The Independent Budget*. This is the 24th year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars have pooled our resources to produce a unique document, one that has stood the test of time.

In developing *The Independent Budget*, 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 accessible burial in a state or national cemetery in every state.

The VA health care 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 provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, traumatic brain injury, and post traumatic stress disorder.

As a partner of *The Independent Budget*, AMVETS devotes a majority of its time with the concerns of the National Cemetery Administration (NCA) and I would like to speak directly to the issues and concerns surrounding NCA.

The National Cemetery Administration

The Department of Veterans Affairs National Cemetery Administration (NCA) currently maintains more than 2.9 million gravesites at 130 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 70 will be open to all interments; 20 will accept only cremated remains and family members of those already interred; and 40 will only perform interments of family members in the same gravesite as a previously deceased family member. NCA also maintains 33 soldiers' lots and monument sites. All told, NCA manages 19,000 acres, half of which are developed.

VA estimates that about 27 million veterans are alive today. They include veterans from World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, and the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the new national cemeteries, annual interments are projected to increase from approximately 111,000 in 2009 to 114,000 in 2010. Historically, 12 percent of veterans opt for burial in a state or national cemetery.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of the NCA's top priorities. Many of the individual cemeteries within the system are steeped in history, and the monuments, markers, grounds, and related memorial tributes represent the very foundation of the United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and cherished.

The Independent Budget veterans service organizations (IBVSOs) would like to acknowledge the dedication and commitment of the NCA staff who continue to provide the highest quality of service to veterans and their families. We call on the Administration and Congress to provide the resources needed to meet the changing and critical nature of NCA's mission and fulfill the Nation's commitment to all veterans who have served their country honorably and faithfully.

In FY 2009, \$230 million was appropriated for the operations and maintenance of NCA, \$49 million over the administration's request, with \$2.7 million in carry-over. NCA awarded 49 of the 56 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded \$40 million in grants for 10 projects.

NCA has done an exceptional job of providing burial options for 90 percent of all veterans who fall within the 170,000 veterans within a 75-mile radius threshold model. However, under this model, no new geographical area will become eligible for a National Cemetery until 2015. St. Louis, Mo. will, at that time, meet the threshold due to the closing of Jefferson Barracks National Cemetery in 2017. Analysis shows that the five areas with the highest veteran population will not become eligible for a National Cemetery because they will not reach the 170,000 threshold.

NCA has spent years developing and maintaining a cemetery system based on a growing veteran population. In 2010 our veteran population will begin to decline. Because of this downward trend, a new threshold model must be developed to ensure more of our veterans will have reasonable access to their burial benefits. Reducing the mile radius to 65 miles would reduce the veteran population that is served from 90 percent to 82.4 percent, and reducing the radius to 55 miles would reduce the served population to 74.1 percent. Reducing the radius alone to 55 miles

would only bring two geographical areas in to 170,000 population threshold in 2010, and only a few areas into this revised model by 2030.

Several geographical areas will remain unserved if the population threshold is not reduced. Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a National Cemetery regardless of any change to the mile radius threshold. A new threshold model must be implemented so more of our veterans will have access to this earned benefit.

National Cemetery Administration (NCA) Accounts

The Independent Budget recommends an operations budget of \$274.5 million for the NCA for fiscal year 2011 so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations.

The NCA is responsible for five primary missions: (1) to inter, upon request, the remains of eligible veterans and family members and to permanently maintain gravesites; (2) to mark graves of eligible persons in national, state, or private cemeteries upon appropriate application; (3) to administer the state grant program in the establishment, expansion, or improvement of state veterans cemeteries; (4) to award a presidential certificate and furnish a United States flag to deceased veterans; and (5) to maintain national cemeteries as national shrines sacred to the honor and memory of those interred or memorialized.

The national cemetery system continues to be seriously challenged. Though there has been progress made over the years, the NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to many national cemeteries are likely to encounter sunken graves, misaligned and dirty grave markers, deteriorating roads, spotty turf and other patches of decay that have been accumulating for decades. If the NCA is to continue its commitment to ensure national cemeteries remain dignified and respectful settings that honor deceased veterans and give evidence of the Nation's gratitude for their military service, there must be a comprehensive effort to greatly improve the condition, function, and appearance of all our national cemeteries.

The IBVSOs is encouraged that \$25 million was set aside for the National Shrine Commitment for FY 07 and 08. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. In 2006 only 67 percent of headstones and markers in national cemeteries were at the proper height and alignment. By 2009 proper height and alignment increased to 76 percent. The NCA has also identified 153 historic monuments and memorials that need repair and/or restoration. With funding from The American Recovery and Reinvestment Act (ARRA), the NCA will make repairs on 32 percent of these monuments and memorials.

The IBVSOs support the NCA's operational standards and measures outlined in the National Shrine Commitment, and in the past *The Independent Budget* advocated for a five-year, \$250 million National Shrine Initiative to assist the NCA in achieving its performance goals. However, over the past few years, the NCA has made marked improvements in the National Shrine Commitment by earmarking a portion of its operations and maintenance budget for the commitment and pending receipt of funding from the ARRA. Therefore, the IBVSOs no longer believe it is necessary to implement the National Shrine Initiative program at \$50 million per year for five years but, rather, propose an increase in the NCA's operations and maintenance budget by \$25 million per year until the operational standards and measures goals are reached.

In addition to the management of national cemeteries, the NCA is responsible for the Memorial Program Service. The Memorial Program Service provides lasting memorials for the graves of eligible veterans and honors their service through Presidential Memorial Certificates. Public Laws 107-103 and 107-330 allow for a headstone or marker for the graves of veterans buried in private cemeteries who died on or after September 11, 2001. Prior to this change, the NCA could provide this service only to those buried in national or state cemeteries or to unmarked graves in private cemeteries. Public Law 110-157 gives VA authority to provide a medalion to be attached to the headstone or marker of veterans who are buried in a private cemetery. This benefit is available to veterans in lieu of a government-furnished headstone or marker. The IBVSOs call on the Administration and Congress to provide the resources required to meet the critical nature of the NCA mission and fulfill the Nation's commitment to all veterans who have served their country so honorably and faithfully.

The State Cemetery Grants Program

The State Cemeteries Grant Program faces the challenge of meeting a growing interest from states to provide burial services in areas that are not currently served.

The intent of the SCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the Veterans Benefits Improvements Act of 1998, the NCA has been able to strengthen its partnership with states and increase burial service to veterans, especially those living in less densely populated areas not currently served by a national cemetery. Currently there are 60 state and tribal government cemetery construction grant pre-applications, 36 of which have the required state matching funds necessary totaling \$121 million.

The Independent Budget recommends that Congress appropriate \$51 million for SCGP for FY 2011. This funding level would allow SCGP to establish 13 new state cemeteries that will provide burial options for veterans who live in a region that currently has no reasonably accessible state or national cemetery.

Burial Benefits

In 1973 NCA established a burial allowance that provided partial reimbursements for eligible funeral and burial costs. The current payment is \$2,000 for burial expenses for service-connected (SC) death, \$300 for non-service-connected (NSC) deaths, and \$300 for plot allowance. At its inception, the payout covered 72 percent of the funeral cost for a service-connected death, 22 percent for a non-service-connected death, and 54 percent of the burial plot cost. In 2007 these benefits eroded to 23 percent, 4 percent, and 14 percent respectively. It is time to bring these benefits back to their original value.

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potters' fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the allowance was changed again, removing the means test. In its early history, the burial allowance was paid to all veterans, regardless of the service-connectivity of their death. In 1973 the allowance was modified to reflect the relationship of their death as service connected or not.

The plot allowance was introduced in 1973 as an attempt to provide a plot benefit for veterans who did not have reasonable access to a national cemetery. Although neither the plot allowance nor the burial allowances were intended to cover the full cost of a civilian burial in a private cemetery, the increase in the benefit's value indicates the intent to provide a meaningful benefit by adjusting for inflation.

The national average cost for a funeral and burial in a private cemetery has reached \$8,555, and the cost for a burial plot is \$2,133. At the inception of the benefit the average costs were \$1,116 and \$278 respectively. While the cost of a funeral has increased by nearly seven times the burial benefit has only increased by 2.5 times. To bring both burial allowances and the plot allowance back to its 1973 value, the SC benefit payment will be \$6,160, the NSC benefit value payment will be \$1,918, and the plot allowance will increase to \$1,150. Readjusting the value of these benefits, under the current system, will increase the obligations from \$70.1 million to \$335.1 million per year.

Based on accessibility and the need to provide quality burial benefits, *The Independent Budget* recommends that VA separate burial benefits into two categories: veterans who live inside the VA accessibility threshold model and those who live outside the threshold. For those veterans who live outside the threshold, the SC burial benefit should be increased to \$6,160, NSC veteran's burial benefit should be increased to \$1,918, and plot allowance should increase to \$1,150 to match the original value of the benefit. For veterans who live within reasonable accessibility to a state or national cemetery that is able to accommodate burial needs, but the veteran would rather be buried in a private cemetery the burial benefit should be adjusted. These veterans' burial benefits will be based on the average cost for VA to conduct a funeral. The benefit for a SC burial will be \$2,793, the amount provided for a NSC burial will be \$854, and the plot allowance will be \$1,150. This will provide a burial benefit at equal percentages, but based on the average cost for a VA funeral and not on the private funeral cost that will be provided for those veterans who do not have access to a state or national cemetery.

The recommendations of past legislation provided an increased benefit for all eligible veterans but it currently fails to reach the intent of the original benefit. The new model will provide a meaningful benefit to those veterans whose access to a state or national cemetery is restricted as well as provides an improved benefit for eligible veterans who opt for private burial. Congress should increase the plot allowance from \$300 to \$1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime. Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model. Congress should increase the service-connected burial benefit from \$2,000 to \$6,160 for veterans outside the radius threshold and

\$2,793 for veterans inside the radius threshold. Congress should increase the non-service-connected burial benefit from \$300 to \$1,918 for veterans outside the radius threshold and \$854 for veterans inside the radius threshold. Congress should enact legislation to adjust these burial benefits for inflation annually.

The NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 2.8 million soldiers who died in every war and conflict are honored by burial in a VA national cemetery. Each Memorial Day and Veterans Day we honor the last full measure of devotion they gave for this country. Our national cemeteries are more than the final resting place of honor for our veterans; they are hallowed ground to those who died in our defense, and a memorial to those who survived.

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

**Prepared Statement of Steve A. Robertson, Director,
National Legislative Commission, American Legion**

Oral Statement

Mr. Chairman and Members of the Committee, thank you for the opportunity for The American Legion to comment on the President's budget request for FY 2011. I ask that my written statement be included in the record and that The American Legion be allowed to submit additional written comments if necessary.

First, The American Legion would like to express its appreciation for the timely enactment of Public Law 111-81 that authorized advance appropriations for the Department of Veterans Affairs medical care accounts.

After reviewing the President's budget request, The American Legion shares the President's vision to continue VA's transform into a 21st Century organization. It is a bold paradigm shift to VA's approach to veterans' care; as a lifetime initiative, from the day the oath is taken until the day they are laid to rest.

Clearly, the budget request appears to direct funding to assure veterans and their families would receive timely access to the highest quality benefits and services provided by VA. The American Legion sees these benefits and services as earned through honorable military service.

Secretary Shinseki explained that this budget request focuses on three specific concerns that are of critical importance to the veterans' community:

- easier access to benefits and services;
- reducing the disability claims backlog and the wait before veterans receive earned benefits; and
- ending the downward spiral that results in veterans' homelessness.

The American Legion is pleased with the President's budget request of \$125 billion for the Department of Veterans Affairs. This budget request would meet or exceed most of the funding recommendations offered by The American Legion National Commander Clarence Hill last September during the joint hearing of the Committees on Veterans' Affairs.

VA has identified "six high priority performance goals" which this budget request must support:

- **Reducing the Claims Backlog,**
- **Eliminating Veteran Homelessness,**
- **Automating the GI Bill Benefits System,**
- **Establishing a Virtual Lifetime Electronic Record,**
- **Improving Mental Health Care, and**
- **Deploying a Veterans Relationship Management System.**

These are priorities shared by The American Legion.

There are other areas addressed in the budget request supported by The American Legion such as expanding health care eligibility, meeting the needs of women veterans, timely access to quality health care for veterans in rural and highly rural areas, and expanding access to burial in a VA National Cemetery.

In reviewing this budget request, it is obvious that Information Technology is going to play an enormous role in achieving the President's vision and many of these goals and objectives.

Mr. Chairman, thank you for the opportunity to participate in this review of the President's budget request.

This concludes my oral remarks and I welcome any questions you or your colleagues may have for The American Legion.

Prepared Statement

Mr. Chairman and Members of the Committee:

The American Legion welcomes this opportunity to comment on the President's budget request for Fiscal Year 2011/2012. The American Legion is pleased by the \$125 billion total appropriations for the Department of Veterans Affairs (VA) in FY 2010 and the projected \$64.7 billion in mandatory appropriations and \$60.3 billion in discretionary appropriations.

As a Nation at war, America has a moral, ethical and legal commitment to the men and women of the Armed Forces of the United States and their survivors. These current defenders of democracy will eventually join the ranks of their 23.1 million comrades, we refer to as veterans. The active-duty, Reserve Components and veterans continue to make up the Nation's best recruiters for the Armed Forces. Young men and women across the country see servicemembers and veterans as role models. Chances are, before enlisting in the Armed Forces, these young people will seek the advice of those they see in uniform or family members who have served for their recommendations on military service.

Therefore, it is absolutely critical that the entire veterans' community (active-duty, Reserve Component, and veterans) continue to remain supportive of honorable military service. No servicemember should ever be in doubt about:

- the quality of health care he or she will receive if injured;
- the availability of earned benefits for honorable military service upon discharge; or
- the quality of survivors' benefits should he or she pay the ultimate sacrifice.

The American Legion and many other veterans' and military service organizations are united in advocating enactment of timely, predictable and sufficient budgets for VA medical care. The American Legion greatly appreciated the leadership of this Committee in passing Public Law 111-81 authorizing advance appropriations for VA medical care accounts. With the decision for advance appropriations behind us, The American Legion continues to urge Congress to pass the VA budget for FY 2011 before the start of the new fiscal year.

After reviewing the proposed President's budget request for VA in FY 2011/2012, The American Legion renders its support as follows:

- **Increases funding for VA in FY 2011 by \$11 billion above FY 2010.**
- **Increases funding for VA's medical care by \$4 billion in FY 2011 and a projected \$2.8 billion increase in FY 2012 to \$54.3 billion.**
- **Expands enrollment for 500,000 additional Priority Group 8 veterans by FY 2013.**
- **Enhances outreach and services related to mental health care and cognitive injuries, including post-traumatic stress disorder and traumatic brain injury, with a focus on access for veterans in rural and highly rural areas.**
- **Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.**
- **Full concurrent receipt of military retirement pay and VA disability compensation without offsets.**
- **Combats homelessness by safeguarding vulnerable veterans. Facilitates timely implementation of the comprehensive education benefits that veterans earn through their dedicated military service.**

When National Commander Clarence Hill testified on September 10, 2009 before a Joint Session of the Committees on Veterans' Affairs, he clearly outlined the funding recommendations for FY 2011. This testimony will re-emphasize that support for certain specific areas.

Medical Care

The American Legion fully supports funding "*the best health care anywhere*" in FY 2011 at \$51.5 billion and in FY 2012 at \$54.3 billion. VA reports that 6.1 million veterans will receive timely access to quality health care in FY 2011. This represents an anticipated increase of 168,904 new patients who will "vote with their feet" in making VA their health care provider of choice. VA medical care is still

America's best investment in quality health care delivery—the right care, at the right time, in the right facility.

Medical Care Collections Fund

The Balanced Budget Act of 1997, Public Law (P.L.) 105–33, established the VA Medical Care Collections Fund (MCCF), requiring amounts collected or recovered from third-party payers after June 30, 1997, be deposited into this fund. The MCCF is a depository for collections from third-party insurance, outpatient prescription co-payments and other medical charges and user fees. Funds collected may only be used to provide VA medical care and services, as well as 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 all third-party reimbursements and co-payments. The American Legion adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of these funds come from the treatment of nonservice-connected medical conditions. VA's ability to capture these funds is critical to its ability to provide quality and timely care to veterans. Miscalculations of VA required funding levels result in real budgetary shortfalls.

The American Legion continues to oppose offsetting annual VA discretionary funding by the MCCF goal.

Medicare Reimbursements

As do most American workers, veterans pay into the Medicare system, without choice, throughout their working lives, including while on active duty or as active service Reservists in the Armed Forces. 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. Since over half of VA's enrolled patient population is Medicare-eligible, this prohibition constitutes a multi-billion dollar annual subsidy to the Medicare Trust Fund.

