S. HRG. 111–167

THE FISCAL YEAR 2010 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 10, 2009

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C O N T E N T S

MARCH 10, 2009

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APPENDIX

THE FISCAL YEAR 2010 BUDGET FOR VETERANS' PROGRAMS

TUESDAY, MARCH 10, 2009

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

The Committee met, pursuant to notice, at 9:34 a.m., in Room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Brown, Tester, Begich, Burris, Sanders, Burr and Graham.

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

Chairman AKAKA. This hearing of the U.S. Senate will come to order.

Aloha and welcome to all.

Today, the Committee begins its review of fiscal year 2010 funding for the Department of Veterans Affairs. When we talk about the VA, we are talking about people. I have had a few chats with the Secretary, and that is what we have been talking about—those who have served and the nearly 280,000 VA employees who work on their behalf.

The budget outline presented by the President last month appears to be a good one which reflects many important priorities of this Administration. From my vantage point, as Chairman of this Committee, I am committed to ensuring that veterans receive quality benefits and quality services. When troops are sent into battle on behalf of our Nation, there is a commitment to care for them when they return home. They must be given the best health care and the best rehabilitation. They must be fairly compensated for their injuries. And now, in this time of war, VA must have the resources it needs to carry out its mission.

The troop surge in Iraq and the increases in Afghanistan will soon be felt at VA. To date, this generation of veterans as a group have been slow to come to VA for benefits and services. VA must be prepared to reach out to those now coming home and bring them into the system.

While many details of the Administration's final budget proposal have yet to be presented, the Committee is required to submit the Views and Estimates to the Budget Committee by the end of this week. I intend to meet that deadline, but doing so will not complete our work on next year's budget. We will evaluate the President's

final budget once it is received and make additional recommendations.

One of the most pressing issues facing VA is ensuring timely, sufficient and predictable funding from year to year. Last month, I introduced legislation with bipartisan support to help secure the timely funding of veterans' health care through advance appropriations. Too often, VHA's budget is subject to delay and uncertainty, hampering planning and threatening health care quality. This situation must end.

Another serious issue is the backlog in VA construction. I am eager to learn how the Committee can help the Department complete pending construction projects so that VA can provide veterans with more access to care in better facilities. There are many other important areas of health care that the Committee is concerned about, such as: care in rural areas; the health care needs of women veterans; recruitment and retention of medical providers; research programs; and homelessness among veterans.

On the benefits side of the ledger, timely and accurate adjudication of disability claims and appeals remains a significant problem. Veterans deserve to have their claims addressed fairly and without needless delay. The President's budget proposes to invest in better technology, and I am pleased that the Department will invest in the development of rules-based electronic processes to improve accuracy, consistency and timeliness in claims processing.

As one who knows firsthand the value of education benefits under the GI Bill, I want to hear how VA intends to implement the Post-9/11 GI Bill.

I know that VA shares my commitment to providing a seamless transition from military to civilian life for today's servicemembers. VA must be an active partner with the Department of Defense to ensure that troops are cared for appropriately when they transition from active service to veteran status. I look forward to learning in more detail how the President's budget responds to this issue.

I am committed to working with the Secretary and my colleagues in Congress on both sides of the aisle to ensure that the Department gets what it needs to deliver high-quality benefits and services to veterans. We must acknowledge the fact that the needs of veterans are costs of war.

I look forward to our dialog with Secretary Shinseki as well as the representatives of veterans service organizations here with us today.

And now I would like to call on our Ranking Member, my good friend, Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Senator BURR. And to my colleagues and our witnesses, welcome.

Mr. Secretary, this is the first time you have been before the Committee. Therefore, it is the first time I have been able to address you formally as Mr. Secretary, and I want you to know what a special privilege it is to have you in this position. As I have said in the past, we are fortunate to have a person of your caliber as

the head of the Veterans Administration, and I am personally looking forward to working with you as you chart the future of VA and the shared mission to serve America's veterans. I thank you for being here.

We are here this morning to learn more about the President's fiscal year 2010 budget request. There are very few issues that are more important, in my estimation, than to ensure that the programs and the services for our veterans are adequately funded.

Mr. Secretary, I'm counting on you to be very candid with us and with this budget. More importantly, I am counting on you to make sure that veterans' lives are improved with the resources that we provide the VA.

We have very few details about what is within the budget. In fact, we really only have a 134-page book submitted by the Office of Management and Budget, with only two pages of that devoted to VA's budget.

Let me say that for the upcoming fiscal year this budget appears to be a very strong one, with an 11 percent increase in discretionary spending. This is consistent with the increases shown in recent years.

I am especially pleased that the budget appears to fund legislation I authored and was signed into law last year to help our veterans who are at risk of becoming homeless. This new law, Public Law 110–387, authorized the VA to make grants to nonprofit organizations to provide supportive services to these veterans. I believe that when it comes to dealing with problems of homelessness we must approach it in a proactive and, more importantly, a holistic way. My hope with this new effort is that we can end the cycle of homelessness by ensuring it never begins in the first place. I commend the President for making this a priority of the 2010 budget.

Although the fiscal year 2010 outlook appears promising, I am concerned about what the President's budget tells us for the subsequent years. I am concerned because I believe the President when he says his goal is to bring a new level of transparency to government. In fact, here is what the President had to say about his own budget, "But this Budget does begin the hard work of bringing new levels of honesty and fairness to government. It looks ahead a full 10 years, making good-faith estimates about what costs we would incur."

That is why when I look at the tables in the back of the budget and I see a proposed 2.3 percent increase in fiscal year 2011, 2.6 percent in 2012, 2.7 percent in 2013, 2.8 percent in 2014, I get very concerned. We all know medical inflation alone has been averaging around 4 to 5 percent per year. On top of that, we are expecting more veterans to enter the system in the near future, especially as 100,000 plus troops are drawn down in Iraq and as our weak economy is leaving many veterans out of work; and I might also add the goal of absorbing 500,000 Priority 8s over the next several years.

I do not know how these numbers add up to ensure our veterans get the quality of care that they have earned, more importantly, that we have promised. But, again, if indeed these are good-faith estimates, I am confident you will be able to defend these numbers.

In closing, let me also acknowledge the contributions of the veterans service organizations on our second panel. Not only have they given us the benefit of their expertise in determining appropriate funding levels for the VA for the upcoming year, but they have also given us a guide to reform what I think is a broken budget process.

I have joined as an original co-sponsor of the Veterans Health Care Budget Reform and Transparency Act. I believe this bill will start the discussion in Congress on how we can deliver a timely, predictable and sufficient budget for our veterans. It will also lend new transparency to the budget process which I believe is consistent with the President's own goal.

Mr. Chairman, again, I thank you for calling this hearing, and I look forward to the testimony of not just the Secretary but of the other veterans organizations.

Chairman AKAKA. Thank you very much, Senator Burr, for your opening statement.

And now I would like to call on Senator Rockefeller for his opening statement.

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

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Good morning, Mr. Secretary. We have chatted on two occasions, and I have expressed to you my profound pride in your selection, and all I can do is repeat that with the same heartfelt feeling. I think it is one of the best selections the President has made. If I were in a veterans service organization, I would be jumping up and down with happiness and with a sense that there is somebody who really cares, who understands, who is humble in nature but has steel in the spine, and who will fight hard for veterans.

The veterans have so many problems, it is almost difficult to pick out one or two. Senator Burr mentioned homelessness. That is huge.

He also mentioned the 5-year running budget which, as we discussed, may not actually work out, it being very unique if we were to do that.

He mentioned the health care inflation. I have to leave to go to a Finance Committee meeting on that precise subject.

Let it just be said that the stimulus package gave the veterans an enormous boost. That boost is here to stay.

The question is how do you take the multiplicity of the visible and invisible wounds that veterans bring home with them—and will continue to bring home with them, and will have living with them for the rest of their lives—and help them cope?

I have not even given up an inch on the Gulf War Syndrome. I think that is still out there, still an active matter of consideration and still more or less denied by the Department of Defense.

But I think a lot of Americans thrive on hope. They see somebody or they see something which is turning the corner—let's say, in the economic crisis. If we could see that, it would be nice. They see somebody like you, if they are veterans, and their life gets better simply because there is hope, because of your integrity, your strength.

I think the bond you already have with each of us on this Committee and with the veterans service organizations will serve you well.

I congratulate you. I am really looking forward to your being a superb Secretary.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

Now I would like to call on Senator Brown for his opening statement.

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman.

I echo the words of Senator Rockefeller in saying this is, I believe, one of the President's best choices for Cabinet Secretary.

I also thank the veterans organizations here, particularly the Paralyzed Vets, the DAV, the AMVETS and the VFW for the *Independent Budget*. I think that helped get us on our way and the President's way and Secretary Shinseki's way on a much better VA budget than we have had in years past.

I also thank the Legion and the Vietnam Vets for being with us today and helping us shine a light on the direction we need to go.

I appreciate Secretary Shinseki already having said in earlier discussions that he has had three meetings with Defense Secretary Gates. I guess having a four-star general as VA Secretary helps get into the Pentagon and understand the Pentagon a little better than others and in the relationship he has had with Secretary Gates. And I think that is so important as we have really worked for the last couple of years to try to integrate the two departments better to ease the transition from active duty to veteran status.

I have held probably a dozen roundtables where I will sit down with 20 vets—similar to what I know Senator Rockefeller does in a different format but the same kind of thing—and just talk with them about their experiences and what they are seeing with the VA and what they are seeing with CBOCs and what they are seeing just generally with their treatment as veterans.

One of the most common complaints from veterans service organizations is they cannot find veterans when they come home. The screening for PTSD is not done and the problems happen because we sort of lose track. And veterans do not always step up because when they get home they want to get integrated back—particularly if they are Guard or Reserve—integrated back into their homes and their neighborhoods and their churches and their work places.

I appreciate especially the work that the VA has done, starting 10 years ago, on IT and that success. I know Secretary Shinseki is going to mention that in his opening testimony—what strides that the VA has made with information technology, and how it has made such a difference in cutting down the number of medical errors. That should be instructive to the Finance Committee and to the Health Committee and to the House and Senate on how we do health care in this country because the VA really has done better than anybody else in reducing medical errors.

A couple of other points I wanted to make: I held a vets roundtable the other day in Columbus at the Veterans Memorial, and a

couple of things came up. One is—this is a problem unique to Ohio—Ohio has the second lowest average payment for disability compensation. I want to understand that better and make sure that does not continue to happen.

More national in scope is the VA, as it has moved toward privatization of all kinds of services, it has moved away from hiring the number of veterans they ought to hire. It has probably meant less diversity too at the VA. It is so important that there be a focus on hiring veterans, that I think the VA has lost its way on hiring veterans for a whole host of issues.

I also heard a lot yesterday about dental care; that there is a window during which vets have to get dental care. If they do not get inside that window, they lose their option to have VA dental care. I am not sure of that. That was said by several people at this panel.

And, last, the whole issue of mental health. There were several women there that talked passionately about the VA's inability to deal with sexual trauma from veterans who had been assaulted—men and women veterans, they said, who had been assaulted. I mean, there were soldiers that had been assaulted, and they were not getting help from the VA in terms of counseling because the mental health counselors typically specialized in alcohol and drug abuse and other kinds of PTSD issues, but not a lot about sexual trauma. So that is an issue that we need to raise and work through in the months and years ahead.

I am thrilled that you are the Secretary, General Shinseki, and I look forward to hearing your testimony.

I have another hearing, so I may not get to hear everything today, but I appreciate your being here.

Chairman AKAKA. Thank you very much, Senator Brown.

Now we will call on Senator Tester for the opening statement.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Chairman Akaka, and I want to thank all the distinguished witnesses who are going to testify today on the 2010 budget for veterans' programs.

Secretary Shinseki, it is good to see you again. I want to publicly reaffirm my support and confidence in your leadership. I look forward to the testimony.

As the global war on terrorism enters its eighth year, servicemen and women continue to experience traumatic mental and physical injuries as they are placed in harm's way. Since fighting began, more than 4,914 U.S. servicemembers have been killed, and more than 40,000 have been injured. The lives of our servicemembers and their families have truly been changed forever.

Suicide rates are at an all-time high. The rates of psychological and neurological injuries are high and rising. According to IAVA, about one in five new veterans are experiencing symptoms of PTSD or major depression.

Nineteen percent of Iraq and Afghanistan veterans have experienced probable Traumatic Brain Injury during their deployment. Tens of thousands of new veterans are coping with both the psychological injuries and TBI, the effects of which can compound each

other, but less than half of those suffering from psychological and neurological injuries are receiving sufficient treatment.

Multiple tours and inadequate time at home between deployments are increasing the rates of combat stress.

For me, it is personal. It is serious. Our decisions directly impact the lives of veterans and their families. We have accomplished a lot, but, as just about every Member of this Committee said going around the room, more needs to be done.

More needs to be done to ensure the care of our veterans and their families. Is the VA adequately prepared to address these issues? What more do we need to do?

There are over 100,000 veterans living in Montana. This number includes a significant number of Native American veterans. This is an extraordinary group of veterans that is disproportionately affected by service-connected health conditions. Their access to primary and mental health care is further limited by distance and underfunded—often inadequate—community health care, IHS services.

Veterans living in rural and highly rural areas deserve better. We have to improve the way we administer and deliver VA services in rural areas. The budget needs to fully support these programs, and, personally, I need to know that the dollars allocated to support rural health initiatives are being appropriately applied.

Overall, as I look at this budget, I think it looks pretty decent. It funds IT infrastructure, telemedicine, upgrades VA facilities, improves health care for rural veterans and extends care to our Priority 8 veterans—something that I have heard a lot about.

However, there is still a big gap, almost $2 billion, between the VA-President's budget and the *Independent Budget*. As stewards of the taxpayer dollar, we need to reconcile these differences.

Once again, General Shinseki, very, very good to see you. I look forward to your testimony. I look forward to working on this budget for 2010.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Sanders, your opening statement.

STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT

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

General Shinseki, it is great to see you again, and I concur in the feelings of my fellow Senators, that in these difficult times you are the right person for the job, and we look forward to working with you.

Over the last several years, we have made some significant progress in addressing many areas that have been long neglected, and I want to thank, quite sincerely, our Chairman, Danny Akaka, and Bill Filner in the House, because we have made some real progress.

We have, among other things, begun the process of bringing our Priority 8 veterans back into the system. That is not a small thing.

We have passed a GI Bill which has the greatest expansion in veterans' educational opportunities since World War II, and, especially in these very difficult economic times, that is a huge step forward for hundreds of thousands of veterans and their families.

At a time when we almost had to rush money into the VA several years ago—when the VA ran out of money—we have consecutively, in recent years, proposed record-breaking budgets for the VA. And that is the right thing to do.

We have raised mileage reimbursement rates. That may not seem like a big deal, but when you are in a rural State like mine, the fact that people now can get decent compensation to get to the clinic or get to the hospital is quite a big deal.

So, we have made some progress in recent years, but obviously we have a long way to go. And I think, as Senator Brown indicated a moment ago, one of the reasons that we have made progress is we have worked with the service organizations who are on the ground, who know what the problems are, and we have come very close to matching what the *Independent Budget* has brought forth.

I want to thank Paralyzed Veterans of America, DAV, AMVETS, VFW, the American Legion, and the Vietnam Veterans of America. I thank them very much for their help in making our job easier in terms of allowing us to know what is happening on the ground.

Now, in terms of this budget, let me talk very briefly about what I see as some of the highlights. This budget will allow 500,000 Priority 8 veterans back into the VA health care system over the next 3 years. As you and I discussed the other day, that is, in my view, exactly the right thing to do. It was wrong for the previous administration to throw those people out and deny them admission to our VA system. We are making some progress in bringing them back in.

This budget enhances outreach and other services related to mental health care, TBI and other areas with a focus on rural areas through increased use of Vet Centers and mobile health clinics. We can have the best health care in the world for our veterans, but if they do not know how to access it and if they are not brought into the system, it does nobody any good. So I absolutely support and appreciate the effort to increase outreach. We are making some progress in Vermont in that sense, and I am glad that we are doing it around the country.

Clearly, one of the problems, Mr. Secretary, that you have heard over and over again is the backlog in terms of getting benefits to our veterans in a timely manner. I believe that this budget begins the process of addressing that very serious problem, and I know that that is high on your priority list. In an age of sophisticated hardware and all of this computer technology, it makes no sense that veterans have to wait as long as they are currently waiting for the benefits that they are entitled to.

This budget ends the disabled veterans tax by supporting full concurrent receipt. That is something the veterans organizations have fought for a long time.

And this budget makes sure that the new GI Bill hits the ground running. Once again, we have a wonderful benefit out there in terms of educational opportunities for veterans. It does not do anybody any good unless they fully understand the benefits to which they are entitled and know how to access those benefits.

I share some concerns that my colleagues have raised about this budget. We are going to want to work on the amount of money in the budget. I think we can do a little bit better than the President

has proposed, and we also want to make some more progress on advance appropriations, something that I think many of us believe is the right direction.

So, I think the budget is off to a good start. It is going to need some work, and we look forward, Mr. Secretary, to working with you and the veterans organizations on these issues.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Sanders.

And now I call on Senator Burris for your opening statement.

STATEMENT OF HON. RICHARD W. BURRIS,
U.S. SENATOR FROM ILLINOIS

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

And to Secretary Shinseki and to those who will be testifying on the second panel, my congratulations and hopes, wishes and prayers for you to be very, very successful as we undertake this great mission to deal with those individuals who have enabled us to be where we are today, and those are our veterans.

You know, Mr. Secretary, we have a person who has joined you from the great State of Illinois, a young lady by the name of Tammy Duckworth, and we are looking forward to bringing her knowledge of what she did for veterans in our State. I understand she has met with you, and you have really given her the green light in putting up some of those programs that we have put into place in Illinois for our veterans. I think the President has put together a very good team.

As you know, I was hoping and praying I would get on this Committee, Mr. Chairman. Thanks to the leadership, they did put me on the Veterans' Affairs Committee, and all my activities since I have been in office for these 50 days or 60 days has been dealing with our veterans. I have already been to the Great Lakes Hospital. I met with veterans in my office. I met with all the veterans groups that have come here to Washington because we must take care of our veterans. With your leadership and your knowing what that is, I am pretty sure that that will be dealt with.

So, this proposed 2010 budget has the potential to lead the way in the transformation of the VA. It has provisions to improve many different parts of the VA system from homelessness prevention to the expansion of IT capabilities. Secretary Shinseki and his staff have used their considerable experience and expertise to create this budget, and I commend them for their hard work on behalf of our veterans.

However, as I said last week, veterans advocacy groups like those here today are our eyes and our ears on the ground; and I want to commend each and every one of those groups that are keeping us informed as to what is happening out there with their colleagues. I am to gather from each of you the insight into how we can fully take advantage of the opportunities provided in this budget.

Furthermore, Mr. Chairman, I come here with my own questions. I am also a member of the Homeland Security and Government Affairs Committee, and lately I have been thinking a lot about oversight, transparency and accountability in relation to the Recovery Act.

Well, in fact, I have been thinking about oversight, transparency and accountability for most of my working life, first, as an old Federal bank examiner where I was making sure that the banks were sound—maybe we should do something about that today; and as Comptroller of my State; and as the Attorney General of my State; and now as a United States Senator from my State.

I do not want to squander the opportunity for change afforded by this budget because of miscalculations or misuse of funds. We have increased the budget to some extent, and we must make sure that those dollars are spent and they are spent wisely, effectively, for the benefit, Mr. Secretary, of our veterans.

I will have some questions as soon as I have time. I have to go to my other committee, Mr. Chairman, but I will have some questions since I cannot be at two places at the same time.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Burris.

Now we will hear from Senator Murray.

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

Senator MURRAY. Well, good morning, Mr. Chairman. Thank you and Senator Burr very much for holding this very important hearing on the proposed 2010 VA budget.

I want to extend a warm welcome to the representatives of the veterans service organizations. Every year, you put an incredible amount of time and hard work into producing your own budget estimates and policy recommendations, and every one on this Committee appreciates all the work you do in that regard.

I also want to extend a warm welcome to Secretary Shinseki. As I said at your confirmation hearing, you have one of the most challenging and rewarding positions in our government, and I appreciate what you are doing.

Modernizing our VA into a 21st Century organization is not an easy task. We have a lot of work ahead of us in improving access and understanding mental health, improving the seamless transition process, fixing the disability claims project, leveraging information technology so we can improve the delivery of services, and preparing the VA to care for an increasing number of female veterans. By themselves, none of these is an easy task, and, together, they are very complicated. So we appreciate the tremendous amount of energy you have given, Mr. Secretary, to putting this system to the right.

We have not seen a lot of details on the proposed budget yet, but there are some good things I am seeing, and I want to mention a couple of them.

As the lead sponsor of the Women Veterans Health Care Improvement Act, I was especially glad to see the budget enable the VA to provide additional specialty care for female veterans. Women now make up 14 percent of our active duty forces, and they represent one of the fastest growing groups coming into the VA for health care. So, getting the VA to be ready for the unique needs of women veterans is a very important task ahead of us, and I appreciate that this budget recognizes that reality.

I was also pleased that the budget provides funding to bring more than 500,000 Priority 8 veterans back into the VA system by 2013. I introduced legislation along with others in the 110th Congress to overturn the Bush Administration's 2003 ban on enrollment of new Priority 8 veterans. I believe that all veterans should be able to get the care they have earned. We have made some progress on this issue, and I look forward to working with the VA to make all Priority 8 veterans again eligible.

Additionally, I want to commend you for including in your budget a pilot program to combat homelessness by providing stable housing for vets who are at risk of falling into homelessness. I chaired an appropriations subcommittee last year on this issue, and the VA testified at that committee, saying that, "the best strategy with this new generation of veterans is to reach them very early." That was a quote.

In order to start addressing those needs, I included funding for a similar pilot project in the 2009 Transportation and Housing Appropriations Bill which we are on the floor considering now. I hope we send it very quickly to the President. When we pass that, there will be a demonstration program, and it directs HUD to work with the VA and the Department of Labor—all the agencies—to test different strategies to prevent veterans from becoming homeless.

Finally, I do want to mention one concern I have with the budget—which Secretary Shinseki, you and I talked about it last week—and that is the rumored proposal that would allow the VA to bill a veteran's insurance company for service-connected disabilities and injuries. I believe that veterans with service-connected injuries have already paid by putting their lives on the line for our safety, and when our troops are injured while serving our country we should take care of those injuries completely. I do not think we should nickel and dime them for their care.

I know no formal proposal has been made on this, but I can assure you that it will be dead on arrival if it lands here in Congress; and I think I shared that with you last week.

But, again, Mr. Chairman, I really appreciate the opportunity to take a look at the budget proposal as we see it so far and have our questions.

So, thank you very much for your testimony today.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Begich, for your opening remarks.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Chairman Akaka and Senator Burr, for holding this meeting.

Secretary Shinseki, I know we already had our conversation. It was good information we exchanged. As you know, one of the big issues that I have—and I will be looking closely as the budget progresses—is rural health care for veterans and how we bridge that gap especially in a rural community like Alaska, which is very unique. I know there are some great ideas materializing from the local veterans community as well as the Veterans' Administration on what we can do to achieve that.

Mr. Chairman, I am going to keep my comments brief as always. I like to get to the questions and also to the presentation by our guests. So I will end it there.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Begich.

I would like to now welcome with much aloha, Secretary Eric K. Shinseki. I hope this will be the first of many appearances you will have before this Committee as head of the Department of Veterans Affairs.

I thank you for joining us today to give your perspective on the Department's fiscal year 2010 budget. I think I speak for all of the Members of this Committee when I say that we are here to support you in any manner appropriate, but we do need to know that VA is on track for a fair budget based on our needs for the upcoming fiscal year.

I would just state for the record that VA and OMB are still negotiating on specific amounts for various VA programs. As I said in my opening statement, this Committee must still provide input to the Budget Committee.

Your full statement, Mr. Secretary, of course, will appear in the record of the Committee.

Secretary Shinseki, will you please begin with your statement?

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary SHINSEKI. Thank you, Chairman Akaka, Ranking Member Burr, other Members of this distinguished Committee. Thank you for the opportunity to present an overview of the 2010 budget for the Department of Veterans Affairs.

I appreciate also the opportunity to have had a chance to speak with a number of the Committee Members prior to coming to testimony today, and I regret that I was not able to get to everyone, but I will certainly make up for that in the future.

Let me also acknowledge, as many of you have, and thank the leaders of our veterans service organizations who are present here today. We look at each other as partners in this effort to ensure that our veterans remain the center focus of all that we do. So I welcome them, and I thank them for their help and support to the VA as well as to those of you who sit on this Committee.

As I have said before, President Obama has charged me with transforming the VA into a 21st Century organization—not change for the sake of change, not nibbling around the edges—but a fundamental and comprehensive review of all that we do for veterans and then moving boldly to acknowledge new times, new demographic realities, leveraging new technologies to renew our commitment to our veterans wherever they live.

I have been conducting that comprehensive and fundamental review for nearly 7 weeks now, and it is not nearly over, but I would like to share with you a snapshot of what I have gleaned thus far since my last appearance before this Committee.

A new GI Bill: We hired an outside consultant to conduct a quick-look study to validate our plans and procedures for executing this large new program of educational benefits. The quick look was

completed on 27 February, and it basically validated all the steps and procedures we are to put into place, what we are doing.

They provided eight additional risk areas—risk factors for us to consider—which we had not thought about. I have accepted them all except for one, and that one was solved internally. And I am satisfied that we will get veterans who apply in time into schools this fall.

I will tell you it remains a high-risk enterprise only because of the very compressed timelines we are working with. But we have mitigated that risk responsibly. I have reviewed it, and at this point I classify the risk as acceptable.

But, as you know, there are milestones that have to be met between now and the execution dates in August. If any of those are delayed or founder, I will have to readjust that risk assessment. But that is something I will do and keep the Committee updated as we progress.

The 2009 plan for this new GI Bill will be a computer-assisted manual system. That is the best I can do at this point, a computer-assisted manual system. We hope to move to a fully automated system in 2010, but we are not able to do that this year.

For 2009, user testing of the interim IT solution was completed, and phase one training for our newly-hired 530 employees began yesterday.

The final regulation is at OMB. The contingency plan is finished. Final coordination is underway. My estimation: all is in order to meet the August 2009 implementation date. We still have multiple milestones to meet, as I have indicated, and I will keep you abreast of how we fare in meeting them.

Paperless: Our goal is to re-engineer the claims process into a fully paperless environment by no later than 2012. Our lead systems integrator has been on board since October of this past year, reviewing all of our business processes and beginning key design deliverables which we expect by August of this year. Application developers will then begin building specific components in early fiscal year 2010, capitalizing on recent successes with VETSNET and leveraging funding that should be available early in next year's budget.

We are already processing loan guarantees, insurance and educational claims electronically and plan to conduct a business transformation pilot at the Providence Regional Office later this year.

In conjunction with this paperless initiative, DOD and VA have met three times now to address the potential for automatically enrolling all military personnel into the VA upon their entry into the Armed Forces—just a statement of what we are seeking to do. We call this initiative Uniform Registration. We are in agreement about the goodness of such a system and have people working toward making this a reality.

Uniform Registration will push both the VA and the DOD to create a single electronic record that would govern how we acknowledge, identify, track, and manage each of our clients: those in Active service; those in the Reserve components and when they become veterans, how we continue that same management process.

This automatic enrollment is intended to take place when the first allegiance is sworn by a youngster donning one of our country's uniforms.

Our management decisions will be better, faster, more consistent and fair, and less subject to lost files or destroyed claims. Such electronic records would have a personnel component and a medical component. We have benefited from the insights, experience and advice of Secretary Gates and Deputy Secretary Lynn about not trying to build a single large database. So we are committed, both Secretary Gates and I, to doing this smartly and differently from some of our recent, past, hard lessons learned.

In the VA's experience, the EHR, the electronic health record, has figured prominently in the growth and quality of medical services. In 1997, we rolled out an enterprise-wide update for our EHR. We have had an electronic health record experience for 20 years, but in 1997 we rolled out an enterprise-wide update that, by 1999, provided for us a clinical data repository including privacy protection with real-time data flow across the entire system, with clinical decision support and clinical alert templates, notification systems and disease management features.

Today, it has an imaging capability that allows tracking of all tests done on any patient: everything from EKGs to studies; procedures; endoscopies; scanned documents. Some international observers, I am told, have called it the Gold Standard in clinical informatics.

What has been the impact of this improved EHR for the VA? Between 1996 and 2004, this updated electronic medical record enabled VA's ability to handle a 69 percent increase in patients; reduce the workload by over 35 percent; and hold the cost of medical treatment steady when the cost of health care across the country was climbing significantly.

Now some would suggest that the VA's lower cost of treatment was as much a function of its lean budget in some of those years as they were efficiencies that we practiced. But, in reality, I think it is fair to say that lean budgets were not just not visited on the VA but on other government institutions as well. At Medicare, health costs rose 26 percent at a time when we were able to keep ours under control.

So, that is where we are with what we understand is the potential for what we can achieve working with DOD in coming to this single electronic record. The challenge for all of us is making health care more accessible to more folks, keeping the costs down, and increasing the quality. If we can do those three things, we will have achieved something significant.

Regarding the backlog that some of you have already mentioned, this is the area I have to tell you that I have not made much headway—at least not in 7 weeks—in attacking the problem, either in understanding it or solving this dilemma other than to acknowledge that it is a significant obstacle to building trust with veterans and the organizations who represent them.

I am not sure that I personally have a valid working definition for the backlog. When I ask if a claim is initiated today, is it part of the backlog tomorrow, I am told it is. So, I need a way to come

up with a set of metrics that allow me to solve a problem that right now I cannot address.

So, I am personally working this issue. I intend to develop a valid way of defining what the backlog is—and not defining myself out of a situation but defining myself into a way to measure it properly—and then to set about fixing it. If I cannot do that, I do not think any of us will be able to solve it.

So our efforts to institute Uniform Registration to create a single electronic record will lay the foundation for eventually controlling the inputs to the backlog dilemma, but I must find ways to control and reduce the backlog as it exists today, and I must tell you that is probably a brute force solution which requires a lot of hands on.

Now having provided you this update, let me now report that our proposed 2010 budget is critical to realizing the President's vision for a 21st Century VA, and it is also critical to helping me begin to solve some of the problems I have touched on. The proposal would increase VA's budget to $112.8 billion, up $15 billion or 15 percent from the 2009 enacted budget. This is the largest dollar and percentage increase ever requested by a President on behalf of veterans.

Nearly two-thirds of the increase, $9.7 billion, would go to mandatory programs, up 20 percent. The remaining third, $5.6 billion would be discretionary funding, up 11 percent. The total budget would be almost evenly split between mandatory funding, $56.9 billion, and discretionary funding, $55.9 billion.

The 2010 budget funds the new GI Bill and would allow a gradual expansion of health care eligibility to Priority 8 group veterans who have been excluded from VA care since 2003—an expansion of up to 550,000 new enrollees by the year 2013. Further, it contains sufficient resources to ensure that we will maintain our quality of health care for veterans, which sets the national standard for excellence in my opinion, with no adverse impact on wait times for those already being served.

The 2010 budget provides greater benefits for veterans who are medically retired from active duty. By phasing in an expansion of concurrent receipt eligibility to military disability retirees, the proposal will allow highly disabled veterans to receive both their military retired pay and VA disability compensation benefits.

The budget provides resources to effectively implement the Post-9/11 GI Bill and streamline the disability claims system. It supports additional specialty care in such areas as: aging; women's health; mental health; homelessness; prosthetics; vision; spinal cord injury; and it helps to extend VA services to rural communities which lack access to care.

The details of the President's budget are still being finalized, and I expect that it will be available in April. So, I lack budgetary detail on specific programs and activities today. I do, however, look forward to your questions and will do my best to answer them.

Thank you, Mr. Chair.

[The prepared statement of Secretary Shinseki follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, Senator Burr, distinguished Members of the Committee: Thank you for this opportunity to present an overview of the 2010 budget for the Depart-

ment of Veterans Affairs (VA). President Obama has charged me with transforming VA into a 21st Century organization—a transformation demanded by new times, new technologies, new demographic realities, and new commitments to today's Veterans.

The VA's proposed 2010 budget demonstrates the President's commitment to our Nation's Veterans and a transformed VA that is people-centric, results-driven, and forward-looking. The proposal would increase VA's budget to $113 billion—up $15 billion, or 16 percent, from the 2009 enacted budget. This is the largest one-year dollar and percentage increase for VA ever requested by a President.