The American Legion continues to support a legislative initiative to allow VHA to bill, collect and reinvest third-party reimbursements from the Centers for Medicare and Medicaid Services for the treatment of allowable, nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

Medical and Prosthetics Research

The American Legion believes VA's focus in research must remain on understanding and improving treatment for medical conditions that are unique to veterans. Servicemembers are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theater and the timely access to quality combat medical care. The unique injuries sustained by the new generation of veterans clearly demand particular attention. It has been reported that VA does not have state-of-the-art prostheses like DoD and that the fitting of prostheses for women has presented problems due to their smaller stature.

There is a need for adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects. Congress and the Administration should continue to 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 other research that is conducted jointly with DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends \$700 million for Medical and Prosthetics Research in FY 2011.

Major Construction

The CARES process identified approximately 100 major construction projects throughout the VA Medical Center System, the District of Columbia, and Puerto Rico. Construction projects are categorized as major if the estimated cost is over \$10 million. Now that VA has disclosed the plan to deliver health care through 2022, Congress has the responsibility to provide adequate funds. The FY 2011 President's budget request calls for ongoing construction of a new medical facility in Denver, CO; New Orleans, LA; and Palo Alto, CA. Also work is to begin on new medical facilities in Omaha, NE and Alameda Point, CA.

The American Legion supports these projects; however, we feel the President's budget request for \$864 million in FY 2011 for Major Construction is inadequate and should be increased to \$2 billion to provide for additional facilities particularly Community-Based Outpatient Clinics in rural and highly rural areas and additional Vet Centers.

Minor Construction

VA's minor construction program has also suffered significant neglect over the past several years. Maintaining the infrastructure of VA's buildings is no small task, due to the age of these buildings, continuous renovations, relocations and expansions. 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 overdue. The President's budget request for FY 2011 would fund Minor Construction at only \$468 million.

The American Legion recommends \$1.5 billion for Minor Construction in FY 2011.

State Extended Care Facility Construction Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. Under the provisions of Title 38, U.S.C., VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 133 SVHs in 47 states with over 27,000 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 Care needs of veterans, it is essential the State Veterans' Homes Program be maintained as an important alternative health care provider for the VA integrated health care delivery system.

The American Legion opposes attempts to place a moratorium on new SVH construction grants. State authorizing legislation has been enacted and state funds have been committed. Delaying projects will result in cost overruns 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;**
- **providing prescription drugs and over-the-counter medications to State Homes Aid and Attendance patients along with the payment of authorized per diem to State Veterans' Homes; and**
- **allowing full reimbursement of nursing home care to 70 percent or higher service-connected disabled veterans, if those veterans reside in a State Veterans' Home.**

The American Legion strongly recommends \$275 million for the State Extended Care Facility Construction Grants Program in FY 2011.

Rural Health Care

Research conducted by VA indicates that veterans residing in rural and highly rural areas have poorer health than their urban counterparts. It was further reported that one in five veterans live in a rural setting. Providing quality health care to veterans living in rural and highly rural areas has proven to be an extreme challenge.

The American Legion recommends construction of Community-Based Outpatient Clinics in areas such as Alaska, Montana, Nebraska, Nevada, South Dakota, Utah, Vermont and Wyoming.

Information Technology Funding

Since the data theft occurrence in May 2006, the VA has implemented a complete overhaul of its Information Technology (IT) division nationwide. The American Legion is hopeful VA takes the appropriate steps to strengthen its IT security to regain the confidence and trust of veterans who depend on VA for the benefits they have earned.

Within VA Medical Center Nursing Home Care Units, it was discovered there was conflict with IT and each respective VAMC regarding provision of Internet access to veteran residents. VA has acknowledged the Internet would represent a positive

tool in veteran rehabilitation. The American Legion believes Internet access should be provided to these veterans without delay for time is of the essence in the journey to recovery. In addition, veterans should not have to suffer due to VA's gross negligence in the matter.

The American Legion hopes Congress will not attempt to fund the solution to this problem with scarce fiscal resources allocated to the VA for health care delivery. With this in mind, The American Legion is encouraged by the fact that IT is its own line item in the budget recommendation.

The American Legion believes there should be a complete review of IT security government wide. VA isn't the only agency within the government requiring an overhaul of its IT security protocol. The American Legion urges Congress to exercise its oversight authority and review each Federal agency to ensure that the personal information of all Americans is secure.

The American Legion supports the centralization of VA's IT. The amount of work required to secure information managed by VA is immense. The American Legion urges Congress to maintain close oversight of VA's IT restructuring efforts and fund VA's IT to ensure the most rapid implementation of all proposed security measures.

The American Legion disagrees with freezing funding at the FY 2009 level of \$3.3 billion for Information Technology, as recommended in the President's budget request; therefore, The American Legion recommends \$3.8 billion in FY 2011.

Homelessness

The American Legion notes there are approximately 154,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the civilian sector each year since 2001 with at least a third of them potentially suffering from mental illness, indicates that programs to prevent and assist homeless veterans are needed. The American Legion applauds VA's continued emphasis as one of its priority items the elimination of homelessness among America's veterans.

The American Legion fully supports the \$294 million in the FY 2011 President's budget request to help eliminate homelessness among veterans.

National Cemetery Administration

The mission of the National Cemetery Administration (NCA) is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to this Nation. The American Legion recognizes the NCA's excellent record in providing timely and dignified burials to all veterans who opt to be buried in a National Cemetery. Further the American Legion applauds the new VA guidelines reducing the required population base for creating a National Cemetery from 175,000 to 85,000. This will allow 90 percent of all veterans a realistic option within 75 miles of their home.

The American Legion feels that the President's budget request for \$251 million for NCA and \$46 million for the State Cemetery Construction Grants program is not enough to carry out this hallowed mission. Therefore, The American Legion recommends \$260 million be allocated to the National Cemetery Administration and further that \$50 million be provided for State Cemetery Construction Grants Programs in FY 2011.

Homeless Providers Grant and Per Diem Program Reauthorization

In 1992, VA was given authority to establish the Homeless Providers Grant and Per Diem Program under the Homeless Veterans Comprehensive Service Programs Act of 1992, P.L. 102-590. The Grant and Per Diem Program, offered annually (as funding permits) by the VA, funds community agencies providing services to homeless veterans.

VA can provide grants and per diem payments to help public and nonprofit organizations establish and operate supportive housing and/or service centers for homeless veterans. Funds are available for: assistance in the form of grants to provide transitional housing (up to 24 months) with supportive services; supportive services in a service center facility for homeless veterans not in conjunction with supportive housing; or to purchase vans.

The American Legion recommends \$200 million for the Grant and Per Diem Program for FY 2011.

Veterans Benefits Administration

Clearly, the current VA claims backlog is a major concern to The American Legion and the rest of the veterans' community. Aggressively addressing this growing problem will require actions from an array of approaches. The President's budget request proposes to add both increases in funding (\$460 million) and in personnel (4,048 new FTE). These increases will be helpful, but The American Legion believes more will be required to "turn the tide." The American Legion will continue to work with VA, Congress and the veterans' community to transform the current process into a more timely and accurate process. The American Legion applauds the \$13.4 billion in supplemental funding to address the newly approved Agent Orange claims.

Summary of Legislation Proposed in the FY 2011 President's Budget Request

In reviewing the proposed legislation in the President's budget request, The American Legion would like to address several of them in detail:

Compensation and Pensions—Proposed Legislation

- **Compensation Cost of Living Adjustment (COLA):** Legislation will be proposed to provide a cost of living increase to all Compensation beneficiaries, including DIC spouses and children, effective December 1, 2010. The percent increase will align with increases in the Consumer Price Index and the increase for Social Security benefits. However, current estimates suggest that the CPI will not increase; therefore, no COLA may be enacted.

The American Legion has no official position on this proposal.

- **Expansion of Concurrent Receipt of Department of Defense Retirement Pay:** Legislation will be proposed by the Administration to expand the veteran eligibility for concurrent receipt of military retirement pay and VA disability benefits to veterans who are medically retired from service by the Department of Defense. Eligibility will be phased in over five years based on the degree of disability assigned by VA. While the primary impact will be on Title 10 and the Department of Defense, VA estimates that the cost to VA of concurrent receipt expansion will be \$47 million in 2011 and \$254 million over the five-year period.

The American Legion supports this proposal. Since the offset comes from military retirement pay, The American Legion is somewhat surprised that VA would incur any costs.

- **Use of Health and Human Services (HHS) Data for Purposes of Adjusting VA Benefits:** Public Law 110-157 requires independent verification of HHS data for purpose of adjusting VA benefits based on economic need. This proposal seeks to remove the expiration date of 9/30/11 and extend through 2020. Benefit costs are estimated to be \$2.0 million in 2012 with a net savings in later years.

The American Legion has no official position on this proposal.

- **Special Monthly Pension for Wartime Veterans 65 years of age and older:** This proposal amends Section 1513 of Title 38 and repeals the Court of Appeals for Veterans Claims (CAVC) rendered decision in *Hartness v. Nicholson*. The decision affected the qualifications for the special monthly pension (SMP) awarded to veterans who are housebound (H/B). The court decision excluded the SMP requirement of being permanently and totally disabled for veterans 65 years of age and older. By repealing the court decision, a veteran will once again only be eligible for SMP if, in addition to basic pension qualifications, the veteran shows proof of being permanently and totally disabled. Once a veteran reaches age 65, the requirements for H/B pension will require a single disability rated at 100 percent, and a disability or combined disabilities (separate and distinct from the 100 percent disability) independently ratable to at least 60 percent. This proposal will provide for more equitable treatment of veterans under the pension program; currently, veterans with lower disability ratings may receive larger benefits than veterans who are permanently and totally disabled. The 2011 estimated savings is \$3.2 million with an anticipated caseload of 506,000.

The American Legion strongly opposes this proposal. The American Legion believes this proposal would take away a needed benefit provided to disabled elderly

wartime veterans as allowed by statute and confirmed in a precedential decision of the United States Court of Appeals for Veterans Claims.

- **VA Pension Limitations for Medicaid-covered Veterans Without Spouse or Children:** This provision limits the amount of pension payable to a veteran who has neither spouse nor child (or a surviving spouse with no child) and who is covered by a Medicaid plan for services furnished by a nursing facility. Title 38, U.S.C. section 5503(d) will expire on September 30, 2011. This proposal seeks to extend the expiration date an additional five years. Elimination of this provision would result in increased pension expenditures but money available to veterans and survivors would actually decrease. The maximum pension entitlement is not sufficient to cover the normal cost of nursing home care but receipt of that amount would result in the termination of Title XVI Medicaid benefits which currently cover nursing care costs in excess of the projected amount (\$90) that is payable to the veteran under this provision. This is likely to result in veterans and surviving spouses being unable to afford nursing care. This proposal will result in VA benefit cost savings of \$559.4 million and net government-wide savings of \$246 million in 2012. Mandatory VA savings through 2015 are estimated at \$2.3 billion.

The American Legion has no official position on this proposal.

- **IRS Income Data Matching for VA Eligibility Determinations:** Section 6103 (I) (7) of the Internal Revenue Code of 1986 (26 U.S.C. Section 6103 (I) (D)) requires the Secretary of the Treasury and the Commissioner of Social Security to disclose certain income information to any governmental agency administering certain programs, including VA's pension, dependency and indemnity compensation, and health-care programs. Section 5317 of Title 38, U.S.C., governs VA's use of that information. The duty of the Secretary of the Treasury and the Social Security Commissioner to disclose that information and VA's authority to obtain it from them will expire 9/30/2011. This proposal seeks to extend the expiration date for five years. While this proposal will result in net mandatory and discretionary savings of \$20 million in 2012, it will result in net mandatory costs of \$20 million in 2012. However, the proposal will result in net mandatory savings beginning in 2013 and net mandatory savings between 2011–2016 are estimated at \$21.9 million.

The American Legion has no official position on this proposal.

- **Clarification of Monthly Payment Option for the Month of Death for Compensation or Pensions:** This proposal will amend Title 38 U.S.C. 5310 and 5111 (c) (1) to clarify that all surviving spouses are entitled to receive payment in the amount of the veteran's compensation or pension rate for the month of the veteran's death, and to simplify administration of the month-of-death benefit.

The American Legion supports this proposal. There has been much confusion and misinterpretation of the law by VA regarding the month-of-death benefit that has deprived thousands of beneficiaries of the benefits to which they are entitled, causing additional heartache during an already painful period following the death of a loved one.

- **Extension for Contract Physicians to Perform Disability Evaluations:** P.L. 108–183, Section 704, provides authority under which examinations with respect to medical disability of applicants for compensation and pension benefits are carried out by persons not employed by the VA. These examinations are funded through discretionary funds, and there is no limitation to the number of VA regional offices involved. This authority, extended by P.L. 110–329, Section 105, will expire December 31, 2010. The proposal would extend the authority by two additional years to December 31, 2012.

The American Legion has no official position on this proposal.

Readjustment Benefits—Proposed Legislation

- **Change of Terminology for the Administration of the New GI Bill:** Title 38 U.S.C. uses the term “institution of higher learning” throughout chapter 36. For consistency, this proposal would adjust the administrative language of the new Chapter 33 benefit from the use of “institution of higher education” to “institution of higher learning.”

The American Legion has no official position on this proposal.

- **Change in VA Authority to Approve Educational Programs:** This proposal would amend 38 U.S.C. Chapter 36 to expand VA's authority regarding ap-

proval of courses for the enrollment of veterans (and other eligible persons) that are in receipt of educational assistance under the programs VA administers.

The American Legion has no official position on this proposal.

- **Extend the Delimiting Date for Caregivers Use of Education Benefits:** This proposal would amend Title 38 U.S.C. § 3031(d) and Title 38 U.S.C. § 3512, to permit the extension of delimiting dates for eligible individuals who could not pursue, or had to interrupt, a program of education while acting as the primary caretaker for a veteran or servicemember seriously injured while on active duty in a contingency operation after September 10, 2001.

The American Legion has no official position on this proposal.

- **Expand Employer Support Eligibility:** This proposal would amend Title 38, U.S.C., Section 3116 to expand eligibility for incentives paid to employers who provide on-job training and employment opportunities for veterans with service-connected disabilities who may be difficult to place in suitable jobs.

The American Legion supports this proposal. If enacted this legislative proposal would give employers a greater incentive to hire injured veterans who are trying to obtain gainful employment. The unemployment rate for veterans is above the national average, particularly for those between the ages of 18 to 24. The American Legion believes this legislation will greatly assist servicemembers in their transition into the civilian workforce and allow them to use their expertise and military training to fill desirable positions within high potential industries.

Housing—Proposed Legislation

- **Authority to Pool Loans:** Legislation will be proposed to extend the authority to pool loans for two years to December 2013. This will allow the VA to obtain the best pricing for the pooled and securitized loans and to continue selling loans at a greater return without any additional risk. VA estimates additional revenue of \$87 million in 2012 and overall increased revenue of \$190 million over the 2012–2014 period.

The American Legion has no official position on this proposal.

- **Permission of Occupancy of Veteran’s Child/Children:** Legislation will be proposed to allow occupancy by a dependent child to satisfy occupancy requirements of VA home loans. This will permit a veteran who is unable to occupy a property as his/her primary residence due to active duty status or overseas employment, to use his/her earned Loan Guaranty benefit. No significant costs are anticipated.

The American Legion has no official position on this proposal.

- **First Lien Exemption for Public Entities:** Legislation will be proposed to extend first lien exemption to public entities as well as private entities during disaster relief situations only. This will allow disaster relief agencies and veterans to have more options in the type of assistance available. No significant costs are anticipated.

The American Legion has no official position on this proposal.

Insurance—Proposed Legislation

- **VGLI Increased Coverage Act:** This proposal would provide an opportunity for veterans to increase VGLI coverage in increments of \$25,000 without medical underwriting. The opportunity will be available every 5 years with a total coverage not to exceed current legislated maximum SGLI. Current law limits the amount of VGLI allowed to the amount of SGLI at discharge and as a result, many service-disabled VGLI insured, have no opportunity to increase coverage to meet current family needs. This proposed change would allow veterans, including service-disabled veterans, to purchase adequate amounts of life insurance to protect their families. There are no PAYGO costs associated with this proposal and it does not impact the budget.

The American Legion strongly supports this proposal. The American Legion would welcome such an addition to the VGLI program. This addition would permit veterans who separated from service prior to the latest increases in SGLI coverage, and who are thus restricted by current law to a lower maximum amount of life insurance coverage than those veterans who separated from service after September 1, 2005, when SGLI maximum coverage was raised from \$250,000 to the current \$400,000, a periodic opportunity to increase their VGLI coverage consonant with changes in their family situation and the needs of their beneficiaries. This increases program flexibility and fairness, and provides a greater benefit to this portion of the

veteran population. The American Legion would like to comment further, however, that in the cases of severely service-disabled veterans, a federally subsidized premium relief or waiver element should be included to lessen the financial burden of VGLI's high premium costs, particularly in the older age groups.

- **SGLI Two Year Total Disability Extension Retention Act:** Under current law and procedures, if an insured servicemember is totally disabled at the time of separation from service, the member's SGLI coverage may be continued for up to two years, for free, following separation from service. Effective October 1, 2011, this provision expires and the SGLI extension period will be reduced from two years to 18-months. The SGLI Two Year Total Disability Extension Retention Act will allow for the indefinite retention of the two-year total disability extension period. By maintaining the SGLI Total Disability Extension period at two years, this will maximize the opportunity for totally disabled veterans, who have no hope of obtaining commercial insurance, to make informed decisions regarding their life insurance needs and options. It also guarantees that those most in need, who have been traumatized by their disabilities, will be fully covered under the SGLI program during this transition period with no action or cost on their part. There are no PAYGO costs associated with this proposal and it does not impact the budget.

The American Legion strongly supports this proposal. It is obvious that veterans who separate from service with such extensive disabilities as to render them totally disabled often require a substantial period of time to bring their personal and financial affairs into order, due to the debilitating nature of such disabilities and the resulting period of family adjustment, and so to assist them in later meeting the premium costs of VGLI coverage as the program's structure does not provide for any disability waiver of premiums as other federal and many private life insurance programs do. The American Legion further believes the process for this extension, which requires application by the veteran to the OSGLI center for such, be streamlined and automated so that veterans leaving active duty in a totally disabled status are automatically granted the extension shortly after separation.

Medical Care—Proposed Legislation

- **Homeless Providers Grant and Per Diem Program:** Legislation will be proposed to amend legislative authority in Title 38 U.S.C., Subchapter VII, section 2061, to obtain statutory authority to offer both capital grants and enhanced per diem payments to eligible community-based entities who serve special needs veterans including female homeless veterans, homeless veterans diagnosed with a chronic mental illness, and those veterans who are failing and/or terminally ill. This proposal would grant VA permanent authority to offer capital grants and per diem to agencies that create transitional housing and supportive services for homeless veterans with special needs; allow for enhancement of the current per diem rate for transitional housing services; and remove the requirement to provide grants to VA health care facilities.

The American Legion supports this proposal. If enacted, this legislative proposal would provide resources for public and private sector agencies and organizations who serve special needs veterans, including female homeless veterans, homeless veterans diagnosed with chronic mental illness and those veterans who are failing and/or terminally ill. With the VA and other homeless care service providers continuing to focus on the various needs (i.e., health issues, economic issues, lack of safe/affordable housing, and lack of family and social support networks) of homeless veterans, and the enactment of this legislation, The American Legion believes that homelessness rates will continue to drop among the veterans' community. The American Legion strongly supports taking the necessary means to combat and aid in ending veterans' homelessness.

- **Reinstate the Health Professional Scholarship Program (HPSP):** Legislation will be proposed to reauthorize the HPSP. The authority to provide the financial assistance will be established by extending the expiration date of the Department of Veterans Affairs Health Professional Scholarship Program described in Title 38, U.S.C., Sections 7611–7618. The HPSP, established by Public Law 96–330, awarded scholarships from 1982 through 1995 to 4,650 students earning baccalaureate and masters degrees. Authority for the program expired in 1998. It is recommended that the Health Professional Scholarship Program be reauthorized and funded because there is no other scholarship program with a VA service obligation available to the public at this time. This program, if reauthorized, will provide financial assistance to competitively selected schol-

arship recipients in exchange for 2-year VA service obligations upon graduation and licensing.

The American Legion supports this proposal. The Health Professional Scholarship Program maintains the Department of Veterans Affairs presence in the competitive medical professional market, as well as helps to lower the attrition rate amongst medical professionals employed at VA Medical Centers (VAMC).

- **Remove Requirement that VA Reimburse Certain Employees for Professional Education:** Legislation will be proposed to eliminate Title 38, U.S.C., section 7411 that states “The Secretary shall reimburse any full-time board certified physician or dentist appointed under section 7401 (1) of this Title for expenses incurred, up to \$1,000 per year, for continuing professional education.” VHA has a long history of providing educational and training support to all clinical and administrative staff. The Employee Education System and VA Learning University offer a large course catalog with opportunities for physicians and dentists, as well as other occupations, to obtain continuing professional education at VA expense. VHA will continue to manage training and education funding within long-standing parameters in conjunction with published policies at the national and local levels. Continuance of the entitlement in section 7411 is no longer necessary, given the improved competitive recruitment position resulting from the new pay system.

The American Legion has no official position on this proposal.

- **Provide Care for Newborns as Part of the Uniform Benefits Package:** Legislation will be proposed to amend Title 38, U.S.C., to authorize VA to provide care to newborns of enrolled women veterans who are receiving maternity care through the Department of Veterans Affairs. This proposal is to cover costs of newborn hospitalization and is not to exceed 96 hours after delivery. Longer hospitalization or outpatient costs for the newborn, beyond 96 hours post-delivery, would not be authorized in this maternity benefit.

The American Legion has no official position on this proposal.

- **Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Coverage for Caregivers:** Legislation will be proposed to provide health care coverage through CHAMPVA for any caregiver without entitlement to other health insurance or coverage. Caregivers for severely wounded veterans are in most cases impacted by their inability to sustain employment related health coverage. CHAMPVA health care coverage will help relieve the financial burden of health care costs incurred by the caregiver of severely wounded veterans and allow them the reassurance that their medical care needs will be met while they care for the medical needs of the veteran. This in turn will reduce veterans’ stress as they will not need to worry about how their caregivers health related needs are met.

The American Legion supports this proposal. This legislative proposal would adequately provide timely access to quality health care for those who are unselfishly caring for the Nation’s veterans.

- **Travel Expenses, including Lodging and Subsistence, for Caregivers:** Legislation will be proposed to provide travel, incidental expenses [e.g., per diem (inclusive of lodging allowance), tolls etc.] and subsistence for a caregiver of qualifying veterans receiving care for service-related conditions at a VA or VA authorized facility. The Department does not have authority to provide lodging expenses to an attendant if the veteran is not lodging with the attendant. Since the veteran’s caregiver in most cases is a close family member, providing travel expenses for the caregiver assures the veteran has the appropriate support while traveling to a VA health care facility. This will allow the veteran’s health care provider to communicate directly to the veteran’s caregiver about the needs of the veteran. This will also ensure continuity of the veteran’s care and help the caregiver better understand the needs of the patient.

The American Legion supports this proposal. This legislative proposal would help to ensure veterans receive complete and uninterrupted care.

- **Education and Training for Caregivers:** Legislation will be proposed to allow VA to develop caregiver education materials for caregivers and individuals who support caregivers. In addition, VA would provide outreach to veterans and their caregivers to inform them of the support available through VA as well as public, private, and non-profit agencies. VA currently provides education and training for veterans and their caregivers regarding medical issues. This proposal would codify and expand those efforts. These programs generally dem-

onstrate significant reduction in caregiver burden and the impact of depressive symptoms on their daily life. This proposal provides VA with the opportunity to implement a formal approach to educating and training caregivers so they are better prepared to care for the veteran.

The American Legion supports this proposal.

- **Survey of Caregiver Needs:** Legislation will be proposed to conduct a caregiver survey every 3 years to determine the number of caregivers, the types of services they provide to veterans, and information about the caregiver (age, employment status, and health care coverage). Currently, VA does not have adequate information on the number of caregivers, the number of family caregivers, and the number of veterans receiving caregiver services from caregivers and family caregivers, including the era in which each veteran served in the Armed Forces.

A survey of veteran caregivers will allow VA to gather needed information that will be used to better understand the population of caregivers and to identify and understand their specific needs. This information will allow VA to appropriately develop education, training, and support programs for veteran caregivers.

The American Legion supports this proposal.

- **Nonprofit Corporations:** Legislation will be proposed to establish a Central Nonprofit Corporation for VA research. Currently, there are 88 of these VA affiliated Non-Profit Corporations (NPC). Each NPC is required to report annually a detailed statement of their operations, activities and accomplishments during the previous year. The purpose of the central Non-Profit Corporation will be to: (1) carry out national medical research and education projects under cooperative arrangements with VA, (2) serve as a focus for interdisciplinary interchange and dialogue between VA medical research personnel and researchers from other federal and non-federal entities, and (3) encourage the participation of the medical, dental, nursing, veterinary, and other biomedical sciences in the work of the central NPC for the mutual benefit of VA and non-VA medicine. The central NPC would enable facility directors or the Under Secretary for Health to have an alternative to individual medical-center-based NPCs in those facilities in which the volume of research and education does not enable the resources to assure adequate management controls.

The American Legion has no official position on this proposal.

- **Clarify Breach of Agreement under the Employee Incentive Scholarship Program (EISP):** Legislation will be proposed to amend Title 38, U.S.C., chapter 76, section 7675, subchapter VI, to provide that full-time student participants in the EISP would have the same liability as part-time students for breaching an agreement by leaving VA employment. The current statute clearly limits liability to part-time student status participants who leave VA employment prior to completion of their education program. This allows a scholarship participant who meets the definition of full-time student to leave VA employment prior to completion of the education program, breaching the agreement with no liability. This proposal would require liability for breaching the agreement by leaving VA employment for both full- and part-time students. All other employee recruitment/retention incentive programs have a service obligation and liability component. This proposal would result in cost savings for the Department by recovering the education funds provided to employees who leave VA employment prior to fulfilling their agreement.

The American Legion has no official position on this proposal.

- **Consider VA a Participating Provider for Purpose of Reimbursement (revenues):** Legislation will be proposed that would allow VA to be treated as a participating provider, whether or not an agreement is in place with a health insurer or third-party payer, thus preventing the effect of excluding coverage or limiting payment of charges for care. With the enactment of the Balanced Budget Act of 1997 (BBA), Congress changed the health insurer and third-party program into one designed to supplement VA's medical care appropriations by allowing VA to retain all collections and some other copayments. VA can use these funds to provide medical care to Veterans and to pay for its medical care collection expenses. This law also granted VA authority to begin billing reasonable charges versus reasonable costs for care. Reasonable charges are based on the amounts that health insurers and third-party payers pay for the same care provided by non-government health care providers in a given geographic area. This proposal would prevent a health insurer or third-party payer from denying

or reducing payment, absent an existing agreement between VA and any health maintenance organization, competitive medical plan, health care prepayment plan, preferred provider organization, or other similar plan, based on the grounds that VA is not a participating provider.

The American Legion supports this proposal.

- **Military Surgeon Association:** This proposal would make the Department of Veterans Affairs (VA) an Incorporated Member of the Association of Military Surgeons of the United States (AMSUS). As a result, VA would be authorized to participate in AMSUS activities to the same extent as the military services.

The American Legion has no official position on this proposal.

- **Technical Changes to Fee Basis Authority:** This proposal would amend Title 38 U.S.C. 1703(a) by adding language similar to the language found in Title 38 U.S.C. §8123, Procurement of prosthetic appliances, which will strengthen the Department's interpretation of legal authority to purchase health care on an individual basis when needed.

The American Legion supports this proposal. This legislative proposal would seek to ensure veterans receive adequate and timely care, to include medical appliances.

- **Mandatory Disclosure of Social Security Number (SSN) and 3rd Party Health Insurance:** The provision would deny access to hospital care, nursing home care, or medical services that may be provided to any person under the provisions of Title 38 U.S.C. chapter 17 unless that person has disclosed his/her social security number and the social security number of any dependent or beneficiary and furnish VA with current, accurate third-party health insurance information.

The American Legion has no official position on this proposal.

- **Permanent Authority for Co-Pays:** The provision would amend Title 38 U.S.C. § 1710 (f)(2)(B) to make permanent VA authority to collect an amount equal to \$2 or \$10 for every day the veteran receives hospital care for a veteran who is required to agree to pay to the United States the applicable amount determined under paragraph (2) or (4) or this subsection. This current authority expires September 30, 2010.

The American Legion has no official position on this proposal.

- **Permanent Authority for Collections:** The provision would amend Title 38 U.S.C. § 1729 to make permanent VA authority to recover reasonable charges for care or services for care of nonservice-connected conditions from a third party to the extent that the veteran who has a service-connected disability would be eligible to receive payment for care or services from a third party if the care or services were not provided by VA. This current authority expires October 1, 2010.

The American Legion has no official position on this proposal.

- **Eliminate and Change Dates for Certain Congressional Reports:** This proposal would eliminate the Report on Pay for Nurses and Other Health Care Personnel (Title 38, U.S.C., Section 7451(f)) and Report on Long-Range Health Planning (Title 38, U.S.C., Section 8107) and modify the due date and limit the duration of the Annual Report on Federally Sponsored Gulf War Research Activity.

The American Legion has no official position on this proposal.

- **Codify Rules on Billing of Veterans in CHAMPVA:** This proposal would modify Title 38 U.S.C. § 1781 to codify, consistent with regulations, that the VA determined allowable amount for reimbursement of medical services represents payment in full and the health care provider may not impose additional charges on the beneficiary above the VA-determined allowable amount.

The American Legion has no official position on this proposal.

Other Legislative Proposals

- **Staying of Claims:** This proposal would amend Title 38, U.S.C., to permit the Secretary of Veterans Affairs (VA) to delay adjudications as needed to preserve program integrity and to clarify that the Board of Veterans' Appeals (Board) may decide certain cases out of docket order.

The American Legion opposes this proposal. The American Legion would oppose VA from initiating stays involving implementation of precedential federal court

decisions pending the appeal of the decision without seeking permission of such a stay from the court as is the current practice. The current procedure for initiating stays in claims adjudication in such instances allows for VA to preserve program integrity but also provides a check by not allowing VA to circumvent the court's authority.

- **Revise Time Limits and Dates for Herbicide and Gulf War Presumptions:** This proposal would modify statutory time limits to the review and rule-making process.

The American Legion has no official position on this proposal.

- **Repeal Obsolete Ethics Provision:** This proposal would eliminate the blanket prohibition against VA employees having interests in, or receiving income or services from, certain for-profit educational institutions.

The American Legion has no official position on this proposal.

- **Notice of Disagreement Filing Period:** This proposal would amend Title 38 U.S.C. § 7105(b)(1) to reduce the time period for filing of a notice of disagreement (NOD) following the issuance of a rating decision from one year to 180 calendar days.

The American Legion strongly opposes this proposal. Claimants currently have one year to initiate the appeals process following the issuance of a VA rating decision by filing a notice of disagreement. Arbitrarily reducing this period from 1 year to 6 months for the sake of expediency serves no purpose other than to adversely impact appellants who miss the 6 month cut off. If the percentage of appellants who file after 6 months is large, then a large group of appellants would be denied their appellant rights. If the percentage of those who file after 6 months is small, then there can be no great benefit to timeliness by implementing this change.

- **Automatic Waiver of Agency of Original Jurisdiction Review of New Evidence:** This proposal would amend Title 38 U.S.C. § 7105 to specifically incorporate an automatic waiver of agency of original jurisdiction (AOJ) consideration for any evidence submitted to VA by the appellant or his or her representative following VA's receipt of a VA Form 9 substantive appeal, unless the appellant or his or her representative expressly chooses in writing not to waive such jurisdiction.

The American Legion supports this proposal. The American Legion believes the automatic waiver of agency of original jurisdiction (AOJ) review in instances where the claims file has already been certified and transferred to the Board of Veterans' Appeals (BVA). However, as it takes an average of approximately 600 days for the regional offices (RO) to transfer an appeal to the BVA after the substantive appeal has been filed, an automatic waiver of AOJ review and or submission of the evidence directly to the BVA after the substantive appeal has been received would cause additional delay if the claims file is still at the regional office. It is also in the best interest of the appellant for the RO to review evidence and issue a decision, after the appeal has been perfected, in instances where the claims file is still at the RO and the evidence submitted would allow a grant of the benefit sought. As it now takes a year or more, depending on docket date, for the BVA to make a decision after it has received the claims file, automatically waiving AOJ review in such instances would cause unnecessary delay.

The American Legion also suggests the consideration of legislation addressing the inordinate amount of time it takes the AOJ to certify and transfer the appeal to the BVA after a substantive appeal is received.

- **Board of Veterans' Appeals Video Hearings:** This proposal would amend Title 38 U.S.C. § 7107(d)(1) and (e)(2) to allow the Board to determine the most expeditious type of hearing to afford an appellant (i.e. an in-person hearing or a video conference hearing), restricting the appellant to the hearing selected by the Board unless good cause or special circumstances are shown to warrant another type of hearing.

The American Legion opposes this proposal. The American Legion does not support a denial of the appellant's right to choose the type of Board of Veterans' Appeals (BVA) hearing he or she desires. The majority of BVA appellants do not opt to have a personal hearing and taking away their right to choose their preferred option serves no good purpose.

- **Board of Veterans' Appeals—Rationale in Decisions:** This proposal would amend Title 38 U.S.C. § 7104(d)(1), to define "reasons or bases" to mean "a plau-

sible statement of the reasons for the Board's ultimate findings of fact and conclusions of law."

The American Legion has no official position on this proposal.