Nearly two-thirds of the increase ($9.7 billion) would go to mandatory programs (up 20 percent); the remaining third ($5.6 billion) would be discretionary funding (up 11 percent). The total budget would almost evenly split between mandatory funding ($56.9 billion) and discretionary funding ($55.9 billion).

The President's 2010 budget is the first step toward increasing VA funding by $25 billion over the baseline over the next five years. This strong financial commitment will ensure Veterans receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation.

These resources will be critical to our mission of addressing Veterans' changing needs over time. This funding pledge ensures we can deliver state-of-the-art health care and benefits; grow and maintain a skilled, motivated, and client-oriented workforce; and implement a comprehensive training and leader development program for long-term professional excellence at VA.

The Administration is still developing the details of the President's 2010 budget request, to be released in late April. As a result, I cannot address today the funding for any specific program or activity. However, I want to summarize this budget's major focus areas that are critical to realizing the President's vision and fulfilling my commitment to Veterans.

DRAMATICALLY INCREASING FUNDING FOR HEALTH CARE

VA's request for 2010 provides the funds required to treat more than 5.5 million Veteran patients. This is 9.0 percent above the Veteran patient total in 2008 and is 2.1 percent higher than the projected number in 2009. The number of patients who served in Operations Enduring Freedom and Iraqi Freedom will rise to over 419,000 in 2010. This is 61 percent higher than in 2008 and 15 percent above the projected total this year.

The 2010 budget request enables VA to achieve the President's pledge of strengthening the quality of health care for Veterans. We will increase our emphasis on treating those with vision and spinal cord injury and meet the rising demand for prosthetics and sensory aids. We will respond to the needs of an aging population and a growing number of women Veterans coming to VA for health care. The delivery of enhanced primary care for women Veterans is one of VA's top priorities. The number of women Veterans is growing rapidly. In addition, women are becoming increasingly dependent on VA for their health care. More than 450,000 women Veterans have enrolled for care and this number is expected to grow by 30 percent in the next five years. We will soon have 144 full-time Women Veterans Program Managers serving at VA medical facilities. They will serve as advisors to and advocates for women Veterans to help ensure their care is provided with the appropriate level of privacy and sensitivity.

The Department will continue to actively collaborate with the Department of Defense (DOD) to establish a DOD/VA vision center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of eye injuries. The FY 2010 budget request provides resources to continue development of a network of eye and vision care specialists to assist with the coordination and standardization of vision screening, diagnosis, rehabilitative management, and vision research associated with Traumatic Brain Injury (TBI). This network will ensure a continuum of care from DOD military treatment facilities to VA medical facilities.

EXPANDING HEALTH CARE ELIGIBILITY

For the first time since 2003, the President's budget expands eligibility for VA health care to non-disabled Veterans earning modest incomes. This commitment recognizes that economic conditions have changed and there are many lower-income Priority 8 Veterans who are now facing serious financial difficulties due to the rising cost of health care. This year VA will open enrollment to Priority 8 Veterans whose incomes exceed last year's geographic and VA means-test thresholds by no more than 10 percent. We estimate that 266,000 more Veterans will enroll for care in 2010 due to this policy change. Furthermore, the budget includes a gradual expan-

sion of health care eligibility that is expected to result in nearly 550,000 new enrollees by 2013. The Department's 2010 budget contains sufficient resources to ensure we will maintain our quality of care, which sets the national standard of excellence. Further, there will be no adverse impact on wait times for those already enrolled in our system.

ENHANCING OUTREACH AND SERVICES RELATED TO MENTAL HEALTH CARE AND COGNITIVE INJURIES, INCLUDING POST-TRAUMATIC STRESS DISORDER (PTSD) AND TRAUMATIC BRAIN INJURY (TBI), WITH A FOCUS ON ACCESS FOR VETERANS IN RURAL AREAS

The Department's 2010 budget provides the resources VA needs to expand inpatient, residential, and outpatient mental health programs. A key element of VA's program expansion is integrating mental health services with primary and specialty care. Veterans receive better health care when their mental and physical needs are addressed in a coordinated and holistic manner.

This budget allows us to continue our effort to improve access to mental health services across the country. We will continue to place particular emphasis on providing care to those suffering from PTSD as a result of their service in Operations Enduring Freedom and Iraqi Freedom. The Department will increase outreach to these Veterans as well as provide enhanced readjustment and PTSD services. Our strategy for improving access includes expanding our tele-mental health program, which allows us to reach thousands of additional mental health patients annually, particularly those living in rural areas.

To better meet the health care needs of recently discharged Veterans, the 2010 budget enables VA to expand its screening program for depression, PTSD, TBI, and substance use disorders. The Department will also enhance its suicide prevention advertising campaign to raise awareness among Veterans and their families of the services available to them.

In 2010, VA will expand the number of Vet Centers providing readjustment counseling services to Veterans, including those suffering from PTSD. The Department will also improve access to mental health services through expanded use of community-based mental health centers. We will continue to place VA mental health professionals in community-based programs to provide clinical mental health services to Veterans. Where appropriate, we will provide fee-basis access to mental health providers when VA services are not reasonably close to Veterans' homes. We will also expand use of Internet-based mental health services through "MyHealth*e*Vet," which provides an extensive degree of health information to Veterans electronically. These steps are critical to providing care to Veterans living in rural areas.

The 2010 budget provides resources for vital research projects aimed at improving care and clinical outcomes for Veterans of Afghanistan and Iraq. Some of this key research will focus on TBI and polytrauma, specifically studies on blast-force-related brain injuries, enhancing diagnostic techniques, and improving prosthetics. We will strengthen our burn injury research to improve the rehabilitation and daily lives of Veterans who have suffered burns. VA will also enhance research on chronic pain, which afflicts one of every four recently discharged Veterans. And the Department will also advance research on access to care, particularly for Veterans in rural areas, by studying new telemedicine efforts focused on mental health and PTSD.

INVESTING IN BETTER TECHNOLOGY TO DELIVER SERVICES AND BENEFITS TO VETERANS WITH THE QUALITY AND EFFICIENCY THEY DESERVE

Leveraging information technology (IT) is crucial to achieving the President's vision for transforming VA into a 21st Century organization that meets Veterans' needs. This is critical not only for today's demands, but also for laying a foundation for high-quality, timely, and accessible service to Veterans, whose use of VA services is expected to grow year to year.

IT is an integral component of VA's health care and benefits delivery systems. They enable VA's ability to deliver high-quality health care, ranging from emergency treatment to routine exams in medical centers, outpatient clinics, and in-home care and telehealth settings. These technologies are also the foundation of our benefits delivery systems, to include, for example, compensation, pensions, education assistance, and burial benefits. VA depends on a reliable and accessible IT infrastructure, a high-performing IT workforce, and modernized information systems that are flexible enough to meet both existing and emerging service delivery requirements. Only in this way can we ensure system-wide information security and the privacy of our clients. The President's 2010 budget for VA provides the resources necessary to meet these vital IT requirements.

This budget strongly supports the most critical IT development program for medical care—advancement of VA's "Health*e*Vet" program, which is the future founda-

tion of our electronic health record system. This system includes a health data repository, a patient scheduling system, and a reengineered pharmacy application. "Health*e*Vet" will equip our health care providers with the modern technology and tools they need to improve the safety and quality of care for Veterans.

The Secretary of Defense and I are collaborating to simplify the transition of military personnel into civilian status through a uniform approach to both registering into VA and accessing electronic records data. Through a cooperative effort, we seek to improve the delivery of benefits and assure the availability of medical data to support the care of patients shared by VA and DOD. This will enhance our ability to provide world-class care to Veterans, active-duty servicemembers receiving care from both health care systems, and our wounded warriors returning from Iraq and Afghanistan.

The 2010 budget provides the funds necessary to continue moving toward the President's goal of reforming the benefits claims process to ensure VA's claims decisions are timely, accurate, fair, and consistent through the use of automated systems. VA's paperless processing initiative expands on current paperless claims processing already in place for some of our benefits programs and will improve both the timeliness and accuracy of claims processing. It will strengthen service to Veterans by providing them the capability to apply for and manage their benefits on-line. It will also reduce the movement of paper files and further secure Veterans' personal information. The initial features of the paperless processing initiative will be tested in 2010, and by 2012 we expect to complete the implementation of a fully electronic benefits delivery system.

PROVIDING GREATER BENEFITS TO VETERANS WHO ARE MEDICALLY RETIRED FROM SERVICE

The President's 2010 budget provides for the first time concurrent receipt of disability benefits from VA in addition to DOD retirement benefits for disabled Veterans who are medically retired from service. Presently, only Veterans with at least 20 years of service who have service-connected disabilities rated 50 percent or higher by VA are eligible for concurrent receipt. Receipt of both VA and DOD benefits for all who were medically retired from service will be phased in starting in 2010.

COMBATING HOMELESSNESS BY SAFEGUARDING VULNERABLE VETERANS

The President has committed to expanding proven programs and launching innovative services to prevent Veterans from falling into homelessness. The 2010 budget includes funds for VA to work with the Departments of Housing and Urban Development, Labor, Education, Health and Human Services, and the Small Business Administration, in partnership with non-profit organizations, to improve the well-being of Veterans. This effort focuses on reducing homelessness and increasing employment opportunity among Veterans, and includes a pilot program aimed at maintaining stable housing for Veterans at risk of homelessness while also providing them with ongoing medical care and supportive services.

FACILITATING TIMELY IMPLEMENTATION OF THE COMPREHENSIVE EDUCATION BENEFITS VETERANS EARN THROUGH THEIR DEDICATED MILITARY SERVICE

The Department is on target to implement the Post-9/11 Veterans Educational Assistance Act starting August 1, 2009. VA is pursuing two parallel strategies to successfully implement this new education program, both of which are fully supported by the resources presented in the 2010 budget.

The short-term strategy relies upon a combination of manual claims processing and modifications to existing IT systems. Until a modern eligibility and payment system can be developed, VA will adjudicate claims manually and use the existing benefits delivery network to generate recurring benefit payments to schools and program participants. This budget includes funds to hire and maintain the additional staff required.

The long-term strategy is the development and implementation of an automated system for claims processing. The Department has teamed with the Space and Naval Warfare Systems Command to address the necessary IT components of this strategy. They are the premier systems engineering command for the Department of the Navy, and they have extensive experience in building state-of-the-art IT systems. The automated solution will be available by the end of calendar year 2010, by which time full operational control of the automated system will be in VA's hands.

CLOSING

Veterans are VA's sole reason for existence and my number one priority—bar none. I am inspired by this Committee's unwavering commitment to Veterans, and I look forward to working with you to transform VA into an organization that reflects the change and commitment our country expects and our Veterans deserve.

Chairman AKAKA. Thank you very much, Secretary Shinseki.

I must commend you for what you have been doing for the last 7 weeks. You have certainly accomplished a lot in dealing with the needs of VA and working with the Secretary of Defense on some of these issues. So, I thank you very much.

I do have questions, but I would like to give my Committee Members a chance to ask their questions first. So, I will ask Senator Burr to begin with his questions.

Senator BURR. Well, I thank the Chair for his generosity.

Mr. Secretary, thank you for that report.

Let me go right to the meat of it. I am concerned, as I expressed in my opening statement, that though the 2010 budget I think targets a number that is very realistic, I am concerned with the out years: 2011 at 2.3, 2012 at 2.6.

So I guess my question is multi-pronged. If Priority 8s are being considered in the 2010, what number of the Priority 8s have you modeled into the 2010 and is the 2011, is the 2012 reflective of additional Priority 8s of potentially those active duty that will be part of the Veterans' Administration by 2011, by 2012, by 2013? Is that modeled into the projections that we see reflected?

Secretary SHINSEKI. Senator, the figure for 2010 reflects that we expect about 266,000 Priority 8 group veterans to be registered with us and then, over the period to 2013, building that number up to 550,000 veterans.

I do not have a good figure on the entire population now. Some of that is due to the fact, as you described, we are constantly growing that population. But we are working with trying to get a better estimate, so I can provide a little better detail. But at least for out through 2010, we are looking at 266,000 veterans.

Senator BURR. I would like to ask you on the Committee's behalf today, as we go through 2010 and you begin to bring in Priority 8s, will you regularly make us aware of how many Priority 8s have come into the system?

The pre-enrollment into the VA that you talked about certainly changes the projections for the out years as far as how many veterans would then choose the VA for their home for medicine. Is that policy change also incorporated into these out year budget projections?

Secretary SHINSEKI. Not at this point. We are still working on an agreement on how to do this.

I think for the vast majority the enrollment will be for identity and tracking purposes. The vast majority of youngsters who leave the service do not enroll with the VA for a variety of reasons, but in later years find reasons to come back to us. And the challenge at that point is doing all the kinds of things we could do now: identify, track, and be ready to help with a claims submission in a way that we are not today.

Senator BURR. Many members brought up in their opening statements concerns as it relates to the VA's intent to raise revenue by

billing insurance companies and charging them for the VA's care related, I think, to medical services even for service-connected injuries. Is that policy contained in this budget?

Secretary SHINSEKI. It is a consideration. A final decision has not been made yet, Senator, but it would fall into the category of what I would describe as risk. It is the risk we carry every year in third-party collections.

Senator BURR. I appreciate your candor on this. It is an important matter to be finalized prior to understanding exactly whether the budget allocations are, in fact, correct and certainly as it relies on the out years when you are dealing with such small percentages of projected increase.

If, in fact, you give up a revenue stream as significant as that—and I think I would agree with Senator Murray, I think you will give that up—then it makes those out years look even more problematic.

Mr. Secretary, I appreciate your commitment to using automation to help improve the disability claims process. I think we can all agree that a paperless claims process would be a significant improvement, but automation alone may not be enough to significantly reduce the delays and frustrations experienced by many veterans seeking VA benefits. Do you agree with the *Independent Budget* that the VA also needs to take steps to improve training, quality assurance, and accountability; and, if so, does this budget allow you to accomplish those goals?

Secretary SHINSEKI. I agree with the comment on training and sustainment training for people who do this. And, yes, that kind of training is included.

Senator BURR. Mr. Chairman, my time is expired.

I challenged the VSOs several weeks ago, General, to start with a clean piece of paper and tell us how to design that process so that we would not have a backlog system, and I say to all of them that are here today I am still waiting for those plans. I know they are all working on them, but time is of the essence right now.

Thank you, General.

Secretary SHINSEKI. Senator, I have made the same challenge to my people: If we are going to start with a clean slate here, how would you redesign the process? This is sort of like trying to paint a moving train, and they owe me some answers as well.

Senator BURR. I think we may all be shocked at how close the ideas come.

Secretary SHINSEKI. I just would like to make one comment on the third-party collections, and I know that the VSOs and I have personally had discussions on this. So I know there is a different perspective on this.

Health care delivery has two pieces. One is financing, and the other is the delivery of quality care.

What is not at issue here is the delivery of timely, highest quality care in the Nation that we can provide. That is not a question here.

This is about financing, and that is where the dialog continues.

Senator BURR. General, I believe you on that, and I believe that that is the mission of VA. I know you understand why I have to raise the issue, that if you eliminate a built-in revenue stream that

has gone into the projections for construction of the budget, you eliminate some of that.

When the last administration was operating with a tremendous amount of liberty with respect to revenue streams. Individuals on this Committee questioned the accuracy of the last administration's budget. As a matter of fact, the President was a Member of this Committee, and at that time talked about budget gimmicks in the last administration.

My attempt is to make sure that all of the items that are there to construct the budget are foundational—that they do not go away with the wind. So, if we are going to eliminate some of them, let's eliminate them up front. Let's know what we are going to deal with. Let's have the transparency of the budget process, and I only encourage you to try to get the Administration to come to that conclusion sooner rather than later.

Secretary SHINSEKI. OK.

Chairman AKAKA. Thank you very much, Senator Burr.

Now, Senator Murray, for your questions.

Senator MURRAY. Yes, thank you, Mr. Secretary. Can you tell us what the revenue impact of the third-party billing proposal?

Secretary SHINSEKI. What the impact is?

Senator MURRAY. The revenue impact, yes.

Secretary SHINSEKI. Well, you know I usually have third-party collections for non-service-connected. In the past, we have exceeded our targets. In 2008, I think we are at $2.4 billion, and 2009 looks like it is going to be slightly above, maybe closer to $2.5.