- **Definition of Prevailing Party for the Equal Access of Justice Act (EAJA) and Veterans Benefits Appeals:** This proposal would amend the definition of "prevailing party" for purposes of establishing eligibility to receive attorney fees and expenses fees under Title 28 U.S.C. § 2412 of the Equal Access of Justice Act (EAJA) for cases handled by the United States Court of Appeals for Veterans Claims (Court).

The American Legion has no official position on this proposal.

- **Filing of Substantive Appeals:** This proposal would amend Title 38, U.S.C., § 7105(d)(3), to establish a clear time period for filing a substantive appeal in order to perfect an appeal to the Board of Veterans' Appeals (Board), to make the filing of a timely substantive appeal a jurisdictional requirement for Board review, and to establish that finality attaches to any matter in which a timely substantive appeal is not filed, all for the purpose of promoting efficiency in the adjudication process.

The American Legion is deeply concerned about the potential impact this proposal will have, but without reviewing the exact statutory language we are unable to provide specific comment.

- **Advisory Committee on Homeless Veterans:** This proposal would extend the Congressional authority to continue the Advisory Committee for Homeless Veterans (ACHV) for an additional three years until 2014.

The American Legion supports this proposal. VA's new initiative to eliminate homelessness among the veterans' population in five years will require this Committee's insight and guidance to making this endeavor a reality.

- **Title 38 Pay Authority To Maintain On-Call Pay for Information Technology (IT) Specialists in VA OI&T:** This proposal would amend Title 38 to continue to allow Title 5 IT Specialists authority to serve in an "on-call" status and receive "on-call" pay because of the requirement to support VA's health care mission 24 hours a day, 7 days a week.

The American Legion has no official position on this proposal.

- **Title 38 Pay Authority To Recruit and Retain Health Care Professionals in VA OI&T:** Legislation will be proposed to allow the Office of Information and Technology (OI&T) Title 38 Pay Authority. This will enable OI&T to recruit and retain health care professionals in leadership positions.

The American Legion has no official position on this proposal.

- **Office of Small Business Programs:** This proposal would change the name of the Office of Small and Disadvantaged Business Utilization to the Office of Small Business Programs. This change will bring VA into alignment with DoD's name change in accordance with the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163, Section 904).

The American Legion has no official position on this proposal.

- **Real Property Enhanced Use Leases (EUL):** Legislation will be proposed to extend the current EUL authority from its expiration date of December 31st, 2011 for five years, until December 31st, 2016.

The American Legion has no official position on this proposal.

- **Franchise Fund:** This proposal would modify Public Law 109-114, Military Quality of Life and Veterans Affairs Appropriations Act of 2006, to provide a better financial procedure for the VA Franchise fund to more quickly return refunds to customers when improper payments are inadvertently made by the fund on the customer's behalf.

The American Legion has no official position on this proposal.

- **VA Police Uniform Allowances:** This proposal would update Title 38 U.S.C. § 903-Uniform Allowance for Department Police Officers to make the uniform allowance paid to Department police officers consistent with current Federal statute and regulations.

The American Legion has no official position on this proposal.

CONCLUSION

Mr. Chairman and Members of the Committee, The American Legion will continue to review the President's budget request. The American Legion had less than 24 hours to review the President's budget request and prepare this written testimony.

Once again, The American Legion supports:

- **Increases funding for VA in FY 2011 by \$11 billion above the FY 2010.**
- **Increases funding for VA's medical care by \$4 billion in FY 2011 and a projected \$2.8 billion increase in FY 2012 to \$54.3 billion.**
- **Expands enrollment for 500,000 additional Priority Group 8 veterans by FY 2013.**
- **Enhances outreach and services related to mental health care and cognitive injuries, including post-traumatic stress disorder and traumatic brain injury, with a focus on access for veterans in rural and highly rural areas.**
- **Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.**
- **Full concurrent receipt of military retirement pay and VA disability compensation without offsets.**
- **Combats homelessness by safeguarding vulnerable veterans. Facilitates timely implementation of the comprehensive education benefits that veterans earn through their dedicated military service.**

The American Legion welcomes the opportunity to work with this Committee and the Administration on the enactment of a timely, predictable and sufficient budget for the Department of Veterans Affairs.

Mr. Chairman, this concludes my testimony and The American Legion would welcome any questions you or your colleagues may have.

**Prepared Statement of Richard F. Weidman,
Executive Director for Policy and Government Affairs,
Vietnam Veterans of America**

Good morning, Mr. Chairman, Ranking Member Buyer, and distinguished Members of the committee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to offer our comments on the President's Budget Request for FY 2011. All of us at Vietnam Veterans of America (VVA) wish to thank the leadership shown by this committee, by the leadership of the Budget Committee and of the Appropriations Committee, as well as the Speaker and the leadership of the House of Representatives for your vision in leading the struggle to enact Advance Appropriations. Further, your extraordinary vision in securing the dramatic increases in funding for Department of Veterans Affairs (VA) in both the medical system and in the Veterans Benefits Administration in the last three years has been nothing short of laudatory, and we applaud you for it.

First let me note that Vietnam Veterans of America (VVA) is one of the many organizations that has endorsed *The Independent Budget* of the Veterans Service Organizations (IBVSO). We commend our colleagues at the Veterans of Foreign Wars, AMVETS, Paralyzed Veterans of America, and the Disabled American Veterans for their excellent work on this major undertaking, and thank them for the strenuous effort it takes to produce this excellent document each year.

Further, VVA commends President Obama and his Administration for submitting a budget request that continues to move us toward the goal of full funding of the health care and benefits earned by virtue of military service. It is a relatively "lean year" in regard to the Federal Budget request, yet the President has recognized that caring for "he—or she—who hath borne the battle" and their survivors is both part of the cost of war as well as the duty of the nation and our citizenry. Therefore the President has exempted programs that serve veterans from the projected budget freeze along with the Department of Defense, Department of Homeland Security, and other programs vital to protecting the country.

While VVA does endorse the IBVSO in the main, and lauds the President's Budget Request, there are a few areas that we must comment where we see some needs that are not included in either the IBVSO or in the President's Budget Request for VA.

First, VVA strongly supports the need to indicate where some of the appropriations increases need to be focused by VA managers, such as Post Traumatic Stress Disorder (PTSD) services. The reason for this is that all too often in the past Con-

gress has appropriated additional funds to deal with specific needs, and the money has been redirected at other areas of operation. The well documented instance of money specifically directed by the Congress to start to more properly address the scourge of Hepatitis C a decade ago is one glaring incident of this behavior by VA. Even after being pressed hard by the Congress and the General Accountability Office (GAO), VA could not account for the majority of the funds that were supposedly directed toward correcting the deficiencies of the VA health care system in diagnosing and treating Hepatitis C. There is therefore a natural inclination to ensure that this type of thing does not happen again, both on the part of top managers in the Executive branch and in the Congress.

However, because so much of the funding was centrally directed from Washington, VISN Directors and VA Medical Center Directors reported to us last year that they could not meet certain needs because they only got a small increase of funds from FY 2008 to FY 2009 and/or FY 2009 to FY 2010. Usually those reported increases were from 1 percent to 3 percent. This of course caused VVA to ask how this could be, given that there was a much larger increase than that in the appropriation of the medical operations account? Where did the money go? We were told that it was in the special accounts, such as for PTSD. However, some of the unmet needs that local VA managers said they could not meet because of tight budgets were for additional clinicians to deal with PTSD problems of young soldiers returned from the current conflicts.

The argument against making medical care part of the mandatory side of the budget as opposed to keeping it where it is now, in the discretionary side of domestic spending was that Congress would not have adequate control over how the funds were spent. That was persuasive to the veterans' community, so all agreed that we should go to advance appropriations. With the strong leadership here in the House, and Senator Akaka and his colleagues in the Senate, as well as President Obama, we have achieved this important milestone. As you know, VVA's top legislative agenda item for the 11th Congress was Advance Appropriations for VA health care. Now that this has been achieved, our top legislative agenda item is to assist the Congress in securing much greater accountability in both the efficiency and effectiveness of how each appropriated dollar is spent. What we are saying is that the Director of each Veterans' Integrated Service Network (VISN) and of each VA Medical Center (VAMC) must be given funds to be able to handle the increased costs of everything from electricity to salary to supplies, and then held accountable for how well they use those dollars to deliver high quality medical care to every eligible veteran. VVA suggest that several billion be added to the pool of funds that is sent out to the VISNs under the allocation model. VVA further suggest that Congress direct VA to re-examine the Veterans Equitable Resource Allocation (VERA) model to make it a more finely tuned instrument for allotting resources. At present the VA medical facilities in the north are being shortchanged because the veterans who have resources move south, leaving generally the veterans who are poorer, sicker, and in need of more medical services than the more affluent ones who move to warmer climates. The two tiered system currently employed does not sufficiently account for this phenomena, thereby leaving those VISNs in the north without adequate resources to meet the needs of the veterans in their catchment area.

This does not mean that the President's request should not ask for targeted dollars (e.g., for PTSD, for increased services to homeless veterans, etc.), but that as this is passed down to the local level for actual delivery of services, how much goes where needs to be transparent. VVA National President wrote to VA on April 9, 2009 asking for the allocation by VSN and by VAMC of medical care dollars. While it was partly answered within 30 days, the only information provided was for the previous (FY 2008) Fiscal Year. It is now almost halfway through the second quarter of FY 2010, and we are still waiting for that answer, despite having made repeated efforts to secure same. This is just not acceptable.

Need for Much Greater Transparency in VHA

It is clear to us that mechanisms to achieve a much higher degree of transparency in all parts of the Veterans Health Administration (VHA) needs to be restored, and the trend toward secretiveness that started in 2003-2004 needs to be sharply reversed. There is no better way of securing the undivided attention of the permanent managers employed in the VHA than to make such mandates part of the appropriations process/language, both in the text of the law and in the report language. VVA encourages the Committee to suggest possible language to the Budget and Appropriations Committees in your views and estimates statement.

Further, there needs to be much more consultation and sharing of information between key officials in the VHA and leaders of the veterans' community. The fact that much of the meetings of the Seriously Mentally Ill Advisory Committee now

meets in secret, and the Advisory Committee on PTSD meets totally in secret should give everyone pause, particularly after the missteps and serious problems with these services at VA over the last four or five years.

Outreach and Education to Open the System to ALL Eligible Veterans

VVA encourages the Congress to continue and accelerate the lifting of the restrictions imposed in January 2003, and to allow so-called Priority 8 veterans to register and use the system. As a key element in this effort, VVA strongly urges the Congress to mandate that there be a line item in each division of VA specifically for outreach and education, and that all of these efforts be coordinated through the Office of the Assistant Secretary for Intergovernmental and Public Affairs. Having been turned away one or more times by the VA, many of the veterans who they are trying to reach are very skeptical (to say the least) about responding to any letters that VA may send them to ask them to come in and register for health care services.

If it is to be successful, this effort must be coordinated, done on a media market by media market basis, and involve the Veterans Service Organizations and other key players if it is to be successful in drawing these veterans back to VA.

Veterans Economic Opportunity

While VVA supports adding additional claims processors to the Compensation and Pension system, it is equally important to add additional staff to the rolls of VA Vocational Rehabilitation. VVA strongly favors reorganizing VA to create a fourth element of VA that would be known as the Veterans Economic Opportunity Administration, giving the current Secretary the opportunity to establish a new corporate culture in the VEOA that focuses on helping veterans to be as autonomous and as independent as possible. Frankly, getting, and keeping, veterans who are homeless off of the street a major goal of VA should make expansion of the VA Vocational Rehabilitation program a top priority, both for adding rehabilitation specialists, and for adding more employment placement specialists. There are currently less than 100 employment placement specialists for the entire nation. We have excellent leadership at the top of VA Vocational Rehabilitation Service now. It is time to give her the staff and the resources needed to assist veterans to obtain and sustain meaningful employment at a living wage. It is important that we add at least 400 staff members to the VA Voc Rehab staff, with many of those being placement specialist. If we can add 4,000 new staff members to process claims, then we should be able to add 400 staff to help veterans return to work.

VA Research

While VVA supports the request for \$590 million for VA Research & Development, we hope that all recognize that this is not nearly enough for the tasks at hand. Frankly, much of these funds go to research projects that keep the medical "stars" at VA in the VAMC that are affiliated with a medical school. This is fine, and a useful function. However, there is a glaring need for funding into the wounds, maladies, injuries, illnesses, and medical conditions that stem from service by American citizens in our Armed Forces. The National Institutes of Health (NIH) does virtually no specific veteran related research. Similarly, the same is largely true of the Center for Disease Control (CDC), the National Academies for the Advancement of Sciences (NAAS), and the Agency for Health Research Quality (AHRQ). While VVA strongly supports the work of all of these fine institutions as the only VSO to be a member of the "Research America!" coalition, we also know that there is an immediate and pressing need for veteran specific research. This vitally needed research would include, but not be limited to, projects such as research into the genochromosomal effects of Agent Orange and other toxins across multiple generations, possibly causing health anomalies in grandchildren and great-grandchildren of veterans exposed. Or, similarly, the consequences in regard to MS or MS-like conditions in veterans or the possible birth defects of children of those exposed to the cloud of chemical and biological weapons detonated in Iraq at the end of Gulf War I.

If it is necessary to create a new branch of VA that would be called the Division of Extramural research in order to make it possible to have such directed research grants available to those inside and outside of VA on a competitive basis, then VVA recommend that we move in that direction, and fund these activities to the level of at least \$2 Billion by the year 2015, with commensurate increases of \$260 + million each year to reach that level. Frankly this is important both for the health of current and future veterans already exposed, but also as a force health protection activity that will assist in preventing such maladies in the future, which makes it necessary for our national security.

In this regard in the short term, VVA strongly urges the Congress to allocate an additional \$30 million for VA to begin to analyze and study the mountains of epide-

miological evidence that it has on veterans of every generation, to meet Secretary Shinseki's desire that we not "wait for an Army to die" but rather get answers about patterns of health care problems now, without waiting for prospective studies in the future.

Automating VA IT Functions and Outreach

VA has an ambitious set of proposals to bring the department into the 21st century, and VVA enthusiastically supports these initiatives. However, we are still troubled that VA wants an electronic medical record system that can communicate with the Department of Defense and the private sector, but which will still not be able to communicate with the Compensation & Pension Service.

Further, while we can all be proud that the VA's electronic health care record "VistA" is so popular that it is now being exported to the private sector, VVA is still troubled that this is occurring without a field being added for military history, thereby sending an implicit false message to the private sector that exposures and experiences in military service have no significant impact on the long-term health care risks for veterans. I think it is safe to say that most know this to not be the case for all too many veterans.

Mr. Chairman, thank you for this opportunity to share our thinking and recommendations on these matters.

Prepared Statement of Paul Rieckhoff, Executive Director, Iraq and Afghanistan Veterans of America

Chairman Filner and Ranking Member Buyer, thank you for the opportunity to testify on behalf of Iraq and Afghanistan Veterans of America (IAVA) regarding the "VA's Budget Request for Fiscal Years 2011 and 2012." IAVA is the Nation's first and largest non-partisan, nonprofit organization representing veterans of the wars in Iraq and Afghanistan, and we are honored to be invited here today.

We've come a long way since 2004, when my infantry platoon and I first got home from Iraq. The era of rationing health care for our Nation's veterans, due to late and insufficient funding, has finally ended. Nearly two decades ago veterans' advocates began demanding "sufficient, timely and predictable" funding for the Department of Veterans Affairs. Last year, this Congress and Administration finally delivered. With record increases for the third year in a row, the VA budget was more than just "sufficient." And although the budget was passed 2 months after the start of the new fiscal year, by providing funding for fiscal years 2010 and 2011 we finally had a "timely" and "predictable" VA budget. IAVA didn't exist when this campaign began, but we were proud to be a part of the battle and advance appropriations was our top priority last year. We are sincerely grateful for the work that the Members of this Committee and the veterans groups seated here today did to make advance appropriations possible.

I'm sure the Members of this Committee agree that our work is far from over. Right now, thousands of veterans are unemployed, more than 100,000 are homeless, and hundreds of thousands are desperately waiting months, and sometimes years, for their well-earned VA benefits. Veterans, like former Army Specialist and IAVA member Casey Elder, who suffered a Traumatic Brain Injury when her Humvee struck a roadside bomb in Baghdad in 2004. After nearly a year of waiting, and despite clear evidence for a disability rating from the VA's own neurologist, Casey's initial claim has been denied. She has since appealed the decision, but it could take up to two years for Casey to receive compensation—if she receives it at all.