Using that as a general start point, I would guess that something on the order of $500 million is probably the target that would appear here.

Senator MURRAY. Right. Then we did have this discussion.

I just, again, tell you that I think our veterans already paid, and proposals that just simply balance the VA budget on their backs are, you know, as far as I am concerned, dead on arrival. But, again, we will be looking for that, but I question the revenue impacts on that. So I am sure we will have more discussions if that proposal becomes real.

Secretary SHINSEKI. I am sure we will.

Senator MURRAY. Let me thank you on the Priority 8 veterans again. I think the best thing to do is to completely overturn the 2003 ban. I appreciate your moving forward with your target of 550,000 by 2013, and I will continue to work with you on that.

Secretary SHINSEKI. We will look at that en route and just make sure our metrics are right. Again, part of the decision here is to ensure we do not impact any other services we are providing. So if we can go faster, that is fine. If we have to slow down a little, the end state is still clear.

Senator MURRAY. OK, very good. I appreciate that.

Let me ask you, the economy is number 1 on everybody's mind, and people are very concerned about it. I have been concerned, watching our veterans come home. We know that in 2007 the unemployment rate for veterans aged 18 to 24, who served in Iraq and Afghanistan was considerably higher than the rate for non-veterans. I am assuming that trend is continuing.

As many of our veterans come home and transition into civilian employment, there are a lot of different Federal agencies that have different support services. The VA does, of course. DOL has the Veterans Unemployment and Training Service. I am concerned about the complexity of that and wanted to know what your thoughts are on improving the transition for our veterans into civilian jobs and working with these other agencies to address some of the gaps.

Secretary SHINSEKI. Senator, I will tell you that this is one of those areas where I would describe lots going on, and yet I do not have my fingers around all of it. I am still discovering that there are programs out there, that in fact some of them are doing very well, others less so.

For the transition, I think it is fair to say, and the President has said it, so I will use his words, that veterans lead the country in joblessness, homelessness, substance abuse, mental health problems. So that is a tall order because it is not one thing. It is a multiplicity of things. Some of them touch, some of them do not touch.

But I think, as was said earlier here, if we prevent homelessness, we have a much better chance of solving some of the other things. So the first order of business here is paying attention to that.

Secretary Donovan and I have met. We have met with the Coalition of Homeless Veterans Organizations, representatives of some 20 organizations. We have committed to working together, he and I, with his opportunity to provide safe housing and my opportunity to prioritize how we get people in there. We look at that as sort of the first piece.

Once we have them safely housed, and families are included in our discussions, then we can begin the rest of this: talking about getting them off of whatever ailments they may have, like substance abuse; get mental health treatments going; and then talk about training for either education or jobs. For that, I will have to reach out to other departments much as I have with DOD.

And so, there is a lot of work to be done, but I think, as I say, it is a large issue. Lots going on. I am not sure all of it is as well synchronized as we would like, and I intend to get into that.

Senator MURRAY. I appreciate that. Again, once we get the 2009 bill passed, hopefully tonight, we do have money in there for some pilot projects on homelessness. I agree with you, you got to have home in order to be able to go to work.

But I hope we can really begin to focus on some of the efforts to bring our agencies together to make sure that these young men and women come home and do not end up on unemployment rolls; and really look at how we can get them into the job market.

A quick question: You used the words "brute force," on the claims backlog. I assume that means funding and staffing. Do you have adequate money for that brute force that you are going to need?

Secretary SHINSEKI. For 2009, that is clear. I am still waiting on a report that says we have to increase those numbers. This year alone, we hired another, I think, 1,100 people—3,000 in the last 2 years. And so, we have right now 11,300 people doing this.

If I am going to increase those personnel assets in 2010, I want to see what the return on investment is going to be. Just adding

people to work on this problem may not be the only approach, and so I need to press for doing this better, not just with more hands.

Senator MURRAY. OK. Thank you very much.

Chairman AKAKA. Thank you very much, Senator Murray.

And now I would like to call on Senator Graham for his questions.

STATEMENT OF HON. LINDSEY GRAHAM,
U.S. SENATOR FROM SOUTH CAROLINA

Senator GRAHAM. Thank you, Mr. Chairman.

General, I appreciate your serving your country yet again. You have a tough job.

But when it comes to dealing with the claims backlog, there was an initiative, I think a year ago or 2 years ago, about looking at providing legal representation to our veterans as they pursue claims. How do you feel about that proposal?

Secretary SHINSEKI. Senator, I would never stand in the way of a veteran seeking assistance in putting together the best claim he or she can put together so that we have the best shot of giving a quality decision quickly.

Senator GRAHAM. I tell you what, why don't you, if you could, just have your people look at the proposal a couple years ago and let me know what you think about that idea?

Secretary SHINSEKI. I would prefer that that not be on a paid basis.

Senator GRAHAM. That what?

Secretary SHINSEKI. That that not be on a paid basis. I think I am very comfortable with pro bono support, volunteer support for our veterans. But you know my primary responsibility is to help veterans.

Senator GRAHAM. Would you feel that way about social security? Why should a social security recipient be entitled to paid representation and a veteran not?

Secretary SHINSEKI. I was not aware of that, Senator. I do not know that I have a good opinion today. But my job is to make sure that veterans have what they are entitled to with the least obstruction, and if they seek legal advice on it, I think that is fine. I would hope that we could do this in a way that veterans could get what they deserve.

Senator GRAHAM. Thank you.

How can 500,000 people being added to the system not impede care for some people? I mean are we so well staffed that you could add 500,000 Priority 8 veterans and it not hurt someone who has been permanently disabled or a severely paralyzed veteran in terms of the care they would receive?

Secretary SHINSEKI. I believe that, well, that is our intent. I do not know that I can give you an absolute here, but this is a process by which we grow to 550,000 over a period of time, and we will have to make those assessments as we go.

Senator GRAHAM. And the only reason I raise that is I guess I would be, well, income-wise I would not be eligible.

But if you believe that organizations cannot be all things to all people, you serve as many as you can. Then the military is sort of a triage system here, that we want to make sure that those who

have been most severely injured and have the highest medical needs are taken care of. So we will just cross that bridge when we get there.

The one thing about expanding coverage in terms of the people you treat, something usually has to give unless you just continue to increase the size of the organization, and that is something I would like to talk with you about as we get into this.

Secretary SHINSEKI. Sure.

Senator GRAHAM. Have you looked at Senator Dole-Secretary Shalala proposals about how we would go forward in terms of claims and compensation?

Secretary SHINSEKI. Yes, I have.

Senator GRAHAM. What was your view of that?

Secretary SHINSEKI. Well, frankly, it was one of several views that are being looked at. We have another, the Scott Commission's views that provided similar recommendations. What I have asked for is a harmonizing of these reports out of multiple studies on the same subject and find where there is common ground.

Senator GRAHAM. But that will be part of the study mix, their proposal?

Secretary SHINSEKI. That is correct.

Senator GRAHAM. Have you heard of the Charleston model where the Medical University of South Carolina and the VA hospital in Charleston are trying to build a new hospital in collaboration?

Secretary SHINSEKI. I am aware, yes.

Senator GRAHAM. Does that sound like a reasonable proposal as we go forward to improve health care for veterans?

Secretary SHINSEKI. I think, well, we are reviewing all of our major construction initiatives.

Senator GRAHAM. I would really encourage you to do that because there are a lot of teaching hospitals, university hospitals, private organizations that serve veterans, that if you combined the two funding pools you would have a better service for the veteran and get more bang for your buck. The goal is to add to, not take away. So I appreciate your looking at that.

Secretary SHINSEKI. We do that now, Senator. About 108 of our 153 hospitals are affiliated with medical centers.

Senator GRAHAM. I am talking about as we construct new ones.

Secretary SHINSEKI. Right.

Senator GRAHAM. And I think you can get a bigger hospital to help veterans as well as the people in the area.

One last question. You said something to me that was pretty intriguing, that you have been able to manage the health care costs of the veteran population significantly without the inflationary costs associated with Medicare. Medicare has grown in terms of health care inflation much faster than the VA.

What would you say would account for that and would you be willing to go to the Medicare people and talk to them? We will pay your mileage.

Secretary SHINSEKI. This is an area that has a little bit of debate because part of the cost factor was some lean budgets. So you can say it was induced, but out of that came some tough decisions on what we would keep, what we had to sort of put on the back burner or discard. And so, for a variety of reasons, not just the elec-

tronic health record, our costs were maintained and/or slightly reduced in a period of time when others, to include Medicare, were increasing by 26 percent.

What are the things I am talking about?

Prior to 1997, patient records were available to doctors about 60 percent of the time, which meant the other 40 percent involved either a doctor's time arriving at a patient's bedside and nothing could happen, or maybe even worse—flying by the seat of our pants. That has changed. A hundred percent of our records are available all the time now.

In 1996, we lagged industry in providing pneumonia vaccine to patients over 65—something around 28 or 29 percent. Today, we are at 94 percent and leading the industry.

So, in terms of delivering quality health care when needed, at the appropriate time, without a lot of repeats, without a lot of tests being redone because we did not know what was in the system, we have been able to reduce costs.

Senator GRAHAM. One final comment. I have been following this like most people on the Committee and being a military member myself, pretty closely, and the number of complaints about veterans' health care, at least in my State, has gone down.

I am sure there are problems. But one thing I want you to tell the people that work for you—particularly in the hospitals and the service organizations and our VSOs—I think we have the best system in the world and do not ever lose sight of that. I would like to make it better, but there are a lot of complaints always talked about in Congress. But to those people working in the VA, I think you do a heck of a job.

And you are the right guy at the right time, I agree with that. Thank you very much.

Secretary SHINSEKI. Thanks, Senator.

Chairman AKAKA. Thank you very much, Senator Graham.

Now we will have questions from Senator Tester.

Senator TESTER. Thank you, Chairman Akaka.

And I want to echo those remarks of Senator Graham in that your people do great work. We always need to continue to look for ways to improve the system, as I know you do, but the truth is I get a lot of positive comments from the veterans back in Montana about the health care that they receive.

That being said, just very quickly, could you tell me your perspective on Priority 8 vets as to why you think they should be in the system?

Secretary SHINSEKI. Well, for one thing, Senator, they are part of our veterans' programs.

I mean the fact that they have not been serviced for the past 8 years does not mean they are not veterans. They are veterans. They are part of our system. They have entitlements based on economics and location. And given the current economic situation, I think the stress on all of our veterans is even greater. Therefore, I look forward to taking care of this part of our responsibility.

Senator TESTER. I appreciate your commitment to them. I agree with you wholeheartedly. I guess I am going to push in a little different direction in that the program here talks about a 5-year

schedule to get the Priority 8s into the system. Is there any way it could be done quicker than that, say 2–3 years?

Secretary SHINSEKI. We will certainly look at that, Senator.

I would just say again, bringing Priority 8s on gradually is a function of ensuring that what we do today remains high quality for the variety of services we provide. So it is a rheostat. We will do it faster if we can assure these other things remain at high quality.

Senator TESTER. I appreciate that, General.

The 2009 VA Appropriations Bill provides about $250 million for rural health initiatives. We know where some of the dollars are going. Is it possible, and I do not expect you to do that today unless you know, to get an update on where all the money is going for rural health initiatives?

Secretary SHINSEKI. Certainly, I would like to provide that once I have more detail.

Senator TESTER. That would be good. I am sure, as well as Montana, other rural States including Alaska would love to know that.

Secretary SHINSEKI. I can certainly provide the 2009 priorities now.

Senator TESTER. In how the money is being utilized?

Secretary SHINSEKI. That is correct.

Senator TESTER. That would be great.

You talked about electronic health records pretty extensively in your opening statement and the benefits for moving forward with that with the DOD. I guess my question is, have we allocated enough resources to meet the needs of that transition—number 1? And, number 2, have your conversations with the higher-ups in the DOD indicated a willingness to work with you?

Secretary SHINSEKI. Yes. Yes, there is agreement that uniform registration makes sense and that a single electronic record is something we need to go to work on. As in all things, the devil is in the details here on exactly what that constitutes. But, yes.

Senator TESTER. OK. Have we fully funded the mental health diagnosis and treatment to this point to your knowledge?

Secretary SHINSEKI. I believe so. I can tell you we are doing it, and I would say yes, we have funded it.

Senator TESTER. OK. Kind of along those lines as long as I have about a minute left here, could you give me any indication as to what, if anything, the VA is doing to track mental health concerns amongst our military folks who are in your system?

Secretary SHINSEKI. You are talking OEF/OIF returnees?

Senator TESTER. Yes, specifically, those; and if you want to talk more generally, that is fine because there are issues that revolve around the previous wars too.

Secretary SHINSEKI. I would say that we participate with DOD and have participated with them in assessments that they have done since 2005. Through our joint work, over 93,000 referrals have taken place.

Senator TESTER. Go ahead.

Secretary SHINSEKI. We are participating in demobilization enrollment for our Reserve component personnel in terms of OEF/OIF transitions.

Senator TESTER. Yes.

Secretary SHINSEKI. And so, we are actively engaged in that. Let me just give you some figures. For example, we now have 18,000 full-time equivalent staff, $4 billion going to mental health programs, and we are interviewing veterans, returnees from Iraq and Afghanistan.

Either when they come in for services from us, we screen them or we have called them, phone calls in the number of 600,000. We have only gotten about 150,000 responses, but we continue to work that. We are reaching out to this population.

Senator TESTER. If I just might, Mr. Chairman.

There is a program that deals with Reservists and Guardsmen. It is a pilot program in five States called Beyond the Yellow Ribbon. Are you familiar with that program at all?

Secretary SHINSEKI. I am, yes.

Senator TESTER. Good. Do you think that that program has enough merit to be implemented at least initially with Guardsmen and Reservists throughout all 50 States?

Secretary SHINSEKI. I will have to look at that, but, yes, I think there is merit to the program. When you say all 50 States——

Senator TESTER. OK. And when you are looking at that, see if you think it has merit for active duty too.

The reason I say that is because we had a hearing here 2 or 3 weeks ago that the Chairman called that dealt with mental health issues. It requires screening every 6 months for 2 years after they are out, and it takes away the stigma, I think. It really does help folks that serve that could, quite honestly, get screwed up and helps get them treatment when they need it early and saves money over the long haul.

General, I want to thank you for being here today. I really appreciate your testimony, perspective, and leadership in the VA. Thank you.

Secretary SHINSEKI. OK. Thank you.

Chairman AKAKA. Thank you very much, Senator Tester.

Now we will have Senator Begich ask his questions.

Senator BEGICH. Thank you, Mr. Chairman.

Just a couple. I want to do a little follow-up. I know Senator Graham had some questions regarding the claims; and I thought maybe—I don't know if it was when we were talking about it—but of the claims that are filed for disability and services, what is the percentage of approval rate?

In other words, after they go through a process, maybe the short process; in other words, right when they come in the door or before they go through an appeal process, what is it usually?

Secretary SHINSEKI. Well, I think the stats I have looked at say that of a set of claims that are handled, 90 percent of them are accepted. In other words, whether it was an approval or a declination, 90 percent do not result in an appeal. About 10 percent do.

Now, of that 90 percent, 2 years down the road someone may have another.

Senator BEGICH. Additional.

Secretary SHINSEKI. Yes, another opportunity to reinitiate. That is why the backlog issue is complex because you have all these factors playing in each case.

Senator BEGICH. I know when we talked, we talked a lot about system changes and system improvements. Is there a process you are going through to not only look at the data of claims, but are there systematic issues where it seems there is a certain group we are just routinely approving at some point anyway, that maybe there is a front-end improvement that could be done so they do not go through this long process? Am I making sense there?

Secretary SHINSEKI. Right. There are claims that have two or three or maybe up to six cases associated with it, and if one of those claims would result in immediate payment, we start that. Then we work through the other issues. We do not do this as well as I would like. We need to continue doing that.

But this whole area of the claims backlog is something that I have taken on, and I will get into it.

Senator BEGICH. Great. With the GI system, I know you have mentioned to me and we on the Committee know that it is a tight timeframe to get to where you need to be.

Secretary SHINSEKI. Right.

Senator BEGICH. And you will be a kind of automated/manual combo this year and then next year to try to get to a full automation. I think you answered yes, but I want to confirm. Does the 2010 budget give you enough resources to get to full automation as you see it or do you think you might have to have an adjustment after you go through this first 6 months, or whatever that period might be, where you have the combo?