VA employees are highly-dedicated, and we're extremely appreciative of their service to veterans. However, the Department of Veterans Affairs must do better. It must do better for Casey Elder, and for veterans of all generations. IAVA believes that this year's VA budget request of \$125 billion for fiscal year 2011 and \$50 billion in advance appropriations for health care in 2012 signals the beginning of this new era. One might even be tempted to call this the "advance appropriations era," but we will borrow a term from VA Secretary Shinseki, and call it the "Transformation Era." Government budgets are the clearest expression of a Nation's priorities. IAVA believes that this VA budget and all future budgets, during this transformative era, should be evaluated on the following four principles:

- Guarantee the Best Care Anywhere
- Modernize Benefits Delivery
- Recruit Veterans and their Families into the VA system
- Support Female Veterans

True VA transformation will mean building a VA capable of handling the care of veterans and their families recovering from multiple injuries. Transformation means satisfying the expectations of an internet generation who can track a package anywhere in the world, but have no idea what happens to their VA claims once they are mailed. Transformation means treating a rapidly increasing number of female veterans using VA facilities. Transformation means providing top quality care for the surge home of veterans of Iraq and Afghanistan. And transformation means realigning resources to accommodate a steadily declining national veterans population. Transformation will not be easy. But working together, we can make it a reality by focusing on the following areas:

I. Guarantee the Best Care Anywhere for Veterans

The VA Funding Levels Must Match the Independent Budget Recommendations

To continue to provide the best care anywhere for our veterans the VSO Independent Budget (IB) recommendations should be the standard for future VA budgets. The IB budget is a blueprint for constructing a VA budget that meets the needs of our Nation's veterans. IAVA fully endorses it. We are grateful that VA funding levels have matched and sometimes exceeded the IB recommendations over the past three years. And we are pleased that the President's VA budget request for 2011 appears to have also met the IB's recommendations. We hope to see this convention for years to come.

The VA Must Collaborate with All Stakeholders to Successfully Implement Advance Appropriations

In addition to sufficiently funding the VA we must ensure the responsible and successful implementation of advance appropriations for veterans' health care. Successful implementation hinges on the VA's ability to accurately project their financial needs two years in advance. Everyone here knows this is no small task. I know from personal experience running a dynamic organization that projecting needs one year in advance is difficult. Tackling the budget for the largest health care provider in the United States two years in advance will require a herculean collaborative effort involving the VA, Congress and the veterans' community.

Successful collaboration on this scale requires complete transparency throughout the entire budgeting process. Previous Presidential VA budget submissions were developed using projection models based on proprietary data and political scrubbing at OMB that were not made public. The VA must eschew this closed door approach and embrace a fully transparent budgeting process where all stakeholders have access to the core budget data and the projection models being used. While it may not make for great ratings on C-Span, opening the budgeting process to review and critique will allow the VA to harness the full expertise of Congress and the veterans' community.

VA's implementation of the new GI Bill last year was another transformative program that required an extraordinary effort. Arguably, one of the most valuable lessons learned during that process is that when the VA reaches out and involves Congress and the veterans' community in their decision-making process the overall implementation runs more smoothly. For example, The VA held three town hall meetings to develop their implementation regulations for the New GI Bill. After these meetings they issued rules that students, schools and veterans groups accepted and generally understood. This was a successful collaboration. Alternatively, when the VA did not collaborate, and acted unilaterally, the GI Bill veered off course. This resulted in unacceptable delays and widespread confusion. The message to the VA from IAVA and the VSO community is clear: we are here to help. But you have to answer the phone and listen to what we are hearing from our Members.

II. Modernize Benefits Delivery

It's long overdue to bring our benefits system into the 21st Century. Iraq and Afghanistan veterans, like Casey Elder, the wounded veteran I described earlier, are receiving benefits under a VA disability system that was outdated years before most of them were born. This antiquated system, which focuses on quantity over quality, leads to frequent errors, mountains of bureaucratic red tape, and a lengthy wait for benefits. With the VA benefits backlog nearing 1 million claims, the need for transformation has never been greater. We therefore join with the chorus of other veterans groups in recommending that the VA modernize their claims processing system by digitizing records, holding processors accountable for the accuracy of their work, and removing unnecessary steps in the evaluation process. This issue is of the utmost importance and urgency so IAVA has made disability reform our number one legislative priority for 2010. These issues are further described in IAVA's

groundbreaking issue report, “Red Tape: Veterans Fighting New Battles for Care and Benefits,” available outside the door today and at www.IAVA.org/reports.

The greatest obstacle to the VA’s modernization of benefits delivery is its archaic IT system, which cannot exchange electronic health records between DoD and VA and does not allow veterans to track the processing of their benefits claims. The DoD still relies on a paper-based system for military service records, and as troops transition from the DoD to the VA, medical records and military service records regularly get lost in the shuffle. Hundreds of thousands of wounded troops and veterans are forced to wait months, and sometimes years, for disability compensation because of these IT deficiencies. VA and DoD have been working on the ability to seamlessly share veterans health records for over a decade, but progress has been slow and transparency limited.

In April 2009, the Administration announced a bold initiative to create the Lifetime Verification Electronic Record (LVER), integrating health and service data into a format usable between DoD, VA and the private sector. If successful, benefits processing time will be cut by months and veterans will receive higher quality health care across the board. A project of this magnitude is something in our world akin to landing a man on the moon, and should be given all the resources and attention necessary to ensure success. Like advance appropriations and the GI Bill, this initiative will require a truly collaborative effort on all of our parts.

IAVA is pleased to see that the President’s budget submission contained \$52 million for the development of the LVER. We look forward to seeing regular progress reports from the VA on the strategic goals to have the LVER up at 3 pilot sites by the end of the year and to have developed a working prototype by 2012. And we encourage VA to work with Congress and the veterans’ community to ensure that adequate resources are being provided to guarantee the success of this critical initiative.

Upgrading these systems better serves our veterans and also makes the system more efficient. Efficiency results in significant cost savings, low hanging fruit in a time of historic national deficits. We are glad to see the VA bringing in one of IAVA’s Board members, Craig Newmark—the Craig in Craigslist. VA leadership will certainly benefit from his technological expertise and strategic vision. And we also hope that they will learn from his incredible focus on customer service. Craig’s business card famously reads “Customer Service Representative,” and Craig is not joking. He is committed to providing Craigslist’s users with the best possible experience, and he literally spends hours a day personally answering customer service emails. This commitment to customer service has made Craigslist a dynamic, responsive company that is in close touch with its customers. This has allowed Craigslist to build an extremely strong and trusted brand. Changing the culture and processing claims quickly and accurately will make VA that same kind of trusted brand for veterans.

III. Recruit Veterans and their Families into the VA system

Innovative and Aggressive Outreach is a Must

The Department of Veterans Affairs must shed its passive persona, by adopting a customer-centered approach, and by recruiting veterans and their families more aggressively into VA programs. This means developing a relationship with the servicemember, while they are still in the service. They can learn from successful college alumni associations who greet students at orientation and hold student programs throughout their time in college. And once a veteran leaves the military, the VA should create a regular means of communicating with veterans about events, new programs and opportunities. If I got half as many letters and emails from the VA as I do from my College Alumni Association, we would be in great shape. The VA must also reach out to those veterans who have yet to access their VA benefits and aggressively promote VA programs.

In order to accomplish this phase of transformation, IAVA believes that the VA must prioritize outreach efforts and include a distinct line item for outreach within each VA appropriation account. These line item should help fund successful outreach programs such as the OEF/OIF Outreach Coordinators, Mobile Vet Centers and the VA’s new social media presence on Facebook and Twitter. Right now, these outreach programs are still too small and under-resourced to make a transformative difference. IAVA was disappointed that there were only a few brief mentions of outreach activities throughout the President’s VA budget submission. Not one of these mentions described a dedicated outreach campaign.

Based on experience with our own historic Public Service Announcement (PSA) campaign with the Ad Council, we have learned a thing or two about veteran outreach campaigns. Hopefully by now you’ve seen our iconic PSAs, like the one featuring two young veterans shaking hands in an empty New York City street. I know

Chairman Filner has seen the ad, because he encouraged us to reenact that scene with the actual vets on the steps of the Capitol last year.

These TV ads are just one component of this groundbreaking campaign. That famous ad is complimented by billboards, radio commercials, and web banners that have blanketed the country and touched millions of Americans. In just the first year of the campaign, IAVA has already received \$50 million dollars in donated media, and reached millions of veterans.

This entire campaign directs veterans to an exclusive online community that strongly demonstrates to our Nation's new veterans that "We've Got Your Back." It also directs them to a wide range of mental health, employment and educational resources—operated by both private non-profits AND the VA. This campaign is an example of the type of innovation coming out of the VSO and non-profit community that can help guide the VA. Innovative, aggressive outreach programs like this should become part of the new VA culture, and can fuel-inject desperately needed outreach efforts. We are learning what works, and we are happy to share our knowledge with anyone.

We Must End the Suicide Epidemic

IAVA's outreach efforts are also designed to make a dent in the suicide epidemic ripping through the military and veterans' community. During the first eight days of this new year, eight servicemembers have already taken their own lives. And in 2009, a record 334 servicemembers committed suicide. Last year, more servicemembers died due to suicide than combat in Iraq. These numbers do not even include the veterans who commit suicide after their service is complete—whose fatalities are tragically insufficiently tracked. Untreated mental health problems can and do lead to substance abuse, homelessness, suicide, and difficulties at home.

In 2008 a RAND study reported that almost 20 percent of Iraq and Afghanistan veterans screened positive for Post Traumatic Stress Disorder (PTSD) or major depression. A recent study by Stanford University found that this number may be closer to 35 percent. Less than half of those suffering from mental health injuries are receiving sufficient treatment. Exacerbating the problem of inadequate treatment is the heavy stigma associated with receiving mental health care. More than half of the soldiers and Marines in Iraq who test positive for a psychological injury, report concerns that they will be seen as weak by their fellow servicemembers. One in three of these troops worry about the effect of a mental health diagnosis on their career. As a result, those most in need of treatment may never seek it out.

In order to end the suicide epidemic and forever eliminate combat stress stigma we believe that VA and DoD must declare war on this dangerous stigma by launching a nationwide campaign to combat stigma and to promote the use of DoD and VA services such as Vet Centers and the Suicide Prevention Hotline. This campaign must be well-funded, research-tested and able to integrate key stake-holders within Veterans Service Organizations and community-based non-profits like the members of the Coalition to Support Iraq and Afghanistan Veterans (CIAV). Furthermore, the VA should develop and aggressively disseminate combat stress injury training programs for civilian behavioral health professionals that treat veterans outside of the VA (e.g., college counselors, rural providers, behavioral health grad students and professional associations).

IAVA is pleased to see that the VA has allocated \$5.2 billion toward the treatment of hidden injuries such as PTSD and TBI, a sizeable 8.5 percent increase over last year's budget. However, the VA must allocate specific resources towards battling this dangerous stigma or we will never see the critical mass of veterans coming into the VA to seek help.

End Veterans' Homelessness

The VA estimates there are 131,000 homeless veterans on any given night and nearly twice as many veterans experience homelessness at some point during the year. New veterans are especially at risk. At the height of the housing crisis, foreclosure rates in military towns were increasing at four times the national average, and already more than 3,700 Iraq and Afghanistan veterans have been seen in the Department of Veterans Affairs' homeless outreach programs. Unlike previous generations of veterans, Iraq and Afghanistan veterans are often appearing in the Nation's homeless shelters within two years of separation from the military, and a significant percentage of the homeless are female veterans and their children.

In 2009, the VA laid out a bold vision to fully eradicate homelessness among veterans within the next 5 years. This ambitious plan will require a new model for serving veterans and extensive collaboration between government agencies, traditional Veterans Service Organizations (VSOs), and the new breed of grassroots and nontraditional nonprofit organizations. This partnership between the public and pri-

vate sector must also be utilized to smooth the transition home for all veterans. IAVA believes the VA should be granted discretion to match the Grant and Per Diem (GPD) program payment rates to the actual cost of helping a homeless veteran. We must also expand the HUD-VA Supportive Housing (HUD-VASH) voucher program, to include the funding of 30,000 additional housing vouchers, will transform the lives of tens of thousands of homeless veterans.

IAVA applauds the VA's goal to cut in half the number of veterans sleeping on our streets by the end of this year and we believe that the additional \$294 million for joint VA-HUD programs in the President's budget request will go a long way towards accomplishing that goal.

IV. Support Female Veterans

While it has made strides in recent years, the VA is still underprepared to provide adequate care to the surge of female veterans coming to its hospitals and clinics. Women veterans are the fastest growing segment of the veteran population, and their enrollment in the VA is expected to more than double in the next 15 years. Women veterans make up 15 percent of IAVA's membership, and still face several barriers when seeking care at the VA, including fragmentation of services, health care and service providers with poor understanding of women's unique health issues, lack of knowledge regarding eligibility for benefits, an unwelcoming VA culture, inadequate privacy and safety practices at facilities, and no access to childcare. IAVA supports the President's request to increase funding for female health by an additional 9.4 percent, bringing the total up to \$217.6 million.

IAVA also believes that in addition to increased funding, Congress must establish a firm deadline for the VA to meet its own goal of providing comprehensive health care to women and require the VA to layout clear steps and benchmarks for all VA facilities. We also recommend increasing funding for Vet Centers and VA medical facilities to hire female practitioners, especially those who specialize in women's physical and mental health. Lastly, the VA should provide health care services to a newborn child of a female veteran who is receiving maternity care furnished by the Department.

These issues are further described in IAVA's groundbreaking issue report, "Women Warriors: Supporting 'She Who Has Borne the Battle,'" available outside the door today and at www.IAVA.org/reports.

V. Conclusion

The President's budget submission for 2011 and 2012 has all the right ingredients for transforming the VA. It is a message to veterans, like Casey Elder, that "We've got their back."

IAVA strongly supports this budget request, and looks forward to collaborating with the VA, Congress and the rest of the veterans' community to see this budget and the priorities listed above realized.

Next week, IAVA will be bringing dozens of our members, from across the country, to Capitol Hill for our annual "Storm the Hill" legislative trip. Our highly-motivated veterans already have over a hundred meetings scheduled to share their stories and our 2010 Legislative Agenda. We look forward to meeting with your offices to discuss these priorities in more detail.

Thank you.

Prepared Statement of Paul Sullivan, Executive Director, Veterans for Common Sense

Oral Statement

Chairman Filner, Ranking Member Buyer, and Members of the Committee, thank you for inviting Veterans for Common Sense to testify about the Department of Veterans Affairs' proposed budget for 2011.

VCS strongly endorses President Obama's \$125 billion VA budget, especially the new \$300 million in funding to end homelessness by the end of 2014.

However, we do have some concerns about two cohorts of veterans: first, our Iraq and Afghanistan veterans, and, second, our Gulf War veterans.

VCS urges Congress to require VA to develop more accurate casualty estimates as well as implement a long-range strategic casualty plan.

As of June 2009, VA reported 480,000 veteran patients and 442,000 disability claims from the Iraq and Afghanistan wars. This is far above any worst case scenario for casualties.

VA treats nearly 9,000 new patients per month from the two wars. For VA's 2012 budget, VA estimated less than 500,000 patients. A more realistic estimate for 2012, based on VA data, is as high as 800,000 new patients and claims from Iraq and Afghanistan veterans.

One factor that may increase health care use and claims activity is multiple deployments, as Stanford University researchers estimated 35 percent of new war veterans may return with post traumatic stress disorder—PTSD.

VA's failure to accurately forecast demand is serious because one-in-four patients wait more than 1 month to see a doctor. According to the Veterans Benefits Administration, more than one million veterans are now waiting 161 days for an initial answer for a disability claim.

We are alarmed VA's 2011 budget request shows VBA taking a staggering 190 days to process an initial claim. That's one more month of waiting for our veterans.

While we support hiring additional VBA staff to process the one-million claim backlog, VBA must also work smarter. VCS urges Congress to fund development of a one-page claim form plus new, simpler regulations VBA staff can learn in 6 months, not 2-to-3 years currently required. VCS urges Congress to fund a specific program to implement the proposed lifetime electronic record to end the epidemic of lost and difficult-to-find military service and military medical records.

VCS supports the Veterans' Benefits Improvement Act of 2008 as a strong move by Congress to improve quality at VBA. We urge Congress to hold accountable those VBA leaders who openly flaunted the law by failing to provide several reports and implement sections of the new law designed to overhaul VBA's broken claims system.

Specifically, VBA has not created temporary disability rating systems or reports required under Title II, Modernization of VA's Disability Compensation System, Subtitle A, Benefits Matters, Section 211.

VCS remains deeply concerned that funding for the Board of Veterans Appeals only increased three percent when there is a backlog of 200,000 unprocessed appeals, and where veterans wait four years for a decision.

VCS also urges Congress to fund full-time, permanent VBA claims staff at every military discharge location plus every VHA medical center and clinic.

Here are some VCS budget recommendations for our Gulf War veterans.

First, VCS urges Congress to create and fund a robust Gulf War veteran advocacy committee to provide advice directly to VA Secretary Shinseki on Gulf War illness, treatments, and benefits.

Second, VCS urges Congress to fully fund the Congressionally Directed Medical Research Program, that identifies "off the shelf" treatments.

Third, VCS encourages VA to restore funding for Dr. Robert Haley's research at the University of Texas Southwestern Medical Center. VA's IG confirms that VA Central Office employees "impeded the ability of the contracting officers . . . to effectively administer the contract." In our view, a few VA staff sabotaged Dr. Haley's research.