Secretary SHINSEKI. Yes. We are setting those numbers now, but, yes, my intent is to have an automation program funded for 2010.

Senator BEGICH. OK. So the resource is in the budget itself. That is the hope.

Secretary SHINSEKI. It will be.

Senator BEGICH. That is a good attitude.

I do not know the debate, and I am afraid to get into it because it sounds like both Majority and Minority members do not want you to do this. So I am afraid to ask about it, but it is such a big number on the third-party collection issue. If I got the numbers right, and I know you were just kind of ranging them because you did not have the document right in front of you, but you thought it was around $500 million.

Secretary SHINSEKI. That is an estimate based on collections I have done in the past. We have been collecting for non-service-connected disabilities for a number of years now. Since 2004, that account has grown from $1.7 billion to $2.4 billion last year. So, we have exceeded our targets each year.

Senator BEGICH. Can you give me just a brief overview—and again I do not want to get into the great debate on this topic today—on what some of the discussion might be around it? Why? Because it is hard in these formats to get that kind of discussion.

If you do not want to do that right now, that is fine.

Secretary SHINSEKI. Well, it is a consideration. It is under consideration, and I would say the basis is the same for non-service-connected disabilities that are currently approved and we are collecting on, and it is to see whether or not there is a contribution from insurance companies that makes sense.

Senator BEGICH. In the budget proposal—and you have heard some of the discussion already—will you have some opportunity if you do include this, an option if not included, and what kind of service reduction and/or other revenue sources? Will that be part of the discussion if you go down that path?

Secretary SHINSEKI. I intend for it to be.

Senator BEGICH. OK. Great.

I know my time is up, Mr. Chairman, but, again, thank you very much.

Thank you for the time that you spent with me. Thanks for coming to the Committee meeting and presenting. I know there will be a lot of discussion, especially around rural health care.

Secretary SHINSEKI. Yes.

Senator BEGICH. Thanks.

Secretary SHINSEKI. Thanks, Senator.

Chairman AKAKA. Thank you very much, Senator Begich.

Mr. Secretary, I continue to have concerns about the effectiveness of VA's outreach efforts, especially as it applies to those who suffer from PTSD and TBI. This is especially true for those National Guard and Reserve members who live in rural areas. Will you please explain how the proposed budget addresses improving the effectiveness of VA's outreach efforts?

Secretary SHINSEKI. Well, Senator, I indicated that we are reaching out to OEF/OIF veterans as they return, both with DOD and in particular with Reserve component units. We have participated at their demobilization, within their demobilization process, this contact. We have 27 VHA liaison personnel at DOD hospitals, at 13 of the DOD hospitals to facilitate this outreach and transition.

We in the VA have contacted OEF and OIF veterans who have enrolled with us, and there are a number who have not enrolled with us. But for the ones who have enrolled with us, we put them through a PTSD/TBI screen, so we have some sense of what the impacts from combat are, or traumatic experiences are, even though they are not carried as PTSD or TBI accounts. We are coming up with patients.

We have also reached out to about 630,000 veterans, as I indicated, and have spoken with about 150,000, trying to get them to come in and talk to us at VA health care.

We have PTSD clinical teams or specialists at each of 153 medical centers and many of our larger community-based outpatient clinics—so, professional people onsite.

We have provided training to over 1,200 providers in evidence-based psychotherapy.

A key element of our treatment has been to move mental health into the primary care area of the hospital to reduce the stigma of folks not wanting to be seen going into the mental health clinic. So, in the primary care area we have included mental health, and we have included training of primary care personnel in how to get into the discussion here and begin to identify people that may need follow-up and then get them into the professional care. By and large, these are our efforts to increase awareness and access to mental health.

For us, PTSD increased. From fiscal year 2009, 120,000 people were carried on our rolls with PTSD issues to 342,000 veterans as of September of last year—so, a significant growth in PTSD.

About 23 percent of returning OEF and OIF veterans who come to VA have received a preliminary diagnosis of PTSD, and about 50 percent of those with another mental health diagnosis. Our standards have been: initial evaluation within 24 hours, with immediate urgent care where needed; and a full evaluation and treatment plan initiated within 14 days for people who have been validated for PTSD.

In terms of TBI, we have been involved with TBI for about 15 years and have just learned more as a result of ongoing operations. Early intervention and specialized care can reduce physical and cognitive impairment. So the sooner we identify and get into this makes a huge difference.

Since April, 2007, any OEF/OIF veteran seen by a VA health care provider is screened. If the screen is positive, again, the veteran is referred for an evaluation by a specialized team.

Through fiscal year 2008, 235,000 OEF/OIF veterans were screened. About 43,000 of them came up with indications for follow-up, possible TBI; 28,000 received follow-up evaluations; 12,000 confirmed with diagnosis of TBI. About 10,000 were not validated, and we still have about 5,000 follow-ups to do.

So we are doing this, but not as quickly as we would like. We are reaching the veterans who enroll with us, and I cannot give you data for the veterans whom we are not able to contact, which goes back to the earlier discussion about why this automatic enrollment becomes important, and now we have a wider safety net where we can begin to get a better assessment on the larger problem.

Chairman AKAKA. Mr. Secretary, you brought up the quick-look study of VA's plans for implementation of the new GI Bill. I just want to ask a question on that. That was completed at the end of February and identified eight high-risk areas that needed to be addressed. Could you expand on what those areas are and how they are being addressed and, especially, how one of the eight was addressed in-house?

Secretary SHINSEKI. One of the eight was: No single executive with authority over the integrated product team. And I have fixed that by appointment. The recommendation was that I hire somebody from outside. I thought the amount of time to take someone from the outside to come in and learn what we were trying to do is probably time I could not afford. So, I appointed someone from within my organization as the expediter with those authorities.

The other seven observations were: Regulations were not complete. They are now complete.

No critical path defined for milestones. We are in the process now of laying those out. The milestones are clear. It is identifying a critical path.

Training materials not complete. Training started yesterday. So we completed. In the time between when the survey started and ended, we have now completed our training materials.

Call center telephone structure inadequate. That, I do not have a final response on, and I will look into that.

The phase one of the front-end tool is compromised due to limited resources, short development time, unstable requirements. All of that is true. But we are where we are, and we are working to improve on those things. Phase one training began yesterday, and so I will know more as training evolves.

Workflow to support BDN changes is inefficient. We will do better.

Not all DOD data required to determine eligibility may be readily available. That is being corrected.

So those were the eight items.

Chairman AKAKA. I was very interested in your comments about your schedule in putting the GI Bill into effect, and we are looking to the fall as you are in trying to implement that.

I have been pleased with the efforts of the joint VA and DOD Senior Oversight Committee, and I am encouraged that you and Secretary Gates have continued these efforts and recently co-chaired the SOC yourselves.

Secretary SHINSEKI. Yes.

Chairman AKAKA. Would you please address how this budget will improve the level of collaboration and cooperation between VA and DOD?

Secretary SHINSEKI. I am not sure there will be a direct impact on the budget, but I will tell you there is a direct impact on Gates and Shinseki taking responsibility for the SOC. The reason we held the first meeting was that both he and I were without deputies who would normally chair this. I am still without a deputy. And so, we will have the second meeting. He has agreed to co-chair it with me even though his new deputy has arrived.

At some point, we will transition that over to our deputies, but for the time being he and I have accepted responsibility for conducting the SOC, setting the agenda and providing vectors for what we would like to accomplish. I shared some of those priorities with you.

Chairman AKAKA. Secretary, I have no other questions. But let me ask, do you have any further questions?

Secretary SHINSEKI. No, sir.

Chairman AKAKA. As we may, we might put some of these questions in the record for you. So, Secretary Shinseki, once we see the details on the budget, we will have more questions. Perhaps we will submit them in writing or perhaps, who knows, maybe have another hearing on this another time.

So, for now, I want to thank you so much for your testimony, your responses to all our questions. We look forward to continuing to work with you. Of course, we want to wish you well, with much aloha.

Secretary SHINSEKI. Thank you, Mr. Chairman.

Thank you, Senators.

Chairman AKAKA. I welcome our second panel of witnesses.

First, I welcome Carl Blake, the National Legislative Director of the Paralyzed Veterans of America.

I also welcome Kerry Baker, Assistant National Legislative Director for the Disabled American Veterans.

I welcome Raymond Kelley, National Legislative Director of AMVETS.

I would also like to welcome Dennis Cullinan, National Legislative Director for Veterans of Foreign Wars.

We have Steve Robertson, Director of the National Legislative Commission of the American Legion.

And, finally, we have Rick Weidman, Director of Government Relations of Vietnam Veterans of America.

A very warm welcome to all of you and warm aloha to each of you.

Mr. Blake will begin, and then we will move down the table in order. *The Independent Budget* will have 20 minutes total to make its presentation. The American Legion and Vietnam Veterans of America will be recognized for 5 minutes each. Your prepared remarks will, of course, be made part of the hearing record.

So, Mr. Blake, will you please begin?

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

Mr. BLAKE. Thank you, Mr. Chairman.

Chairman Akaka, Senator Tester, on behalf of the co-authors of *The Independent Budget*, PVA is pleased to be here today to present our views on the fiscal year 2010 funding requirements for the Department of Veterans Affairs health care system.

First, Mr. Chairman, I would like to say thank you to your staff and also to Senator Burr's staff for affording us the opportunity about a month ago to go through a lot of the nuts and bolts of the *Independent Budget* already. So we have had a good opportunity to work with them already to begin developing, as we go forward, the 2010 numbers.

We are pleased to see that the initial information provided by the Administration suggests a very good budget for fiscal year 2010. The discretionary funding levels provide for what would truly be a significant increase. However, we will withhold final judgment on the budget submission until we have much more details about the 2010 budget.

For fiscal year 2010, the *Independent Budget*, or the *IB*, recommends approximately $46.6 billion for total medical care, an increase of $3.6 billion over the fiscal year 2009 operating budget level.

Our recommendation includes approximately $36.6 billion for medical services. Our medical services recommendation includes approximately $34.6 billion for current services, $1.2 billion for projected increase in patient workload and $800 million for policy initiatives.

The policy initiatives include $250 million, approximately, for mental health needs and expansion of that area, $440 million to bring the long-term care capacity level in the VA up to the mandated level of the Millennium Health Care Act and approximately $100 million additional for centralized prosthetics funding.

For medical support and compliance, the *IB* recommends approximately $4.6 billion, and for medical facilities we recommend approximately $5.4 billion. This amount includes an additional $150 million for nonrecurring maintenance for the VA to begin addressing the massive backlog of infrastructure needs beyond those addressed through the recently enacted Stimulus Bill.

And I would like to offer our thanks as well to the Committee and to Congress as a whole for the funding that was provided in the Stimulus Bill directed at infrastructure needs in the VA because it is certainly a critical need.

The IBVSOs contend that despite the recent increases in VA health care funding, VA does not have the resources necessary to completely remove the prohibition on enrollment of Priority 8 veterans who have been blocked from enrolling in the VA since January 2003. However, we certainly believe that it is time for the VA and Congress, along with our assistance, to develop a workable solution to allow all eligible Priority Group 8 veterans to begin enrolling in the system.

For medical and prosthetic research, the *Independent Budget* recommends $575 million. This represents a $65 million increase over the fiscal year 2009 appropriated level. 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.

Mr. Chairman, we would like to express our sincere thanks for your introduction of S. 423, the Veterans Health Care Budget Reform and Transparency Act. Moreover, we would like to extend our thanks to the Members of the Committee who have agreed to cosponsor this important legislation, including Ranking Member Burr. This funding mechanism will provide an option that the IBVSOs believe is politically more viable than mandatory funding and is unquestionably better than the current process.

Finally, Mr. Chairman, I would like to express PVA's serious concerns that we have regarding the policy proposal that has already been discussed here today, which we have been told may be included in the Administration's budget submission later this year, and which may be one of the factors that allow for the budget increase in the fiscal year 2010 numbers released on February 26.

As mentioned, we have been told that they may be considering a proposal that would allow the VA health care system to bill a veteran's insurance for the care and treatment of a disability or injury that was determined to have been incurred in or the result of the veteran's honorable military service to our country. I think some of the comments made already here today sort of affirm our worst fears in that respect.

Such a consideration from our community, I think I am free to say, is wholly unacceptable as evidenced, hopefully, by the letter that you received from 11 service organizations, including PVA and I believe everyone seated here at the table, outlining our concerns.

This proposal simply ignores the solemn obligation that this Nation has to care for those men and women who have served this Nation with distinction and were left with the wounds and scars of that service. The blood spilled in service to this Nation is the premium that they have already paid for that care. While we understand the fiscal difficulties this country faces right now, placing the burden of those fiscal problems on the men and women who have already sacrificed a great deal for this country is unconscionable.

We strongly urge you to investigate whether such a proposal is being considered—which I think we have already gone down that road today—and to forcefully reject it if it is brought before you in April.

Mr. Chairman, this concludes my portion of the testimony on behalf of the *IB*, and I would be happy to take any questions you have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA, CONCERNING *THE INDEPENDENT BUDGET*

Chairman Akaka, Ranking Member Burr, 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 2010.

PVA, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, is proud to come before you this year to present the 23rd edition of *The Independent Budget*, a comprehensive budget and policy document that represents the true funding needs of the Department of Veterans Affairs. *The Independent Budget* uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year, the document is endorsed by over 60 veterans' service organizations, and medical and health care advocacy groups.

The process leading up to FY 2009 was extremely challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the *IB*. Moreover, for only the third time in the past 22 years, VA received its budget prior to the start of the new fiscal year on October 1. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying Military Construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the last two years, the larger appropriations process is completely broken.

PVA is pleased to see that the initial information provided by the Administration suggests a very good budget for the VA in FY 2010. The discretionary funding levels provide for a truly significant increase. However, we will withhold final judgment on the budget submission until we have much more details about the FY 2010 budget. Moreover, we would like to highlight our concern that the out year projections for VA funding do not seem to reflect sufficient budgets to serve the needs of veterans. In fact, the projected increases in all cases are less than three percent. We would be very interested in an explanation and justification for the small out year spending increases.

For FY 2010, *The Independent Budget* recommends approximately $46.6 billion for total medical care, an increase of $3.6 billion over the FY 2009 operating budget level established by Public Law 110–329, the "Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009." Our recommendation reinforces the long-held policy that medical care collections should be a supplement to, not a substitute for, real dollars. Until Congress and the Administration fairly address the inaccurate estimates for Medical Care Collections, the VA operating budget should not include these estimates as a component.

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 2010, *The Independent Budget* recommends approximately $36.6 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$34,608,814,000
Increase in Patient Workload	1,173,607,000
Policy Initiatives	790,000,000
Total FY 2010 Medical Services	$36,572,421,000

Our increase in patient workload is based on a projected increase of 93,000 new unique patients—Priority Group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $639 million. The increase in patient workload also includes a projected increase of 90,000 new Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans at a cost of approximately $279 million. Finally, our increase in workload includes the projected increase of new Priority Group 8 veterans who will use the VA health care system as a result of the recent decision to expand Priority Group 8 enrollment by 10 percent. The VA estimated that this policy change would allow enrollment of approximately 265,000 new enrollees. Based on a historic Priority Group 8 utilization rate of 25 percent, we estimate that approximately 66,250 of these new enrollees will become users of the system. This translates to a cost of approximately $255 million.

Our policy initiatives include a continued investment in mental health and related services, returning the VA to its mandated long-term care capacity, and meeting prosthetics needs for current and future generations of veterans. For mental health and related services, the *IB* recommends approximately $250 million. In order to restore the VA's long-term care average daily census (ADC) to the level mandated by Public Law 106–117, the "Millennium Health Care Act," we recommend $440 million. Finally, to meet the increase in demand for prosthetics, the *IB* recommends an additional $100 million.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $4.6 billion. This new account was established by the FY 2009 appropriations bill, replacing the Medical Administration account. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.4 billion. This amount includes an additional $150 million for non-recurring maintenance for the VA to begin addressing the massive backlog of infrastructure needs beyond those addressed through the recently enacted Stimulus bill.

The IBVSOs contend that despite the recent increases in VA health-care funding VA does not have the resources necessary to completely remove the prohibition on enrollment of Priority Group 8 veterans, who have been blocked from enrolling in VA since January 17, 2003. In response to this continuing policy, the Congress included additional funding to begin opening the VA health care system to some Priority Group 8 veterans. In fact, the final approved FY 2009 appropriations bill included approximately $375 million to increase enrollment of Priority Group 8 veterans by 10 percent. This will allow the lowest income and uninsured Priority Group 8 veterans to begin accessing VA health care.