Finally, Mr. Chairman, you are correct that VBA's Veterans Benefits Management System is nothing more than a new name for several existing broken VBA computer systems.

Disney has Pixar studios, and James Cameron has his movie Avatar that thought outside the box. VCS urges Congress to fund a high-priority task force to overhaul VBA immediately, from application to payment and access to health care.

Essentially, if the VBA claims process can be described as a bridge, then the current one-lane obsolete wooden structure lacks the capacity to handle the millions of veterans now using it. There are traffic jams trying to cross, and veterans constantly fall over the side or through the cracks and plunge into the icy waters below.

An entirely new concrete and steel high-capacity bridge needs to be built as a replacement. The more time spent adding timber, changing the name, and applying paint to the wooden bridge only means more delays for our veterans seeking health care and benefits.

Thank you. I will be glad to answer your questions.

Prepared Statement

Chairman Filner, Ranking Member Buyer, and Members of the Committee, thank you for inviting Veterans for Common Sense to testify about the Department of Veterans Affairs' proposed budget for 2011.

VCS strongly endorses VA's \$125 billion budget. Specifically, we thank the President Barack Obama and VA Secretary Eric Shinseki for increasing funding by nearly \$300 million to end homelessness by the end of 2014.

Our testimony today focuses on two cohorts of veterans that require additional funding: first, our new Iraq and Afghanistan veterans, and, second, our Gulf War veterans.

Our 2.2 Iraq and Afghanistan Servicemembers

More than seven years ago, Veterans for Common Sense voiced concerns regarding the lack of a funding request by VA to care for casualties for the impending invasion of Iraq. The Congressional Budget Office had no cost estimate for health care and benefits for veterans. This was an oversight of enormous magnitude—an oversight still haunting this country and veterans today with long delays accessing health care and benefits.

Tragically, the scope of the Iraq and Afghanistan war casualties reached far above any worst case scenario. As of June 2009, VA reported 480,000 veteran patients from the two wars. VA also reported 442,000 disability claims filed. Nearly 300 first-time Iraq and Afghanistan war veterans flood into VA medical facilities every day.

VCS is disappointed that VA does not have an accurate casualty estimate and a long-range strategic casualty plan. Two months ago, VA estimated 419,000 Iraq and Afghanistan War veteran patients treated by VA through the end of September 2010. VA's estimate was wrong. By June 2009, VA had already treated 480,000 patients.

At the current rate of nearly 9,000 new patients per month, a more realistic VA estimate should have been a cumulative total of 615,000 patients treated as of September 2010. VA's 200,000 patient underestimation is a colossal failure because VA may lack the mental health care providers, disability claims processors, and education benefit processors to meet the need of this increasing cohort of veterans.

One factor that may increase health care use and claims activity is multiple deployments, as Stanford University researchers estimated 35 percent of new war veterans may return with post traumatic stress disorder in a study published last year.

VCS is concerned about VA's continued underestimation of casualties. For 2012, VA estimated less than 500,000 patients from the two wars. However, a more realistic estimate, based on VA data, may be as high as 800,000 by the end of 2012.

As the five years of free health care for Iraq and Afghanistan war veterans expires, VBA should expect the number of disability claims to catch up to and then surpass the number of patients. In order to provide a continuity of care, Congress may want to consider extending free VHA health care indefinitely to Iraq and Afghanistan war veterans with pending disability claims stalled at VBA.

This issue is serious because, according to three reports issued by VA's Office of the Inspector General, one-in-four patients wait more than 1 month to see a doctor. According to the Veterans Benefits Administration, more than one million veterans now wait 161 days for an initial answer for a disability claim.

VCS is highly alarmed that VA's 2011 budget request shows VBA taking a staggering 190 days to process an initial claim—that's an unacceptable 1 month addition to the current delays facing our veterans and families.

VCS remains deeply concerned that funding for the Board of Veterans Affairs only increased three percent. The Board remains a very serious unresolved bottleneck in VA's broken claims system, with a backlog of 200,000 unprocessed claims. Veterans wait, on average, four to five years for a claim decision from the Board, indicating that staffing, training, policies, procedures, and oversight must be strengthened.

VCS offers a solution for Iraq and Afghanistan war veterans. VA and DoD must develop and implement a transparent strategic casualty plan. This means VA and DoD must improve data collection and forecasting so it is more accurate. VA and DoD must hire more medical professionals, especially mental health professionals.

Furthermore, our government needs to perform pre- and post-deployment medical exams, launch a broad national anti-stigma campaign encouraging veterans to seek medical care, and place full-time, permanent VBA claims staff at every military discharge location and every VHA medical center.

VBA must also streamline the claim process with a one-page form and simpler regulations VBA staff can learn in 6 months—not the current three years. While VBA has additional funding to hire staff and process an expected surge of Agent Orange claims, VA's budget does not appear to contain additional funding to hire staff and process post traumatic stress disorder claims under new VA's new, streamlined regulations expected to be finalized this year.

Our 700,000 Gulf War veterans.

The second cohort of veterans in need of additional funding are our Gulf War veterans. Nearly 20 years after the conflict began, VA and DoD still do not have a comprehensive plan for medical research to better understand and treat the 175,000 ill Gulf War veterans.

VCS urges the Obama Administration and Congress to create and fund a robust Gulf War veteran advocacy committee to provide advice directly to VA Secretary Shinseki on Gulf War illness, treatments, and benefits.

Furthermore, VCS urges Congress to fully fund the Congressionally Directed Medical Research Program, a highly effective approach to identify “off the shelf” treatments for our ailing Gulf War veterans. We urge VA and Congress to work with veterans’ advocates to expand scientific research, especially in the areas of depleted uranium and chemical warfare agents.

VCS encourages VA to fund the research led by Dr. Robert Haley and his excellent team at the University of Texas Southwestern Medical Center in Dallas, Texas.

Finally, VCS urges Congress to ask VA to respond in writing about how they are implementing the recommendations made by the Institute of Medicine regarding veterans’ health. For example, VA and the military should indicate when they will implement IOM’s recommendation to use the best available testing method to determine DU exposure rather than the flawed test they are currently using. Congress should fund the best tests, research, treatment, and benefits for our Gulf War veterans.

Thank you. I will be glad to answer any of your questions.

**VA Fact Sheet
Consequences of Iraq and Afghanistan Wars**

Updated January 27, 2010

U.S. Veteran Patients Treated at VA: 480,324

Veteran Disability Claims Filed Against VA: 442,413

Chart #1, U.S. Troops Deployed to Iraq and Afghanistan War Zones ¹

Deployed to War Zones	Servicemembers Still in Military	Percent in Military	Veterans Now Eligible for VA	Percent Veterans
1,946,042	786,405	40%	1,159,637	60%

Chart #2, Iraq and Afghanistan Veteran Patients Treated by VA ^{2 3}

Category	Number of Veterans	Percent
Veteran Patients	480,324	41% of Veterans
Mental Health Patients	227,205	47% of Patients
PTSD Patients	134,103	28% of Patients

Chart #3, Iraq and Afghanistan Veterans’ Claims Against VA ⁴

Category	Number of Veterans	Percent
Disability Claims Filed	442,413	38% of Veterans
Claims Pending	69,397	16% of Claims Filed
Approved PTSD Claim	67,052	50% of PTSD Patients

Prepared by Veterans for Common Sense using documents obtained through the Freedom of Information Act:

¹ Department of Veterans Affairs (VA), “VA Benefits Activity: Veterans Deployed to the Global War on Terror,” Nov. 18, 2009.

² VA, “Analysis of VA Health Care Utilization Among U.S. Global War on Terrorism Veterans,” Oct. 2009.

³ VA, “VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD Through 3rd Qt FY 2009,” Sep. 2009.

⁴ VA, “VA Benefits Activity: Veterans Deployed to the Global War on Terror, Nov. 18, 2009.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
 Washington, DC.
 March 25, 2010

Honorable Eric K. Shinseki
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled "The Department of Veterans Affairs Budget Request for Fiscal Year 2011 and Fiscal Year 2012" on February 4, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 7, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
 Chairman

DMT:ds

Questions for the Record
House Committee on Veterans' Affairs
The Honorable Bob Filner
U.S. Department of Veterans Affairs Budget Request
for Fiscal Year 2011 and Fiscal Year 2012
February 4, 2010

Question 1: Reducing the claims backlog is at the top of the VA's six high priority performance goals that are supported by the FY 2011 budget request. In addition to the additional FTE investments for VBA, what other solutions is VA exploring in the near-term to address the claims backlog?

Response: Bold and comprehensive changes are needed to transform VA into a high-performing 21st century organization that provides the best services available to our Nation's Veterans and their families. VA's transformation strategy leverages the power of 21st century technologies applied to redesigned business processes.

There are a number of claims process improvement initiatives in various stages of concept development or execution. Some of the initiatives are quickly implemented changes to build momentum and reach out to our Veterans. For example, in an effort to speed up our work and to connect with our Veteran-clients, VBA now requires staff to reach out and call Veterans more often during the claims process rather than to rely solely on written communication. VA is also currently working to develop over 60 new medical questionnaires to take the place of current VHA examination templates to improve rating efficiency.

Another initiative is being conducted at our St. Petersburg Regional Office (RO) to identify and pay Veterans at the earliest point in time when claimed disabilities are substantiated by evidence we already have on record. In addition, four ROs are testing the concept of an "Express Lane" to expedite single-issue claims to improve overall processing efficiencies and service delivery. Yet another initiative will allow employees and Veterans to communicate regarding VA benefits using on-line live chat capabilities through the new portal called e-Benefits. All of the initiatives described and a number of others are being tracked for impact on timeliness and quality, and we will launch the successful initiatives nationally. For example, VA has initiated a new shorter application form—cutting the previous 23-page form down to 12 pages. In many cases we expect to see significant improvement in Veteran satisfaction with the application process.

Pilot programs are underway at four of our regional offices to support our business transformation plan to reduce the claims backlog, improve service delivery, and increase efficiencies. Each pilot functions as a building block to the development of an efficient and flexible paperless claims process. The results of all four pilots will be incorporated into the nationwide deployment of the Veterans Benefits Management System (VBMS) in 2012.

The Little Rock Compensation Claims Processing Pilot began in July 2009 following completion of the VBA Claims Development Study by Booz Allen Hamilton. The Little Rock pilot focused on a “Lean Six Sigma” approach to streamlining current processes and procedures. The Veterans Service Center converted from the VBA’s existing claims processing model into new fully integrated claims processing teams or pods. The pilot concluded in May 2010, and VBA is evaluating the outcomes to determine next steps.

The Business Transformation Lab (BTL) in Providence, RI, serves as a “test ground” for defining processes and testing functionality that will be incorporated into the development and deployment of VBMS. The primary purpose of the BTL is to utilize a structured approach to identify the most efficient way to process claims in an electronic environment incorporating current technology. As part of this process, the Providence RO is testing paperless claims processing using a small population of claims. The business process improvements identified by the BTL will be supported by technology enhancements and be integrated into VBMS.

The Pittsburgh RO began the Case-Managed Development Pilot in January 2010. The purpose of the pilot is to identify opportunities to reduce the time required to request and receive evidence, providing direct assistance to Veterans in compiling the necessary documentation to support their claims throughout the claims process. A second important aspect of the pilot is to enhance relationships and partnerships with our Veteran-clients through personal communications. Goals of the pilot include more personalized service to Veterans and greater advocacy on their behalf; more accurate decisions; and a more transparent understanding of VA’s claims process.

The fourth pilot, the Virtual Regional Office (VRO), has already produced excellent results. The single and focused purpose of the VRO pilot was to deliver the specifications for an implementable, professional-grade technical front end “dashboard” of the new system. This dashboard will enable VBMS users to do their jobs more efficiently and effectively. Based on the role of that individual user, the dashboard will provide relevant information about a Veteran’s claim that will enable faster and more accurate processing of claims. The specifications were not developed in a vacuum but rather side-by-side with VBA employees who gave input to the developers. The initial field use of dashboard capabilities is scheduled to begin in November 2010, and will be primarily focused on testing the software. Each iterative version of the dashboard will add improved functions and tools.

VBMS will be built upon a service-oriented architecture, enabling electronic claims processing by providing a shared set of service components derived from business functions. Initially, VBMS will focus on scanned documents to facilitate the transition to a paperless process. Ultimately, it will provide end-to-end electronic claims workflow and data storage.

VA is also seeking contractor support in development of a system to support evidentiary assembly and case development of the new Agent Orange presumptive claims. The system will enable Veterans to proactively assist in the development of their claims through a series of guided questions and will automate many development functions such as Veterans Claims Assistance Act notification and follow up.

In addition to an electronic claims processing system, VA is committed to improving the speed, accuracy, and efficiency with which information is exchanged between Veterans and VA, regardless of the communications method. The Veterans Relationship Management (VRM) transformational initiative will provide the capabilities to achieve on-demand access to comprehensive VA services and benefits in a consistent, user-centric manner to enhance Veterans’, their families’ and their agents’ self-service experience.

Questions 2: The FY 2011 budget requests \$44.1 million to complete the automated solution for processing Post-9/11 GI Bill claims and to begin the development and implementation of electronic systems to process claims associated with other education programs. What are the projections for FY 2012 and beyond on the out-year resource needs to fully automate Post-9/11 GI Bill claims and the claims associated with other education programs.

Response: The Post-9/11 GI Bill automated solution is scheduled for completion prior to 2012. We are still planning the adaptation of the Long-Term Solution (LTS) to fully automate the claims associated with other education programs, to include

incorporating lessons learned from its initial deployment and use. VA is currently formulating its FY 2012 budget request. As part of this process, the immediate and out-year funding requirements of the Post-9/11 GI Bill claims and the claims associated with other education programs are being considered.

Question 3: Please provide an update on the expanded enrollment of Priority Group 8 Veterans in the VA health care system. It is our understanding that the VA plans to enroll about 500,000 new Priority Group 8 Veterans with the funds provided in the 2009 appropriations bill. How much additional funding is needed to meet the 500,000 target enrollment figure?

Response: No additional funding is needed at this time because the appropriations already provided for fiscal years 2010 and 2011, along with the President's Budget request for 2012, includes the funding needed for the continued enrollment of moderate-income veterans into the VA health care system by 2013.

VA is closely monitoring observed demand for enrollment and patient access, and proposes expansion of enrollment only based on the availability of resources to meet current demand and projected demand through subsequent relaxations of enrollment restrictions. The resource requirements for the continued expansion of Priority 8 enrollment will be included in future budget submissions to Congress.

Question 4: The FY 2011 budget estimates obligating \$2.575 billion for OEF/OIF Veterans in FY 2011, an increase of \$597 million in estimated obligations for FY 2010. Forecasting the cost to care for OEF/OIF Veterans has been difficult in the past. What specific steps has VA taken to improve the cost projections? For example, is VA collaborating with DoD to better estimate the number of returning Servicemembers who will enroll in the VA's health care system?

Response: Due to operational readiness issues and sensitivity surrounding actual plans for military deployments, VA utilizes data from the Congressional Budget Office (CBO) to project the overall number of Servicemembers that may seek care at VA in any given year. The VA enrollee health care projection model projects separately OEF/OIF Veteran enrollment and utilization. The model is updated annually to reflect VA's most recent experience among the OEF/OIF Veteran population. The overall FY 2011 and FY 2012 funding levels for medical care takes into account the impact of publically announced increases in troop deployment levels. In addition, VA meets regularly with Army and Navy officials to determine the number of VA Liaisons stationed at Military Treatment Facilities to transition Servicemembers from DoD to VA.

Question 5: The FY 2011 budget requests \$4.2 billion in 2011 to prevent and reduce homelessness among Veterans, which includes over \$3.4 billion for medical services and nearly \$800 million for specific homeless programs. Please provide specific details regarding VA's plan to end homelessness including implantation projections regarding actions that VA can take using current authorities along with the metrics the Department plans on utilizing to judge whether these steps are successful or not.

Response: VA estimated that during the last year, on any given night, 107,000 homeless Veterans were living in shelters, on the streets or in places not meant for human habitation. While there has been a significant reduction in the number of homeless Veterans, VA's efforts are focused on eliminating and preventing Veteran homelessness.

- The average homeless Veteran profile:
 - served in the post-Vietnam era (1975–1990).
 - age 51, male, single, and equally likely to be African-American or Caucasian.
 - is unemployed and has an income of less than \$125 per week.
- At the time of contact with the VA, the average homeless Veteran is living outdoors or in a homeless shelter and suffers from medical and mental health/substance use disorders. Many homeless Veterans suffer with depression, substance use and significant physical health problems.
- Minority Veterans are overrepresented (48 percent of total) in the homeless population compared to the number of minority Veterans in the population.
- Female Veterans are the fastest growing segment of the homeless population.

In order to end homelessness among Veterans, VA must proactively provide needed health care assistance to enable these Veterans to regain the physical and mental health to move on with their lives. Our 2011 budget requests \$3.4 billion to provide core medical services for homeless Veterans.