The Independent Budget believes that providing a cost estimate for the total cost to reopen VA's health care system to all Priority Group 8 veterans is a monumental task. That being said, we have developed an estimate based on projected new users and based on second hand information we have received regarding numbers of Priority Group 8 veterans who have actually been denied enrollment into the health care system. We have received information that suggests that the VA has actually denied enrollment to approximately 565,000 veterans. We estimate that such a policy change would cost approximately $545 million in the first year, assuming that about 25 percent (141,250) of these veterans would actually use the system. If, assuming a worst-case scenario, all of these veterans who have actually been denied enrollment were to become users of the VA health care system, the total cost would be approximately $2.2 billion. These cost estimates reflect a total cost that does not include the impact of medical care collections. We believe that it is time for VA and Congress to develop a workable solution to allow all eligible Priority Group 8 veterans to begin enrolling in the system.

For Medical and Prosthetic Research, *The Independent Budget* recommends $575 million. This represents a $65 million increase over the FY 2009 appropriated level. 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. 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 2010, we recommend that the VA

IT account be funded at approximately $2.713 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*.

Paralyzed Veterans of America is pleased that the "American Recovery and Reinvestment Act of 2009" (also the Stimulus bill) included a substantial amount of funding for veterans programs. The legislation identified areas of significant need within the VA system, particularly as it relates to infrastructure needs. While we were disappointed that additional funding was not provided for major and minor construction in the Stimulus bill, we recognize that the funding that was provided will be critically important to the VA going forward.

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 2010, *The Independent Budget* recommends approximately $1.123 billion for Major Construction and $827 million for Minor Construction. The Minor Construction recommendation includes $142 million for research facility construction needs.

Mr. Chairman, we would like to express our sincere thanks for your introduction of S. 423, the "Veterans Health Care Budget Reform and Transparency Act." Moreover, we would like to extend our thanks to the Members of the Committee who have agreed to co-sponsor this important legislation, including Ranking Member Burr. For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations including PVA, and our *IB* co-authors, has advocated for reform in the VA health-care budget process. The Partnership worked with the Senate and House Committees on Veterans' Affairs last year to develop this alternative proposal that would change the VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option the IBVSOs believe is politically more viable than mandatory funding, and is unquestionably better than the current process.

Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Congress to reflect the accuracy of its estimates for VA health-care funding, as determined by the Government Accountability Office (GAO) audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process. We ask this Committee in your views and estimates for FY 2010 to recommend to the Budget Committee an advance appropriations approach to take the uncertainties out of health care for all of our Nation's wounded, sick and disabled veterans.

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*.

Finally, Mr. Chairman, I would like to express PVA's serious concern that we have regarding a policy proposal that we have been told may be included in the budget submission later this year, and that may be one of the factors that allowed for the increased budget request for FY 2010, released on February 26. We have been told that the Administration may be considering a proposal that would allow the VA health care system to bill a veteran's insurance for the care and treatment of a disability or injury that was determined to have been incurred in or the result of the veteran's honorable military service to our country. Such a consideration is wholly unacceptable. This proposal ignores the solemn obligation that this country has to care for those men and women who have served this country with distinction and were left with the wounds and scars of that service. The blood spilled in service for this Nation is the premium that service-connected veterans have paid for their earned care.

While we understand the fiscal difficulties this country faces right now, placing the burden of those fiscal problems on the men and women who have already sacrificed a great deal for this country is unconscionable. We strongly urge Congress to investigate whether such a proposal is being considered and to forcefully reject it if it is brought before you.

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

Chairman AKAKA. Thank you very much, Mr. Blake.
Mr. Baker.

STATEMENT OF KERRY BAKER, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. BAKER. Aloha, Mr. Chairman, Members of the Committee. It is a pleasure to be here today on behalf of the *Independent Budget*.

Today, I will focus on issues affecting the Veterans Benefits Administration. On behalf of VBA, we have come before you for many years, requesting additional funding to reverse its chronic history of understaffing. You have answered that call. In just the past few years, VBA has hired over 3,000 additional claims processors. More continue to be hired as we speak.

This year, the IBVSOs recommend that Congress adopt both short- and long-term strategies for improvements—strategies focused on VBA's IT infrastructure, as well as the claims and appeals process. We are also seeking improvements in training, accountability and quality assurance.

To improve the claims process, VBA must do more to upgrade its IT infrastructure. It must also be given flexibility to manage those improvements.

Despite the growing problems in the claims process, Congress has steadily reduced funding for IT initiatives over the past several years. In fiscal year 2001, Congress provided $82 million for IT initiatives. By 2006, that funding had fallen to $23 million.

Congress has, however, noticed the disconnect between IT and improvements in claims processing. Section 227 of the Veterans Benefits Improvement Act of 2008 places new requirements on VBA to closely examine all uses of current IT and comparable outside IT systems with respect to claims processing. Following that examination, VBA is required to develop a new plan to use these and other relevant technologies to reduce subjectivity, avoid remands, and reduce variances in VA regional office disability ratings.

Section 227 will require VBA to examine IT systems that it has been attempting to implement and improve for years. We believe that examination will reveal that progress has been impeded due to lack of directed funding to underwrite IT development.

The IBVSOs believe a conservative increase of at least 5 percent annually in IT initiatives is warranted. VA should give the highest priority to the review required by the Veterans Benefits Improvement Act of 2008 and double its efforts to ensure these ongoing initiatives are fully funded and accomplish their goals.

Further, the Secretary should examine the impact of IT centralization under the Chief Information Officer, or CIO, and, if warranted, shift appropriate responsibility for their management from the CIO to the Undersecretary for Benefits.

Additionally, as long stated by the IBVSOs, the VA must invest more in training adjudicators and decisionmakers. It should also hold them accountable for higher standards of accuracy. The VBA's problems caused by a lack of accountability do not begin in the claims development and rating process. They begin in the training program. The lack of accountability during training reduces or even eliminates employee motivation to excel.

The VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence and should require mandatory and comprehensive testing by all trainees, as well as the claims process and appellate staff.

In addition to training, accountability is a key to quality. However, there is a gap in quality assurance for purposes of individual accountability and decisionmaking. In the STAR program, the sample drawn each month from a regional office workload is simply too inadequate to determine individual quality.

The Veterans Benefits Improvement Act of 2008 requires VA to conduct a study on the effectiveness of the current employee work credit system and work management system. The legislation requires VA to submit a report to Congress which must explain how to implement a system for evaluating VBA employees no later than October 31, 2009. This is an historic opportunity for VA to implement a new methodology, a new philosophy by developing a system with a primary focus on quality through accountability. Properly undertaken, the outcome would result in a new institutional mindset across VBA, one that achieves excellence and changes a mindset focused on quantity to one focused on quality.

The IBVSOs believe the VA's upcoming report must concentrate on how the VA will establish a quality assurance and accountability program that will detect, track and hold responsible those employees who commit errors. VA should generate this report in consultation with the veterans service organizations most experienced in the claims process.

That concludes my oral statement, and it has been an honor to give it to you today.

[The prepared statement of Mr. Baker follows:]

PREPARED STATEMENT OF KERRY BAKER, 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) 2009.

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 23rd *IB*, the four partners 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. Consequently, 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.

THE VETERANS BENEFITS ADMINISTRATION AND ITS CLAIMS PROCESS

To improve administration of VA's benefits programs, the *IB* veterans' service organizations (IBVSOs) recommend that Congress adopt both short- and long-term strategies for improvements within the veterans Benefits Administration (VBA). These strategies focus on the VBA's information technology (IT) infrastructure as well as the claims and appeals process, to include the resulting backlog. Consequently, we are also seeking improvements in VBA's training programs and en-

hancements in accountability and quality assurance with respect to disability ratings. If Congress accepts our recommendations, VBA will be better positioned to serve all disabled veterans and their families.

VBA INFORMATION TECHNOLOGY

To maintain and improve efficiency and accuracy of claims processing, the VBA must continue to upgrade its information technology (IT) infrastructure. Also, VBA must be given more flexibility to install, manage and plan upgraded technology to support claims management improvement.

To meet ever-increasing demands while maintaining efficiency, the VBA must continually modernize the tools it uses to process and resolve claims. Given the current challenging environment in claims processing and benefits administration, and the ever-growing backlog, the VBA must continue to upgrade its IT infrastructure and revise its training to stay abreast of program changes and modern business practices. In spite of undeniable needs, Congress has steadily reduced funding for VBA initiatives over the past several years. In fiscal year 2001, Congress provided $82 million for VBA-identified IT initiatives. In FY 2002, it provided $77 million; in 2003, $71 million; in 2004, $54 million; in 2005, $29 million; and in 2006, $23 million.

Funding for FY 2006 was only 28 percent of FY 2001 funding, without regard to inflation. Moreover, some VBA employees who provided direct support and development for VBA's IT initiatives have been transferred to the VA Chief Information Officer (CIO) when VA centralized all IT operations, governance, planning and budgeting. Continued IT realignment through FY 2007 and 2008 shifted more funding to VA's agency IT account, further reducing funding for these VBA initiatives in the General Operating Expenses account to $11.8 million. It should be noted that in the FY 2007 appropriation, Public Law 110–28, Congress provided $20 million to VBA for IT to support claims processing, and in 2009 Congress designated $5 million in additional funding specifically to support the IT needs of new VBA Compensation and Pension Service personnel—also authorized by that appropriations act.

All IT initiatives are now being funded in the VA's IT appropriation and tightly controlled by the CIO. However, needed and ongoing VBA initiatives include expansion of web-based technology and deliverables, such as web portal and Training and Performance Support Systems (TPSS); "Virtual VA" paperless processing; enhanced veteran self-service and 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.

We believe 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's system for electronic education claims files, storage of imaged documents, and work flow 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 Education Service and VR&E nationwide.

The VBA should accelerate implementation of Virtual Information Centers (VICs). 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 VICs will more timely accomplish this beneficial effect.

With the effects of inflation, the growth in veterans' programs, and the imperative to invest more in advanced IT, the *IB* veterans service organizations (IBVSOs) believe a conservative increase of at least 5 percent annually in VBA IT initiatives is warranted. Had Congress increased the FY 2001 funding of $82 million by five percent each year since then, the amount available for FY 2010 would be nearly $130 million. Unfortunately, these programs have been chronically underfunded, and now with IT centralization, IT funding in VBA is even more restricted and bureaucratic.

Congress has taken notice of the chronic disconnect between VBA IT and lagging improvements in claims processing. Section 227 of Public Law 110–389 places new requirements on VA to closely examine all uses of current IT and comparable outside IT systems with respect to VBA claims processing for both compensation and pension. Following that examination, VA is required to develop a new plan to use

these and other relevant technologies to reduce subjectivity, avoid remands and reduce variances in VA Regional Office ratings for similar specific disabilities in veteran claimants.

The act requires the VA Secretary to report the results of that examination to Congress in great detail, and includes a requirement that the Secretary ensure that the plan will result, within three years of implementation, in reduction in processing time for compensation and pension claims processed by VBA. The requirements of this section will cause heavy scrutiny on IT systems that VBA has been attempting to implement, improve and expand for years. We believe the examination will reveal that progress has been significantly stymied due to lack of directed funding to underwrite IT development and completion, and lack of accountability to ensure these programs work as intended.

Recommendations:

- Congress should provide the Veterans Benefits Administration adequate funding for its IT initiatives to improve multiple information and information-processing systems and to advance ongoing, approved and planned initiatives such as those enumerated in this section. We believe these IT programs should be increased annually by a minimum of five percent or more.
- VA should ensure that recent funding specifically designated by Congress to support the IT needs of VBA, and of new VBA staff authorized in fiscal year 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 Secretary should 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 CIO to the Under Secretary for Benefits.

THE CLAIMS PROCESS

In order to make the best use of newly hired personnel resources, Congress must focus on the claims process from beginning to end. The goal must be to reduce delays caused by superfluous procedures, poor training, and lack of accountability.

During the past couple of years, the VA hired a record number of new claims adjudicators. Unfortunately, as a result of retirements by senior employees, an increase in disability claims, the complexity of such claims, and the time required for new employees to become proficient in processing claims, VA has achieved few noticeable improvements.

The claims process is burdensome, extremely complex, and often misunderstood by veterans and many VA employees. Numerous studies have been completed on claims-processing delays and the backlog created by such delays, yet the delays continue. The following suggestions would simplify the claims process by reducing delays caused by superfluous procedures, inadequate training, and little accountability. Other suggestions will provide sound structure with enforceable rights where current law promotes subjectivity and abuses rights.

The subjectivity of the claims process results in large variances in decisionmaking, unnecessary appeals, and claims overdevelopment. In turn, these problems contribute to the duplicative, procedural chaos of the claims process. Congress and the Administration should seek to simplify, strengthen, and provide structure to the VA claims process.

In order to understand the complex procedural characteristics of the claims process, and how these characteristics delay timely adjudication of claims, one must focus on the procedural characteristics and how they affect the claims process as a whole. Whether through expansive judicial orders, repeated mistakes, or variances in VA decisionmaking, some aspects of the claims process have become complex, loosely structured, and open to the personal discretion of individual adjudicators. By strengthening and properly structuring these processes, Congress can build on what otherwise works.

These changes should begin by providing solid, nondiscretionary structure to VA's "duty to notify." Congress meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court of Appeals for Veterans Claims (Court) decisions have expanded upon VA's statutory duty to notify, both in terms of content and timing. However, with the recent passage of Public Law 110–389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's

support, took an important step to correct this problem. However, the IBVSOs believe VA can do more.

The VA's administrative appeals process has inefficiencies. The delays caused by these inefficiencies force many claimants into drawn-out battles for justice that may last for years. Delays in the initial claims development and adjudication process are insignificant when compared to delays that exist in VA's administrative appeals process. The IBVSOs believe VA can eliminate some of the delays in this process administratively, and we urge VA to do so. For example, VA can amend its official forms so that the notice VA sends to a claimant when it makes a decision on a claim includes an explanation about how to obtain review of a VA decision by the Board of Veterans' Appeals (Board) and provides the claimant with a description of the types of reviews that are available.

Another problem that seems to plague the VA's claims process is its apparent propensity to overdevelop claims. One possible cause of this problem is that many claims require medical opinion evidence to help substantiate their validity. There are volumes of *Veterans Appeals Reporters* filled with case law on the subject of medical opinions, i.e., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, and which ones are more probative, etc.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, we recommend to VA that when it issues proposed regulations to implement the recent amendment of title 38, United States Code, section 5103 that 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.

We believe that if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that are ultimately decided in an appellant's favor—more often than not. If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions.

Congress should consider amending section 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 department health-care facility. Some may view this suggestion as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, it does not. The language we suggest adding to section 5103A(d)(1) would not 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.

The IBVSOs also believe that other procedures add unnecessary delays to the claims process. For example, we believe VA routinely continues to develop claims rather than issue decisions even though evidence development appears complete. These actions result in numerous appeals and unnecessary remands from the Board and the Court. Remands in fully developed cases do nothing but perpetuate the hamster-wheel reputation of veterans law. In fact, the Board remands an extremely large number of appeals solely for unnecessary medical opinions. In FY 2007, the Board remanded 12,269 appeals to obtain medical opinions. Far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are, we respectfully submit, a serious waste of VA's resources.

The suggested rulemaking actions and recommended changes to sections 5103 and 5103A(d)(1) may have a significant effect on ameliorating some problems. But to further improve these procedures, Congress should amend title 38, United States Code, section 5125. Congress enacted section 5125, for the express purpose of eliminating the former title 38, Code of Federal Regulations, section 3.157(b)(2) requirement that a private physician's medical examination report be verified by an official VA examination report before VA could award benefits. However, Congress enacted section 5125 with discretionary language. This discretionary language permits, but

does not require, VA to accept medical opinions from private physicians. Therefore, Congress should amend section 5125 by adding new language that requires VA to accept a private examination report if the VA determines that the report is (1) provided by a competent health-care professional; (2) probative to the issue being decided; (3) credible; and (4) otherwise adequate for adjudicating the claim.

Recommendations:

• VA should amend its notification forms to inform claimants of the procedures that are available for obtaining review of a VA decision by the Board of Veterans' Appeals along with providing an explanation of the types of reviews that are available to claimants.

• VA should issue proposed regulations to implement the recent amendment of title 38, United States Code, section 5103 as quickly as possible. The VA's proposed regulations should include provisions that will require VA to notify a claimant, in appropriate circumstances, of the elements that render medical opinions adequate for rating purposes.

• Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a department health care facility.

• Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the VA "must" accept such report if it is (1) provided by a competent health care professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

TRAINING

The IBVSOs have consistently maintained that VA must invest more in training adjudicators and decisionmakers, and should hold them accountable for higher standards of 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 has not been a high enough priority in VA. We have consistently asserted that proper training leads to better quality decisions, and that quality is the key to timeliness of VA decisionmaking. VA will only achieve such quality when 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 VBA's problems caused by a lack of accountability do not begin in the claims development and rating process—they begin in the training program. There is little measurable accountability in the VBA's training program.

The VBA's unsupervised and unaccountable training system results in no distinction existing between unsatisfactory performance and outstanding performance. This lack of accountability during training further reduces, or even eliminates, employee motivation to excel. This institutional mind-set is further epitomized in VBA's day-to-day performance, where employees throughout VBA are reminded that optimum work output is far more important than quality performance and accurate work.

The effect of VBA's lack of accountability in its training program was demonstrated when it began offering skills certification tests to support certain promotions. Beginning in late 2002, VSR job announcements began identifying VSRs at the GS–11 level, contingent upon successful completion of a certification test. The open book test consisted of 100 multiple-choice questions. VA allowed participants to use online references and any other reference material, including individually prepared notes in order to pass the test.

The first validation test was performed in August 2003. There were 298 participants in the first test. Of these, 75 passed for a pass rate of 25 percent. The VBA conducted a second test in April 2004. Out of 650 participants, 188 passed for a pass rate of 29 percent. Because of the low pass rates on the first two tests, a 20-hour VSR "readiness" training curriculum was developed to prepare VSRs for the test. A third test was administered on May 3, 2006, to 934 VSRs nationwide. Still, the pass rate was only 42 percent. Keep in mind that these tests were not for training; they were to determine promotions from GS–10 to GS–11.

These results reveal a certain irony, in that the VBA will offer a skills certification test for promotion purposes, but does not require comprehensive testing throughout its training curriculum. Mandatory and comprehensive testing designed cumulatively from one subject area to the next, for which the VBA then holds trainees accountable, should be the number one priority of any plan to improve VBA's

training program. Further, VBA should not allow trainees to advance to subsequent stages of training until they have successfully completed such testing.

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 explain herein. Measurable improvement in the quality of and accountability for training will not occur until such mandates exist. It is quite evident that a culture of quality neither exists, nor is much desired, in the VBA.

Recommendation:

VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should 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.

STRONGER ACCOUNTABILITY

In addition to training, accountability is the key to quality, and therefore to timeliness as well. As it currently stands, almost everything in the VBA is production driven. Performance awards cannot be based on production alone; they must also be based on demonstrated quality. However, in order for this to occur, the VBA must implement stronger accountability measures for quality assurance.

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, there is a gap in quality assurance for purposes of individual accountability in quality decisionmaking. In the STAR program, a sample is drawn each month from a regional office workload divided between rating, authorization, and fiduciary end-products. However, VA recognizes that these samples are only large enough to determine national and regional office quality. Samples as small as 10 cases per month per office are woefully inadequate to determine individual quality.

While VA attempts to analyze quality trends identified by the STAR review process, claims are so complex, with so many potential variables, that meaningful trend analysis is difficult. As a consequence, the VBA rarely obtains data of sufficient quality to allow it to reform processes, procedures, or policies.

As mentioned above, STAR samples are far too small to allow any conclusions concerning individual quality. That is left to rating team coaches who are charged with reviewing a sample of ratings for each rating veteran service representative (RVSR) each month. This review should, if conducted properly, identify those employees with the greatest problems. In practice, however, most rating team coaches have insufficient time to review what could be 100 or more cases each month. As a consequence, individual quality is often under-evaluated and employees with quality problems fail to receive the extra training and individualized mentoring that might allow them to be competent raters.

In the past 15 years the VBA has moved from a quality-control system for ratings that required three signatures on each rating before it could be promulgated to the requirement of but a single signature. Nearly all VA rating specialists, including those with just a few months' training, have been granted some measure of "single signature" authority. Considering the amount of time it takes to train an RVSR, the complexity of veterans disability law, the frequency of change mandated by judicial decisions, and new legislation or regulatory amendments, a case could and should be made that the routine review of a second well-trained RVSR would avoid many of the problems that today clog the appeals system.

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 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.

Recommendation:

• The VA Secretary's upcoming report must 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.

We invite your attention to the *IB* itself for the details of the remaining recommendations, but the following summarizes a number of suggestions to improve benefit programs administered by VBA:

• allow veterans eligible for benefits under title 38, United States Code, sections 31 and 33 to choose the most favorable housing allowance from the two programs
• support legislation to clarify the intent of Congress concerning who is considered to have engaged in combat
• repeal in whole the offset between disability compensation and military retired pay
• provide cost-of-living adjustments for compensation, specially adapted housing grants, and automobile grants, with provisions for automatic annual increases in the housing and automobile grants based on increases in the cost of living
• propose a rule change to the *Federal Register* that would update the mental health rating criteria
• provide a presumption of service connection for hearing loss and tinnitus for combat veterans and veterans who had military duties involving high levels of noise exposure who suffer from tinnitus or hearing loss of a type typically related to noise exposure or acoustic trauma
• increase the maximum coverage and adjustment of the premium rates for Service-Disabled Veterans' Life Insurance
• increase the maximum coverage available in policies of Veterans' Mortgage Life Insurance
• enforce VA's benefit of the doubt rule in judicial proceedings
• appoint judges to the Court of Appeals for Veterans claims who are advocates experienced VA law
• support legislation to increase Dependency and Indemnity Compensation (DIC) for certain survivors of veterans, and to no longer offset DIC with Survivor Benefit Plan payments. And
• authorize rates of DIC for surviving spouses of servicemembers who die while on active duty to the same rate as those who die while rated totally disabled.

We hope the Committee will review these recommendations and give them consideration for inclusion in your legislative plans for FY 2009. Mr. Chairman, thank you for inviting the DAV and other member organizations of the *IB* to testify before you today.

Chairman AKAKA. Thank you very much, Mr. Baker.
Mr. Kelley.

STATEMENT OF RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. KELLEY. Good morning, Mr. Chairman. Thank you for inviting AMVETS to testify on behalf of the *Independent Budget* today.

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

In fiscal year 2008, $195 million was appropriated for the operations and maintenance of NCA, $28.2 million over the Administration's request, with only $220,000 in carryover. NCA awarded 39 of 42 minor construction projects that were in the operating plan. The State Cemetery Grants Service awarded $37.3 million of the

$39.5 million that was appropriated. Additionally, $25 million was invested in the National Shrine Commitment.

NCA has done an exceptional job of providing burial options for 88 percent of all veterans who fall within the 170,000 veterans within a 75-mile radius threshold model. However, under this model, no new geographic area will become eligible for a National Cemetery until 2015. An analysis shows that the five areas with the largest veteran population will not become eligible for the National Cemetery because they will not reach the 170,000 threshold.

Lowering the population threshold to 100,000 veterans would immediately make several areas eligible for a National Cemetery regardless of any change of the mile radius threshold, and a new threshold model must be implemented, so more of our veterans will have access to that earned benefit.

The Independent Budget recommends an operations budget of $241.5 million for NCA for fiscal year 2010, so it can meet the increasing demands of interments, gravesite maintenance, and related essential elements of cemetery operations. Congress should include as part of the NCA appropriations $50 million for the first stage of a $250 million 5-year program to restore and improve the condition and character of the existing NCA cemeteries.

The Independent Budget recommends that Congress appropriate $52 million for the State Cemetery Grants program. This funding level will allow the program to establish six new cemeteries that will provide burial options for 179,000 veterans who live in regions that currently have no reasonable access to State or National Cemeteries.

The national average cost for a funeral and burial in private cemeteries has reached $8,555, and the cost for a burial plot is $2,133. 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 veterans who live outside the threshold, the service-connected burial benefit should be increased to $6,160. Non-service-connected veterans burial benefits should be increased to $1,918, and the plot allowance should be increased to $1,150 to match the original value of the benefit. For veterans who live inside the threshold, the benefit for a service-connected burial will be $2,793. The amount provided for non-service-connected burial will be $854, and the plot allowance will be $1,150.

This will provide a burial benefit at equal percentages based on the average cost for a VA funeral and not on a private funeral 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 to those veterans whose access to a State or National Cemetery is restricted as well as provide an improved benefit for eligible veterans who opt for private burial.

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

This concludes my testimony, and I am happy to answer any questions you may have.

[The prepared statement of Mr. Kelley follows:]

PREPARED STATEMENT OF RAYMOND C. KELLEY, NATIONAL LEGISLATIVE DIRECTOR, AMVETS, CONCERNING *THE INDEPENDENT BUDGET*

Chairman Akaka, Ranking Member Burr, 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 2010. 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 23rd 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 healthcare system is the best in the country and responsible for great advances in medical science. VHA is uniquely qualified to care for veterans' needs because of its highly specialized experience in treating service-connected ailments. The delivery care system provides a wide array of specialized services to veterans like those with spinal cord injuries, blindness, Traumatic Brain Injury, and Post Traumatic Stress Disorder.

Mr. Chairman, I want to thank you for introducing H.R. 1016, the Veterans Health Care Budget Reform and Transparency Act of 2009. Providing sufficient, predictable and timely funding for VA health care will go a long way in ensuring our veterans receive the care they need from fully staffed, state-of-the-art VA medical centers. I also want to thank each Member of the Committee who has co-sponsored this act, and for those who still have questions. I look forward to further discussions so we can solve the problems of the current funding system.

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 125 national cemeteries in 39 states and Puerto Rico. Of these cemeteries, 65 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 17,000 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 100,000 in 2007 to 111,000 in 2009. 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 f 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 2008, $195 was million appropriated for the operations and maintenance of NCA, $28.2 million over the administration's request, with only $220,000 in carryover. NCA awarded 39 of the 42 minor construction projects that were in the oper-

ating plan. The State Cemetery Grants Service awarded $37.3 million of the $39.5 million that was appropriated. This carryover was caused by the cancellation of a contract that NCA had estimated to be $2 million but the contractor's estimation was considerable higher. Additionally, $25 million was invested in the National Shrine Commitment.

NCA has done an exceptional job of providing burial options for 88 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 $241.5 million for the NCA for fiscal year 2010 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.

Therefore, in accordance with "An Independent Study on Improvements to Veterans Cemeteries," which was submitted to Congress in 2002, *The Independent Budget* again recommends Congress establish a five-year, $250 million "National Shrine Initiative" to restore and improve the condition and character of NCA cemeteries as part of the FY 2008 operations budget. Volume 2 of the Independent Study provides a system wide, comprehensive review of the conditions at 119 national cemeteries. It identifies 928 projects across the country for gravesite renovation, repair, upgrade, and maintenance. These projects include cleaning, realigning, and setting headstones and markers; cleaning, caulking, and grouting the stone surfaces of columbaria; and maintaining the surrounding walkways. Grass, shrubbery, and trees in burial areas and other land must receive regular care as well. Additionally, cemetery infrastructure, i.e. buildings, grounds, walks, and drives must be repaired as needed. According to the Study, these project recommendations were made on the basis of the existing condition of each cemetery after taking into account the cemetery's age, its burial activity, burial options and maintenance programs.

The IBVSOs is encouraged that $25 million was set aside for the National Shrine Commitment for FY 2007 and 2008. The NCA has done an outstanding job thus far in improving the appearance of our national cemeteries, but we have a long way

to go to get us where we need to be. By enacting a five-year program with dedicated funds and an ambitious schedule, the national cemetery system can fully serve all veterans and their families with the utmost dignity, respect, and compassion.

In addition to the management of national cemeteries, the NCA 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 medallion 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. Congress should provide NCA with $241.5 million for fiscal year 2010 to offset the costs related to increased workload, additional staff needs, general inflation and wage increases and Congress should include as part of the NCA appropriation $50 million for the first stage of a $250 million five-year program to restore and improve the condition and character of existing NCA cemeteries.

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 55 state and tribal government cemetery construction grant pre-applications, 34 of which have the required state matching funds necessary totaling $120.7 million.

The Independent Budget recommends that Congress appropriate $52 million for SCGP for FY 2010. This funding level would allow SCGP to establish six new state cemeteries that will provide burial options for 179,000 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.

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

Mr. Dennis Cullinan.

STATEMENT OF DENNIS CULLINAN, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS

Mr. CULLINAN. Aloha, Chairman Akaka.

Chairman AKAKA. Aloha.

Mr. CULLINAN. It is a pleasure to be here again today. On behalf of the *IB* group and the men and women of the Veterans of Foreign Wars, I want to thank you for including us in today's most important discussion.

I will be limiting my remarks today to the construction portion of the *IB*.

VA's most recently asset management plan provides an update of the state of CARES projects including those only in the planning of acquisition process. They show a need for future appropriations to complete these projects of $2.193 billion. Meanwhile, VA continues to identify and reprioritize potential major construction projects.

In a November 17th, 2008 letter to the Senate Veteran Affairs Committee, then Secretary Peake said the Department estimates that the total funding requirement for the major medical facilities 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 show this.

In light of these things, the *IB* recommendation for major construction is a total $1.123 billion, and we are requesting $827 million for the minor construction portion.

With respect to nonrecurring maintenance, for years, the *IB* has highlighted the need for increased funding for the nonrecurring maintenance account. Projects in this area are essential because, if left undone, they could really take a toll on a facility, leading to more costly repairs in the future and the potential of 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 project because early repairs were not done, it creates an even larger inconvenience and problem for veterans and staff.

With respect to nonrecurring maintenance, the VA must dramatically increase the nonrecurring maintenance in line with a 2 to 4 percent total that is the industry standard, so as to maintain clean, safe and efficient facilities. That means VA needs an interim budget of at least $1.7 billion. Portions of the NRM account should continue to be funded outside of VERA as we have recommended in the past and as Congress has done so that funding is allocated to the facilities that actually have the greatest need for maintenance and repair.

Congress should also consider the strengths of allowing VA to carry over some of the maintenance funding from one fiscal year to another so as to reduce the temptation that some VA hospital managers have of inefficiently spending their nonrecurring maintenance money at the end of the fiscal year. For the past several years, in the last quarter, approximately 60 percent of NRM funds are expended. That is just not very efficient.

VA must also 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 physical infrastructure. This ensures safe and fully functional facilities long into the future. VA's facilities have an average age of 55 years, and it is essential that funding be increased to renovate, repair and replace these aging structures.

VA must also maintain its critical infrastructure. We are concerned with VA's recent attempts to back away from the original infrastructure blueprint laid by CARES, and we are worried that the plan to begin widespread leasing and contracting for inpatient services would not meet the needs of veterans. To summarize a point here, it comes down to an issue of providing proper services and care to veterans, and it has been pointed out earlier to maintaining VA's own capacity to maintain cost control.

VA is a very efficient and effective provider of VA health care. That is one of the reasons we believe that the system is certainly

not spending out at the rate of Medicare. It is a health care provider, and it provides the bulk of this through its own facilities and through its own resources. It is essential that they continue in this vein.

The last thing I will touch on here is VA research infrastructure funding shortfalls. In recent years, funding for VA medical and prosthetic research has failed to provide the resources needed to maintain and upgrade and replace VA's aging research facilities. Many VA facilities have exhausted their available research space.

Mr. Chairman, this is certainly something that needs to be addressed, and that concludes my statement.

[The prepared statement of Mr. Cullinan follows:]

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

Mr. Chairman and Members of the Committee: On behalf of the 2.4 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.

On May 5, 2008, VA released the final results of its Capital Asset Realignment for Enhanced Services (CARES) business plan study for Boston, Massachusetts. The decision to keep the four Boston-area medical campuses open was the culmination of many years of work and tens of millions of dollars as it marked the final step of the CARES planning process.

CARES—VA's data-drive 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. Appendix E (pages 93–95) shows a need of future appropriations to complete these projects of $2.195 billion.