VA is taking decisive action toward its goal of ending homelessness among our Nation's Veterans. To achieve this goal, VA has developed a 5-Year Plan to End Homelessness among Veterans that will assist every eligible homeless Veteran willing to accept services. VA will help Veterans acquire safe housing; needed treatment services; opportunities to return to employment; and benefits assistance. These efforts are intended to end the cycle of homelessness by preventing Veterans and their families from entering homelessness. VA's philosophy of "no wrong door" means that all Veterans seeking to prevent or exit from homelessness must have easy access to VA programs and services. Any door a Veteran comes to—at a medical center, a regional office, or a community based outpatient clinic—will offer them assistance.

VA plans to expand existing programs and develop new initiatives to prevent Veterans from becoming homeless and to aggressively treat those who are currently homeless. These program enhancements will provide housing, health care, benefits, employment, and residential stability to more than 500,000 Veterans and their families. Additional expansion of these efforts will begin in fiscal year (FY) 2011 through FY 2014, subject to the availability of appropriations.

The plan seeks to:

- Increase the number and variety of housing options including permanent, transitional, contracted, community-operated, and VA-operated.
- Provide more supportive services through partnerships to prevent homelessness, improve employability, and increase independent living for Veterans.
- Improve access for VA and community based mental health, substance abuse, and support services.

The 5-Year Plan to End Homelessness Among Veterans is built upon six strategic pillars:

- Outreach/Education;
- Treatment;
- Prevention;
- Housing/Supportive Services;
- Income/Employment/Benefits; and
- Community Partnerships.

The provision of safe housing is fundamental. However, programming must include: mental health stabilization; substance use disorder treatment services; enhancement of independent living skills; vocational and employment services; and assistance with permanent housing searches and placement.

The performance metrics to determine progress toward the goal of ending homelessness among Veterans will include the number of Veterans identified by VA as homeless or at risk of becoming homeless, and those who transition to stability using programs for housing vouchers and other supportive services.

Our FY 2011 funding includes \$799 million in targeted homeless assistance for a variety of programs that will help to prevent some from ever falling into homelessness and also rapidly assist those who are homeless in that condition. The major initiatives are described below:

EXPANSION OF EXISTING PROGRAMS:

• Health Care for Homeless Veterans (HCHV):

HCHV provides "in place" residential treatment beds through contracts with community partners and VA outreach and clinical assessments to homeless Veterans who have serious psychiatric and substance use disorders. Expansion of the program will provide services to 4,800 Veterans in FY 2010, and will ensure that every VA medical center has the capacity to offer services that are targeted to, and prioritized for, homeless Veterans who are transitioning from literal street homelessness. VA expects to spend nearly \$116 million and provide services to 9,500 Veterans in 2011. A total of 70,000 Veterans are expected to receive services through HCHV Contract Residential Care between FY 2010 and FY 2014.

• Housing and Urban Development-VA Supported Housing (HUD-VASH):

HUD-VASH is the Nation's largest supported permanent housing initiative that targets homeless Veterans by providing permanent housing with case management and supportive services that promote and maintain recovery and housing stability. More than 6,900 Veterans and their families obtained permanent housing in FY 2009. Program expansion will provide additional permanent housing opportunities for Veterans by allocating 10,000 new Housing Choice Vouchers in FY 2010. VA expects to spend nearly \$151.1 million and provide housing and case management

services to a total of 24,268 Veterans in 2011. A total of 60,000 Veterans are expected to enter the HUD-VASH program by FY 2014.

- **Grant and Per Diem (GPD) Program:**

GPD provides grants to community providers to create and operate transitional housing programs and provide services for homeless Veterans. Currently, the program funds over 500 community-based agencies and provides more than 11,000 transitional housing beds. It is estimated that program expansions will create capacity to serve approximately 20,000 Veterans in FY 2010. VA expects to spend nearly \$192 million and provide services to 22,000 Veterans in 2011. A total of 138,000 Veterans are projected to receive services from this program between FY 2010 and FY 2014.

- **Veterans Justice Outreach (VJO) Program:**

The Veterans Justice Outreach (VJO) program, formally launched in 2009, aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts. Program enhancement is expected to provide services for 7,500 Veterans in FY 2010. VA expects to spend \$12.6 million to provide direct services to more than 11,000 Veterans in 2011.

- **VA Residential Rehabilitation Treatment Programs (RRTP)/Domiciliary Care for Homeless Veterans (DCHV):**

There are currently 237 operational Mental Health RRTPs providing nearly 8,500 treatment beds. DCHV provides homeless Veterans with 24 hour-per-day, 7 day-per-week (24/7), time-limited, residential rehabilitation and treatment services that include medical, psychiatric, substance abuse treatment, and sobriety maintenance. Program expansion will increase capacity and access by establishing five 40-bed DCHV programs in large urban locations in FY 2011. VA expects to spend nearly \$153.0 million and provide services to 6,900 Veterans in 2011 in the DCHV Program. A total of 39,000 Veterans are projected to receive services from the DCHV Program between FY 2010 and FY 2014.

DEVELOPMENT OF NEW PROGRAMS:

- **New HUD/VA Prevention Pilot:**

This new prevention initiative is a multi-site 3-year pilot project designed to provide early intervention to recently discharged Veterans and their families to prevent homelessness. Priorities for site selection for this pilot project are in communities where there are high concentrations of returning OEF/OIF soldiers and rural communities. Under this pilot HUD will select sites to receive funding to support housing and supportive services for Veterans and their families and VA will provide coordinated case management to keep Veterans in their housing, maintain employment and connect them with VA health care and benefit assistance. Implementation of this program is expected to provide services to nearly 100 Veterans and their families in FY 2010. VA expects to spend \$5 million to provide services to approximately 200 Veterans and families in 2011. A total of 650 Veterans are projected to receive services from this program between FY 2010 and FY 2014.

- **National Referral Call Center:**

This new prevention initiative establishes a National Call Center that provides linkages for homeless Veterans, their families and other interested parties to appropriate VA and community-based resources. It is anticipated that in FY 2010, the Call Center will provide information and referral assistance to 15,000 Veterans and other interested parties. VA expects to spend nearly \$3.0 million to assist Veterans in 2011.

- **Supportive Services for Veterans and Families:**

This new homeless prevention initiative will provide grants and technical assistance to community non-profit organizations to provide supportive services to Veterans and their families in order to maintain them in their current housing and to prevent homelessness. Regulations have been drafted and are under review. Under the 2011 proposed budget VA will enhance prevention by offering more than \$50 million for Supportive Service Grants for Low Income Veterans and Families at 50 percent or less of area median income. We expect to award funding in 2011 that will provide services for 10,000 Veterans and families. A total of 65,000 Veterans are projected to receive services from this program between FY 2011 and FY 2014.

DEVELOPMENT OF NEW INITIATIVES:

- **National Homeless Registry:**

VA will establish a database to track and monitor expansion of existing homeless programs, prevention initiatives, and treatment outcomes for approximately 200,000 Veterans in FY 2010. The Registry will serve as a data warehouse for Veteran Homeless Services identifying and monitoring the utilization and outcomes for VA funded homeless services. It will enhance VA's capacity to monitor program effectiveness and the long-term outcome of Veterans who have utilized VA funded services. VA expects to spend nearly \$5.9 million for the National Homeless Registry in 2011.

- **Management Information System:** VA will establish an information management system (dashboard) for the homeless programs. The system will include specific program metrics that address structural, process, and outcome measures. Data from the management system will be turned into monthly and quarterly reports for senior VA leadership to monitor progress and to address barriers in helping Veterans exit homelessness.
- **Homeless Interdiction Initiative:** VA Regional Offices will develop a homeless interdiction plan specific to their area of jurisdiction that identifies the segment of Veteran homelessness they can best address, specific goals for their targeted clients, and the resources required to properly execute the plan.
- **Foreclosure Notification Initiative:** VA will develop a strategy to identify Veterans with VA home loans referred for foreclosure that may need expedited claims processing, benefits counseling and/or referrals to assistance programs.
- **Effectiveness:** Each initiative under VA's 5-Year Plan is judged on its effectiveness to limit Veterans from entering homelessness (prevention programs), or quickly and permanently returning Veterans to independent living.

Question 6: The FY 2011 budget assumes \$5.235 billion in obligations, an increase of \$410 million over FY 2010 for mental health. Is this sufficient to meet the needs of our returning OEF/OIF Veterans who suffer from PTSD or TBI? If additional resources were provided which additional programs or activities, would the Department undertake?

Response: Yes, the funding level for FY 2011 includes the needed resources to meet the mental health needs of returning OEF/OIF Veterans who suffer from post-traumatic stress disorder (PTSD) and other mental health problems that may exist either as co-occurring conditions with PTSD or separately. While the treatment of traumatic brain injury (TBI) is not primarily a function of mental health services, mental health conditions associated with TBI can be adequately addressed by the proposed funding increase.

For those Veterans specifically with TBI, the FY 2011 funding level adequately supports the full continuum of outpatient and inpatient rehabilitation programs targeted to meet the individualized care needs, including identification, assessment, treatment, and rehabilitation of the physical, mental and psychosocial problems that accompany TBI and Polytrauma.

Question 7: The VA estimates \$250 million in obligations for rural health initiatives in FY 2011. To clarify, does the \$250 million in estimated obligations support the grants awarded by the Office of Rural Health? Please explain how the funds will be used to meet the challenges facing rural Veterans. How does this fit into the VA's overall strategy for increasing access to health care among rural Veterans?

Response: Yes, the \$250 million in estimated obligations does support the grants awarded by the Office of Rural Health. VA is committed to enhancing access to health care for Veterans residing in rural and highly rural areas. To meet the challenges facing rural Veterans, VA is planning to invest \$87.8 million in FY 2011 rural health funding to sustain funding for CBOCs in 11 Veterans Integrated Service Networks (VISNs) for the second year of operation. In addition, \$100 million will be supporting the Contract Care Pilot Program for Highly Rural Veterans (Section 403, P.L. 110-387) in VISNs 1, 6, 15, 18 and 19. Also, in FY 2011, \$62.2 million will be utilized to sustain previously approved rural and highly rural projects including, but not limited to, mobile clinics, rural telehealth and telemental health initiatives, home based primary care (HPBC) programs, rural health outreach clinics, and mental health intensive care management (MHICM) programs and expansions.

Question 8: The FY 2011 budget requests \$590 million for medical and prosthetic research, which is a modest increase from \$581 million provided in FY 2010. This is well below the 3.2 percent increase in the biomedical research and development price index, which is developed by the Bureau of Economic Analysis. Does this mean

that VA will be awarding a smaller number of research grants in FY 2011? How will VA meet any shortfalls if projections regarding other federal funding sources prove to be too optimistic?

Response: The increase in appropriations from FY 2009 (\$510 million) to FY 2011 (\$590 million) is 16 percent. The Office of Research & Development (ORD) will be able to execute its mission without any adverse impacts. The number of projects that ORD fund is not dependent on other federal funding sources.

Question 9: The Secretary's written testimony states that "after a cumulative increase of 26.4 percent in medical care budget since 2009, we will be working to reduce the rate of increase in the cost of the provision of health care by focusing on areas such as better leveraging acquisitions and contracting, enhancing use of referral agreements, strengthening DoD/VA joint ventures, and expanding applications of medical technology." As a percentage of your medical care budget, how much do you expect to realize in savings if these initiatives are successful looking toward the future?

Response: The FY 2011 advance appropriation for the three medical accounts is \$48.183 billion. The estimated savings from the initiatives listed above are approximately \$177 million, or 0.4 percent of the advance appropriation amount.

Question 10: Please provide a detailed list of specific cost-saving proposals that could be utilized by the VA to reduce future medical care increase, along with estimated dates as to when these proposals are expected to be pursued and when cost-savings will be achieved?

Response: The estimated savings referenced in the answer to question # 9 are for increased use of regional and programmatic blanket purchase agreements and consolidated national contracts, decreased use of sole source contracts and increased competition, and improvements in the contract management process. The specific details of each individual proposal and the expected dates that the savings will be achieved have not yet been finalized. In addition to the above, we also anticipate approximately \$252 million in reduced dialysis purchased care costs, which will be contingent upon the publication of a final Federal Register notice regarding the specific rates that VA will pay when purchasing dialysis services from private sector providers.

Question 11(a): The Administration requests \$3.3 billion for IT in FY 2011, which is the same level as the amounts provided in FY 2010. How does this budget request support all of the ambitious IT initiatives, such as VLER and the creation of bi-direction, interoperable health care records?

Response: Our budget provides the resources necessary to continue our aggressive pursuit of the President's two overarching goals for the Department—to transform VA into a 21st Century organization and to ensure that we provide timely access to benefits and high quality care to our Veterans. The \$3.307 billion budget request is sufficient to meet VA's IT needs and in FY 2011 represents a 32.9 percent increase as compared to FY 2009. Funding for maintenance and operational costs will be sustained to keep the systems at current capability and acceptable performance levels with due consideration made for risk.

VA's decision to centralize IT in the summer of 2006 has resulted in improved fiscal and budgetary discipline in our IT operations and development, thus enabling VA to move forward with 21st Century technology initiatives such as the Virtual Lifetime Electronic Record (VLER).

We have implemented new, tighter management, including Project Management Accountability System (PMAS) and prioritization that will assist VA in making better use of IT funding. The PMAS uses an incremental development and fiscally responsible approach that will control development spending and ensure early identification and correction of failing IT programs. Halting development programs that fail to meet their delivery milestones will prevent wasteful spending and provide accountability in the delivery of technologies to help transform VA.

Our Major Investments will continue to increase above the FY 2010 level to meet the on-going demands for our Veterans and transforming VA:

- Veterans Benefits Management System (VBMS) with \$145.3 million requested, is a 104 percent increase above 2010, and is designed to transition from paper-intensive claims processing to a paperless environment.
- The Post-9/11 GI Bill (Chapter 33) with \$44 million requested is a 28 percent increase above 2010 and will provide the long-term solution to deliver an end-to-end solution to support the delivery of tuition, university fee payments, housing allowance and yearly books and supply stipend.

- Financial and Logistics Integrated Technology Enterprise (FLITE) with \$120 million requested, is a 52 percent increase above 2010, and will effectively integrate and standardize financial/asset management data and processes across VA.
- Virtual Lifetime Electronic Record (VLER) with \$52 million requested, is a 23 percent increase above 2010, and will create the capability for VA and DoD to electronically access and manage the health, personnel, benefits, and administrative information needed to efficiently deliver seamless health care, services, and benefits to Servicemembers and Veterans.
- Tele-Health and Home Care Model with \$48.6 million requested, will enable VA to become a national leader in transforming primary care services to a medical home model of health care delivery with a new generation of communication tools that can be used to disseminate and collect information related to health, benefits and other services.

Question 11(b): Please provide an update on the key deliverables that the VA has met for the Department's priority IT initiatives.

Response: The Department has identified 13 goals for FY 2010 that IT supports as their priority initiatives. These goals and key deliverables in the last 6 months include:

1. Eliminate Veteran Homelessness
2. Enable 21st Century Benefits Delivery and Services (through Veterans Benefits Management Systems-VBMS)
3. Automate GI Bill Benefits (Chapter 33)
4. Implement Virtual Lifetime Electronic Records (VLER)
5. Improve Veteran Mental Health (IVMH)
6. Veteran Relationship Management (VRM)
7. New Health Care Model (NHCM)
8. Expand health care access for Veterans (i.e. women and rural populations through ACCESS)
9. Preparedness
10. Enterprise Wide Cost Accountability (EWCA)
11. Integrated Operated Model (IOM)
12. Transformation of the Human Capital Improvement Plan (HCIP)
13. Perform research and development (R&D) to enhance the long-term health and well-being of Veterans

Currently, we report the following updates:

1. Eliminate Veteran Homelessness.

An initial Plan of Action and Milestones (POAM) was developed for activities known at this time, in concert with the Office of Public and Intergovernmental Affairs (OPIA), the Office of Policy and Planning (OPP), Enterprise Infrastructure Engineering (EIE), the Office of Acquisition and Logistics (OAL), and the Veteran Benefits Administration Office of Policy and Program Management. VA and Department of Housing and Urban Development are meeting to establish data sharing capabilities.

2. Enable 21st Century Benefits Delivery and Services (e.g., backlog reduction) (Veterans Benefits Management System—VBMS).

The Veterans Benefits Management System (VBMS) Initiative is a business transformation initiative supported by technology and is designed to improve VBA service delivery. It is a holistic solution that integrates a Business Transformation Strategy (BTS) to address process, people, and organizational structure factors and a 21st Century paperless claims processing system—VBMS.

VBMS will provide a modern electronic repository and a new graphical user interface (GUI), which will enable end-to-end electronic claims processing. The VBMS technology solution started with the Virtual Regional Office (VRO), which was completed on May 5, 2010. The VRO resulted in a system specification and business requirements for the new GUI. Following the VRO are three iterative pilots leading to the rollout of the software solution. Pilot 1 is currently under development and scheduled to be deployed to one VBA Regional Office in November 2010.

3. Automate GI Bill Benefits (Chapter 33).

Chapter 33 Long-Term Solution (LTS) version 1 was released in March 2010. Version 1.01, which provided some enhancements, was released April 26, 2010.

These releases, the first of several planned, will provide increasing functionality as we automate the GI Bill process.

6. Build Veteran Relationship Management (VRM) capability to enable convenient, seamless interactions.

Version 1.3.0 of the Veteran Tracking Application (VTA)—Disability Evaluation System (DES) was released in March 2010. Version 2.3 of the eBenefits Web Portal, which provides Veterans and Servicemembers with Web portal access to health and benefits information and transactions, was released in April 2010.

9. Ensure preparedness to meet emergent national needs (e.g., hurricanes, H1N1 virus) (Integrated Operations Center—IOC).

The intent of Initiative #9, Preparedness, is to provide oversight and management direction over those programs that have a substantial effect on VA continuity and security efforts. Although the two initiatives—the IOC and Homeland Security Presidential Directive 12 and Personal Identity Verification (HSPD–12//PIV)—are not directly related, they both are cornerstones in security and preparedness management.

- The IOC will provide a situational center during crisis or national emergency to serve as a fusion point/single office focal point for collecting, analyzing, planning, and disseminating information to its stakeholders.
- The HSPD–12//PIV Program will increase the security of VA facilities and IT systems through identity verification and strong authentication to prevent logistical and physical intrusions, and provide better protection for Veterans, VA employees, information systems, and VA facilities.

11. Establish strong VA management infrastructure and integrated operating model (IOM).

One component of the Financial and Logistics Integrated Technology Enterprise (FLITE) solution was deployed as a pilot project. The Strategic Asset Management System (SAM) Pilot project was deployed on a limited basis for testing purposes prior to full deployment.

Question 12: The FY 2011 budget request provides \$468 million for minor construction projects, which is \$235 million or 33 percent below the amount provided in FY 2010. In a time when there are long lists of projects awaiting funding, what is the VA's rationale for a significantly lower budget request in FY 2011.

Response: Fiscal Year 2011 request is second largest budget ever proposed for minor construction. The largest ever proposed was in Fiscal Year 2010—\$600 million. VA will use the requested minor construction funds, as well as funding for non-recurring maintenance and major construction, to address the Department's highest priority projects.

Question 13: The FY 2011 budget requests \$85 million for grants for construction of state extended care facilities, which is \$15 million or 15 percent below what was provided in FY 2010. However, the most recent State Veterans Home Priority List shows that there are over \$400 million in Priority 1 projects where States have already committed money to the construction process. What is the Department's justification for not seeking additional funding in order to address the Priority 1 backlog?

Response: VA believes it is an unwise public policy to build large numbers of new nursing home beds at this time. The number of Veterans over age 65 will peak by 2013 and decline steadily thereafter, resulting in fewer Veterans needing nursing home care. In addition, nursing home utilization rates are declining steadily as non-institutional home and community-based long-term care alternatives to nursing home care become more widely available both in VA and in the private sector. Overall occupancy in State Veterans Home beds is only 85 percent; although some states still have a great need for new beds. VA believes it is unwise to burden states with a brick-and-mortar infrastructure that will be increasingly difficult for them to maintain in future years, putting the states at risk of recapture of state home construction grant funds if they cease to operate their facilities as State Veterans Homes. Currently, there is no Priority Group 1 backlog of renovation projects (including renovations to protect the lives and safety of Veterans) or of new construction projects in states with a great need for new beds. All of the projects in these categories on the FY 2010 Priority List received Funding Letters in FY 2010. VA is confident that the budget request of \$85 million for FY 2011 will be sufficient to fund all Life Safety and other renovation projects and all new construction projects in states with a great need for new beds.

The Honorable Timothy J. Walz

Question 1: What is the status of the VA's office that handles seamless transition with the Department of Defense? More Specifically:

Question 1(a): Has the VA hired a director for this office? If so, who?

Response: Since its inception in 2008, the VA–DoD Collaboration Service has had an executive director. Robert D. Snyder is the current executive director and has been serving in that position since June 2009.

Question 1(b): How does the office fall into the JEC/SOC structure?

Response: This Service is the lead on VA–DoD seamless transition initiatives and provides support to the Joint Executive Committee (JEC) and the Wounded Ill and Injured Senior Oversight Committee (SOC).

Question 1(c): What is the mission and goals for this office?

Response: The Service's mission is to facilitate the development of joint policies and programs between VA and DoD and to provide oversight for the implementation of joint VA–DoD programs and policies as they relate to activities of the JEC and SOC. The roles and responsibilities of this Service include coordinating VA's efforts within JEC and SOC, coordinating VA responses to external requirements and mandates relative to seamless transition issues, coordinating and facilitating a VA-wide perspective in VA–DoD collaboration activities and initiatives, and developing the VA–DoD Joint Strategic Plan (JSP) in coordination with DoD.

Question 1(d): What are the priorities for the office?

Response: The Service's current priorities are facilitating the expansion of the Disability Evaluation System (DES) pilot model, developing and implementing the VA–DoD integrated mental health strategy, requiring mandatory separation physicals for Servicemembers, creating a process for early communication of VA benefits to Servicemembers prior to their separation from active duty, requiring mandatory attendance during the VA portion of the Transition Assistance Program (TAP), and refining the VA–DoD strategic planning process.

Question 1(e): What help can Congress provide to the office to overcome challenges?

Response: VA appreciates the support of Congress in the role of assisting Servicemembers as they transition from active duty status to Veteran status. Extension of the VA/DoD Senior Oversight Committee from Congress last year will ensure continued oversight and assistance in addressing the issues and challenges of transition activities.

The Honorable Corrine Brown

Question 1: After years of no major hospital construction, there are two VA medical centers that are scheduled to open in 2012—Las Vegas and Orlando. In fact, all money has been appropriated to complete these projects and no money was requested by the Administration this year for their construction.

Question 1(a): Is there enough money in the pipeline to ensure the activation of these medical centers?

Response: Yes.

Question 1(b): What will the final costs for completion be when the construction ends and before the patients are admitted?

Response: The final cost is not available at this time. Since construction is done in phases, buildings are ready for beneficial occupancy when construction is complete on that phase. This often occurs prior to completion of all phases. Therefore, final costs may not be known at time of occupancy of a particular phase, but rather when all phases are financially complete.

Las Vegas, Nevada:

The total estimated cost for the Las Vegas, Nevada, medical center is \$600.4 million. This includes two critical items still in design, the Administration Building and a Photovoltaic system. OALC believes that the final cost for the construction of this project will be within these appropriated funds.

Orlando, Florida:

The total estimated projects cost for the Orlando, Florida, medical center is \$665.4 million. OALC believes that the final cost for the constructions of this project will be within these appropriated funds.

Committee on Veterans' Affairs
Washington, DC.
February 12, 2010

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki,

In reference to our Committee hearing of February 4, 2010, I would appreciate your response to the enclosed additional questions for the record by close of business Wednesday, March 17, 2010.

It would be appreciated if you could provide your answers consecutively on letter size paper, single spaced. Please restate the question in its entirety before providing the answer.

Thank you for your cooperation in this matter.

Sincerely,

Steve Buyer
Ranking Republican Member

SB:dwc
Enclosure

Questions for the Record
The Honorable Steve Buyer, Ranking Member
House Committee on Veterans' Affairs
The Department of Veterans Affairs Budget Request for
Fiscal Year 2011 and Fiscal Year 2012
February 4, 2010

Question 1: Some employees at the Muscogee National Call Center have expressed their frustration with the phone system. Apparently, the system automatically kicks callers out of the system whenever too many customer service representatives are on the phone. Our staff was told that the reason VA chose that particular phone system for the call center was that it was installed at other VA locations. Is there any plan to modernize the phone system at the Muscogee Call Center and if so, is that money in the budget?

Response: The immediate issue expressed by Muskogee National Call Center employees was corrected with configuration changes to the phone system and the plan to modernize the phone system is underway. The modernization plan includes the Veterans Relationship Management (VRM) project, which is intended to address call center system instability issues by modernizing voice access and routing systems. VRM funding is included in VA's budget.

Question 2: How will the Veterans Benefits Management System project interact with IT systems at VHA and the Virtual Lifetime Health Record? Will the systems be interoperable so medical records and compensation exams can be viewed by both parties?

Response: Yes, the systems will be interoperable. VBMS will interact with VHA systems as well as the Virtual Lifetime Electronic Record (VLER). Included within the scope of this overall effort is development of an interface between VBMS and VHA systems to allow for the seamless movement of information, from the request of a disability examination to viewing the examination result. Authorized VHA clinical staff and VBA claims staff will have access to view pertinent claims information to conduct disability examinations.

Medical records and disability examinations from the Veterans Health Administration serve as highly probative evidence in support of Veterans' disability claims. As a result, VA invested in and achieved a significant level of interoperability between VHA and VBA in support of disability claims processing. VHA clinicians and

VBA Compensation and Pension staff already view electronic medical records for the purpose of providing treatment and adjudicating claims. VHA clinicians access information through the VA electronic record known as VistA Computerized Patient Record System, and VBA claims staff access the same information through its Compensation and Pension Records Interchange (CAPRI).

In 2009, VA and DoD formed a partnership to develop the Virtual Lifetime Electronic Record (VLER). VLER will support the full continuum of care and seamless benefits delivery to Servicemembers, Veterans and their dependents. To a VHA clinician or VBA employee, VLER will provide a comprehensive view of the collected health and benefits data, regardless of where those data are stored. Beginning with progressive piloting and implementation of the National Health Information Network (HNIN), the Departments are in the early stages of technology development that will support VLER, VistA and the Veterans Benefits Management System (VBMS).

Question 3: What lessons learned will VA incorporate into the Veterans Benefits Management System program from the numerous other failed paperless and IT systems for Compensation & Pension?

Response: VA is applying several lessons learned to the development approach of VBMS.

Rather than follow the traditional waterfall development approach, VBMS is using a so-called Agile Methodology, a highly collaborative software implementation approach that delivers small, integrated, and testable software in weeks rather than months. Agile calls for tight requirements and clear outcomes on short, even daily, timelines. Of course, changing methodologies is just the first step, but it is an important one.

Another important lesson is that our business requirements were not well articulated, with the predictable result that the technical specifications were similarly compromised. To remedy this, VA successfully implemented the first of our “pilot” programs, the Virtual Regional Office (VRO) which ran from January until May of this year. The sole purpose of the VRO was to create a set of technical specifications based upon actual user requirements; the exercise was successful, and we are now in the implementation phase of creating a new (and modular) user interface, designed to support the eventual replacement of VETSNET.

Finally, we also included a business transformation work stream, which will allow us to transform the business process, rather than just apply technology to the current claims process. VBMS has been placed under VA’s Program Management Accountability System, which tightly manages the products and deliverables of the program.

Question 4: Secretary Shinseki’s testimony stated VA intends to develop and implement an “end-to-end” solution to modernize the delivery of education benefits. First, which system would VA use, Benefits Delivery Network (BDN) or VETSNET for the payment system, and second, how will VA build on lessons learned from the BDN project?

Response: Initially, VA will use BDN as the payment system for the delivery of education benefits. Once the Financial Application System (FAS) can be modified to support the delivery of education benefits, which is scheduled for FY 2011, FAS will be used as the payment system.

We had originally anticipated integrating the “long-term solution” directly to FAS, but recently made the deliberate decision to use BDN for the time being. In our judgment, this temporary solution lowered implementation risk, even though much of the work will be redundant once the FAS interface is in production.

There were several valuable lessons learned as we migrate benefits programs from the outdated legacy mainframe to a more modern and extensible platforms. The most important of these are the technical challenges of creating scalable, maintainable, and modular “wrappers” around the existing software components. As VA takes better advantage of commercial development tools and standards-based environments, we expect to encounter fewer of these impediments.

Question 5: Section 809 of Public Law 110–389 reaffirmed VA’s existing authority to purchase advertising in national media outlets for the purpose of promoting awareness of benefits, including assistance for programs to assist homeless veterans, promote veteran-owned small business, provide opportunities for employment in the Department of Veterans Affairs, and for education, training, compensation, pension, vocational rehabilitation, and health care benefits, and mental health care including prevention of suicide among veterans. We have seen VA’s TV ads to recruit health care employees. When will VA begin using that authority to increase

the awareness and understanding of veterans benefit programs and what is the budget for the national media marketing effort for this fiscal year and FY 2011?

Response: In Fiscal Year 2010 and Fiscal Year 2011 VA will spend at least \$30M to increase awareness and understanding of Veterans benefits and programs (a portion of which will include paid media).

Question 6: The President has proposed using \$30 billion in TARP funds to promote small business. Noting that I have introduced H.R. 295[sic], which would reestablish the VA's Small Business Loan Guaranty Program, what will be VA's role in that effort?

Response: The Department testified in September 2009 in support of the concept of reauthorizing the VA's Small Business Loan Guaranty Program contained in H.R. 294, and more recently introduced in H.R. 4220. However, as we testified, several aspects of H.R. 294, which continue to be reflected in H.R. 4220, led us to conclude that we could not support the bill as written. We do believe an alternative approach to reauthorizing the program could be centered on an Interagency Agreement with the Small Business Administration (SBA) in order to utilize the Certified and Preferred Lenders who currently manage Small Business Loan Guaranty applications. This would allow VA to leverage SBA's expertise in this business area. As the Department has not run a federal credit program involving small business loans in many years, we are still evaluating the programmatic and cost implications associated both with the contractual approach presented in H.R. 294/4220 and the public partnership option with SBA. Once an evaluation of all cost implications and partnership options is complete VA will provide the Committee with these estimates upon completion.

Question 7: Following Mr. Snyder's question during the hearing regarding the complexity of claims, VA does not get full credit for that complexity because VA only reports the number of claims, not the total number of issues which are the driving factor in processing claims. Could VA change the reporting process to include total claims?

Response: We agree that reporting not only the number of claims received and completed but also the number of issues (disabilities) claimed would increase awareness and understanding of the complexity of the claims process. New support architecture is under development that will allow VBA's integration into a comprehensive issue-based reporting structure. We anticipate incorporating this data into our reports by the end of fiscal year 2012.

Question 8: The new IT system for the Post-9/11 GI Bill is scheduled to be in place by December 2010. Let's assume that despite VA and SPAWAR's best efforts to meet that date, full implementation slips by at least a fiscal quarter. In that case, what is the plan and will you need additional funds to retain at least some of the term employees through the implementation and transition periods?

Response: While VA expects the successful delivery of the Post-9/11 GI Bill long-term solution in December 2010, we plan to continue to utilize the interim processing solution to process Post-9/11 GI Bill claims if full implementation of the new IT system is not provided on schedule. VA's budget request includes funding to retain temporary claims examiners through the third quarter of FY 2011.

Question 9: Since the President has taken office, the backlog of disability claims has grown by 25 percent, and this budget projects that the average days to complete a claim will rise from 165 days in FY 2010 to 190 days in FY 2011. How will the budget request reduce the backlog?

Response: VA anticipates continued growth in incoming disability claims. VBA experienced a 14 percent increase in 2009, and we project a 13 percent increase in 2010 and an 11 percent increase in 2011. On top of these projections, additional claims are anticipated as a result of the Secretary's decision to add three new diseases to the list of conditions presumed related to herbicide exposure. The budget request includes funding to hire 1,820 additional employees to assist in addressing the increased workload in 2011. However, we recognize that additional staffing alone is not sufficient to keep up with the growing workload. We are actively exploring process and policy simplification and short-term technology enablers, in addition to the traditional approach of hiring additional employees, to address this increased demand. VBA established pilot initiatives at the Little Rock, Providence, Baltimore, and Pittsburgh Regional Offices to improve claims processing and services to veterans. As we identify best practices and early successes, we will export those ideas nationwide.

Question 10: Will the Veterans Benefits Management System project involve VETSNET? If not, how does VA justify the millions of dollars spent on this project that is now basically obsolete?

Response: The goal of VBMS is to provide a complete claims processing environment from submission to payment. The underlying architecture of VBMS will allow seamless integration with current or future accounting and claims management systems. The VETSNET suite of applications provides the current tracking and payment infrastructure and will be closely linked to VBMS to enable not only the paperless processing of claims, but also provide a much more effective user interface.

VBMS is based on a service oriented architecture (SOA) that will facilitate long-term maintenance and upgrades, including and especially upgrades of the underlying components. VBMS will use Veterans' data and claim data already contained in the VETSNET database (VBA's corporate database), as well as production services that are currently part of the VETSNET suite. Finally, VBMS will deploy the architecture for the paperless document repository, the workflow engine to facilitate the processing of a claim, and the interface layer to allow the system to utilize the business and policy logic, as well as authoritative corporate records.