Project	Future Funding Needed ($ in thousands)
Pittsburgh	$62,400
Orlando	462,700
San Juan	91,620
Denver	580,900
Bay Pines	156,800
Los Angeles	103,864
Palo Alto	412,010
St. Louis	122,500
Tampa	202,600
TOTAL	$2,195,394

This amount represents just the backlog of current construction projects. It also does not reflect the additional $401 million Congress gave VA as part of the FY 2009 appropriation, which did not earmark specific construction projects.

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://www.va.gov/budget/summary/2009/index.htm.

Pages 7–12 of that document shows the priority scoring of projects. Last year's budget request sought funding for only three of the top scored projects. No funding was requested for any other new project, including those in Seattle, Dallas, Louisville or Roseburg, Oregon. In addition to the already-identified needs from that table, page 7–86 shows a long list of potential major construction projects the department plans to evaluate from now through FY13. These 122 potential 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	$900,000
NCA Construction	80,000
Advance Planning	45,000
Master Planning	20,000
Historic Preservation	20,000
Miscellaneous Accounts	58,000
TOTAL	$1,123,000

• VHA Facility Construction—this amount would allow VA to continue digging into the $2 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—page 7–143 of VA'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	$550,000
Medical Research Infrastructure	142,000
National Cemetery Administration	100,000
Veterans Benefits Administration	20,000

Minor Construction Account Recommendations—Continued

Category	Funding ($ in thousands)
Staff Offices	15,000
TOTAL	$827,000

• Veterans Health Administration—Page 7–95 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 which was nearly $5 billion at the start of FY 2008 (page 7–64).

• Medical Research Infrastructure—a description of our request follows later in the text.

• National Cemetery Administration—Page 7–145 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 7–126 of the Capital Plan lists several minor construction projects in addition to the leasing requirements VBA needs. This funding also includes $2 million it transfers yearly for the security requirements of its Manila office.

• Staff Offices—Page 7–166 lists numerous potential minor construction projects related to staff offices, including increased space and numerous renovations for VA's Inspector General's office.

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%–4% 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 2008 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 2009 Five-Year Capital Plan discusses FCAs and acknowledges the significant backlog, noting that in FY 2007, the number of high priority deficiencies—those with ratings of D or F—had replacement and repair costs of over $5 billion. Even with the increased funding of the last few years, VA estimates that the cost for repairing or replacing the high priority deficiencies is over $4 billion.

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 2008 Asset Management Plan, this metric has gone backwards from 82% in 2006 to just 68% in 2008. VA's strategic goal is 87%, and for it to meet that, it would require a sizable 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% 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%–4% 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 of over 55 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%. 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 FY08 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 2003 through FY 2009, 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 biomedical 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 healthcare 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 healthcare 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 healthcare 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% 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 healthcare delivery.

VA has developed space-planning criteria it uses to allocate space for all VA healthcare projects. These criteria are organized into 60 chapters; one for each healthcare service provided by VA as well as their associated support services. VA updates these criteria to reflect current methods of healthcare 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 healthcare projects. This tool is operational and VA currently uses it on all VA healthcare projects.

The third component used in the design of VA healthcare 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 ten years, VA has embraced the design-build construction delivery system as a method of project delivery for many healthcare 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 healthcare 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 Public Law 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.

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

Now we will have the statement from Steve Robertson.

STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. ROBERTSON. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Mr. ROBERTSON. Thank you again for the opportunity for the American Legion to present our views on President Obama's top-line budget request for fiscal year 2010. I guess the best explanation of our support is the letter we sent to the White House, applauding them for the top-line number that they provided us, and

we look forward to getting the multivolume breakdown as to the specifics of that budget request.

I also would be remiss if we did not thank you and your colleagues for getting the fiscal year 2009 budget done on time at the start of the fiscal year. I am sure that in this transition between administration, Secretary Shinseki's job was a little bit easier when he looked around the cabinet table and saw how many of his colleagues are still waiting on their budget. We have all been there, and we understand what they are going through.

On the same note, I want to thank you for your introduction of the advance appropriations legislation. We have been disseminating that information around to our grassroots folks, trying to muster up additional co-sponsors for that legislation both here and in the House, and it is being very well received.

I would also like to thank you and your colleagues for the contributions to the veterans with the veterans provisions in the stimulus package. A lot of those are right on time. We are hoping that they are fully implemented. I think that they will make a difference.

In looking at the specific outlines of initiatives that the President has prioritized in his budget, we were very pleased to see some of the issues that were addressed—the increase, obviously, in the overall funding for the next 5 years.

Allowing more Priority Group 8 veterans in to the system, I think, is even going to be more critical in an economic downturn when many people may be losing their health care coverage in the private sector, and the VA may be their health care choice of last resort. For those folks, they will really be grateful to be able to come into the system.

You know, one of the things we have always been concerned about with the Priority Group 7s and 8s is that those veterans earned their access into the system because of their military service, not because of their income. Nobody asked them their income when they came in. Nobody asked them their income when they left. So it should not be a defining factor as to whether they get into the system or not. Especially when you talk to World War II veterans that fought in North Africa or landed in Normandy or fought at the Battle of the Bulge, they do not understand why with their fixed income now in their retirement years, that they cannot access the system.

I also want to remind you that back in September we provided testimony addressing specifically the 2010 budget, and we still stand by those recommendations. Hopefully, we think that may have influenced some of the Administration's decisions as well.

Mr. Chairman, I want to apologize for our concluding statement. It seemed that somebody was really thinking of advance funding, and they have some mistakes in the years that we have identified for funding.

But the one thing we were going to ask is that the budget resolution, when it is being compiled, that they give us the advance appropriations in that budget resolution for 2011 as well, just to set the tone. It does not require legislation for them to be able to do that, but it would be a nice gesture. Since we have the out years

already figured out in the President's budget request, they can do it there as well.

Mr. Chairman, again, I thank you for the opportunity for us to be able to testify. We look forward to working with you and your staff and your colleagues in making sure that the VA is adequately funded.

I do want to make one closing comment on the concept of the third-party billing for service-connected disabilities. When I first heard it, I was appalled. I could not believe that anybody would ever think that Great-West or Prudential or Aetna or any of the insurance companies had an obligation to take care of the men and women who have service-connected disabilities. None of those insurance companies sent us into combat. None of those insurance companies put us in harm's way and should not be held responsible for the health care.

Finally, I do not think that they thought through the process of the adverse impact this would have on the service-connected disabled veteran and their family. Some insurance companies have caps that could be quickly met if they were having to reimburse for service-connected disabilities, which would leave their family members kind of on the outs if not being able to access care.

It would also affect premiums to where it may not be affordable, especially for veterans that are self-employed or ones that are on fixed incomes and just cannot see the ability to make that kind of payment to secure insurance.

This would be a terrible, terrible mistake, and I think it needs to be seriously looked at.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Robertson follows:]

PREPARED STATEMENT OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee: The American Legion welcomes this opportunity to comment on President Obama's "top line" budget request for Fiscal Year 2010. The American Legion is pleased by the $113 billion total appropriations for the Department of Veterans Affairs (VA) in FY 2010 and the projected $57 billion in mandatory appropriations and $56 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 23.5 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 served in the Armed Forces 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. In FY 2009, Congress passed and the President signed this budget at the start of the fiscal year. Clearly, Secretary Shinseki is much more fortunate than many of his colleagues in the Cabinet because he has a timely, predictable and sufficient budget with which to administer. The American Legion urges Congress to

once again pass the VA budget for FY 2010 prior to the start of the fiscal year—it does make a difference!

Mr. Chairman, The American Legion sincerely appreciated your introduction of S. 423, Veterans Health Care Budget Reform and Transparency Act of 2009. This legislation should help achieve the timeliness and predictability goals, while giving us the remainder of the budget cycle to assure the sufficiency goal. Working together, the veterans' community is actively seeking additional cosponsors to this legislation.

Mr. Chairman and Members of the Committee, The American Legion greatly appreciates the provisions contained in the American Recovery and Reinvestment Act:

• A Tax Credit for Hiring Unemployed Veterans: Provides a tax credit to businesses for hiring unemployed veterans. Specifically, veterans would qualify if they were discharged or released from active duty from the Armed Forces during the previous five years and received unemployment benefits for more than 4 weeks before being hired.

• Disabled Veterans Payment of $250: Provides a payment of $250 to all disabled veterans receiving benefits from the Department of Veterans Affairs. VA Medical Facilities: Provides $1 billion for non-recurring maintenance, including energy efficiency projects, to address deficiencies and avoid serious maintenance problems at the 153 VA hospitals across the country.

• Increase the Number of VA Claims Processors: Provides $150 million for an increase in VA claims processing staff, in order to address the large backlog in processing veterans' claims. This backlog has been a key complaint of veterans across the country.

• Improve Automation of VA Benefit Processing: Provides $50 million to improve the automation of the processing of veterans' benefits, to get benefits out sooner and more accurately.

• Construction of Extended Care Facilities for Veterans: Provides $150 million for state grants for the construction of additional extended care facilities for veterans.

After reviewing the Office of Management and Budget's Web site with regards to the President's "top line" Budget Request for the Department of Veterans Affairs, The American Legion renders its support as follows:

• Increases funding for the Department of Veterans Affairs by $25 billion above baseline over the next five years.—*Supported by The American Legion**

• Dramatically increases funding for veterans health care.—*Supported by The American Legion**

• Expands eligibility for veterans health care to over 500,000 veterans by 2013.—*Supported by The American Legion**

• 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 areas.—*Supported by The American Legion**

• Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.—*Supported by The American Legion**

• Provides greater benefits to veterans who are medically retired from service.—*Supported by The American Legion**

• Combats homelessness by safeguarding vulnerable veterans.—*Supported by The American Legion**

• Facilitates timely implementation of the comprehensive education benefits that veterans earn through their dedicated military service.—*Supported by The American Legion**

* All support is contingent upon the release of the budget request in April.

On September 11, 2008, The American Legion National Commander David Rehbein testified before a joint session of the congressional Committees on Veterans' Affairs. In that testimony, he clearly outlined the funding recommendations for FY 2010. I am here today to re-emphasize that support for certain specific areas.

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 third-party reimbursements and co-payments; however, The American Legion

adamantly opposes the scoring of MCCF as an offset to the annual discretionary appropriations since the majority of these funds come from the treatment of non-service-connected medical conditions. Previously, these collection goals have far exceeded VA's ability to collect accounts receivable.

Since FY 2004, VHA's total collections increased from $1.7 billion to $2.2 billion; a 29.4 percent increase. The third-party component of VA's collections also increased from $960,000 to $1.26 million; a 31.3 percent increase.

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. Seeking an annual emergency supplemental is not the most cost-effective means of funding the Nation's model health care delivery system. Government Accountability Office (GAO) reports continue to raise the issue of VHA's ability to capture insurance data in a timely and correct manner. In addition, they continue to express concerns of VHA's ability to maximize its third-party collections.

According to a 2008 GAO report, VA lacks policies and procedures and a full range of standardized reports for effective management oversight of VA-wide third-party billing and collection operations. Further, although VA management has undertaken several initiatives to enhance third-party revenue, many of these initiatives are open-ended or will not be implemented for several years. Until these shortcomings are addressed, VA will continue to fall short of its goal to maximize third-party revenue, thereby placing a higher financial burden on taxpayers. In addition, GAO recommended an improvement of third-party billings; follow-up on unpaid amounts, and management oversight of billing and collections.

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

THIRD-PARTY REIMBURSEMENTS FOR TREATMENT OF SERVICE-CONNECTED MEDICAL CONDITIONS

Recently, there has been some talk about VA seeking third-party reimbursements from private health care insurers for the treatment of service-connected medical conditions. The American Legion believes that this would be inconsistent with the mandate ". . . to care for him who shall have borne the battle . . ." The United States government sent these men and women into harm's way, not private insurance companies.

Should private insurance companies be required to reimburse VA for the treatment of service-connected medical conditions, The American Legion has grave concerns over the adverse impact such a policy change would have on service-connected disabled veterans and their families. Depending on the severity of the medical conditions, those medical insurance policies with a calendar year benefit maximum or a life-time benefit maximum could result in the rest of the family not receiving any health care benefits. Many health insurance companies require deductibles to be paid before any benefits are covered.

In addition, there is concern as to what premiums would be to cover service-connected disabled veterans and their families with private health insurance, especially those who are small business owners or self-employed. The American Legion is also concerned with employers who would be reluctant to hire service-connected disabled veterans because of the impact their employment might have on company health care benefits.

The American Legion adamantly opposes any legislative initiative that would require third-party reimbursements from private health insurance providers for the treatment of service-connected disabled veterans by VA.

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, non-service-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 would 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, non-service-connected medical conditions of enrolled Medicare-eligible veterans. This legislative change would generate approximately $3–5 billion in new third-party collections annually. The Congres-

sional Budget Office predicts that enrolled veterans in Priority Groups 7 and 8 alone would generate $12 billion from 2010 to 2014 and $26 billion from 2010 to 2019.

STATE EXTENDED CARE FACILITY CONSTRUCTION GRANTS PROGRAM

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans' Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious: for FY 2004, VA paid a per diem of $59.48 for each veteran it placed in SVHs, compared to the $354 VA claims it cost in FY 2002 to maintain a veteran for one day in its own nursing home care units (NHCUs).

Under the provisions of title 38, U.S.C., VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 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 LTC needs of older veterans, it is essential the State Veterans' Homes Program be maintained as an important alternative health care provider to the VA 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 recommends $275 million for the State Extended Care Facility Construction Grants Program in FY 2010.

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.

The American Legion also supports adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects for FY 2010. 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 $532 million for Medical and Prosthetics Research in FY 2010.

BLINDED VETERANS

There are currently over 35,000 blind veterans enrolled in the VA health care system. Additionally, demographic data suggests that in the United States, there are over 160,000 veterans with low-vision problems who are eligible for Blind Rehabilitative services. Due to staffing shortages, over 1,500 blind veterans will wait months to get into one of the 10 blind rehabilitative centers.

VA currently employs approximately 164 Visual Impairment Service Team (VIST) Coordinators, to provide lifetime case management to all legally blind veterans and all Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) patients, and 38 Blind Rehabilitative Outpatient Specialists (BROS) to provide services to patients who are unable to travel to a blind rehabilitation center. The training provided by BROS is critical to the continuum of care for blind veterans. In addition, the DOD medical system is dependent on VA to provide blind rehabilitative services.

Given the critical skills a BROS teaches to help blind veterans and their families adjust to such a devastating injury, The American Legion urges VA to recruit more

specialists and continue with expansion of Blind Rehabilitation Outpatient Specialists and Visual Impairment Services Teams.

MAJOR VHA 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 CARES plan calls for the construction of new hospitals in Orlando and Las Vegas and replacement facilities in Louisville and Denver for a total cost estimated over $1 billion for these four facilities.

VA has not had this type of progressive construction agenda in decades. Major construction costs can be significant and proper utilization of funds must be well planned. However, if timely completion is truly a national priority, The American Legion continues to have concerns due to inadequate funding.

In addition to the cost of the proposed new facilities, there are many construction issues that have been "placed on hold" for the past several years due to inadequate funding and the moratorium placed on construction spending by the CARES process. One of the most glaring shortfalls is the neglect of the buildings sorely in need of seismic correction. This is an issue of safety. The delivery of health care in unsafe buildings cannot be tolerated and funds must be allocated to not only construct the new facilities, but also to pay for much needed upgrades at existing facilities. Gambling with the lives of veterans, their families and VA employees is absolutely unacceptable.

The American Legion believes VA has effectively shepherded the CARES process to its current state by developing the blueprint for the future delivery of VA health care—we urge Congress to adequately fund the implementation of this comprehensive and crucial undertaking.

The American Legion recommends $1.8 billion for Major Construction in FY 2010.

MINOR VHA 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 American Legion recommends $1.5 billion for Minor Construction in FY 2010.

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 recommends $2.7 billion for Information Technology.

STATE APPROVING AGENCIES

The American Legion is deeply concerned that veterans, especially returning wartime veterans, receive their education benefits in a timely manner. Annually, approximately 300,000 servicemembers (90,000 of which belong to the National Guard and Reserve) return to the civilian sector and use their earned educational benefits from the Department of Veterans Affairs (VA).

Any delay in receipt of education benefits or approval of courses taken at institutions of higher learning can adversely affect a veteran's life. There are time restrictions on most veterans' education benefits; significantly, the National Guard and Reserve must remain in the Selected Reserve to use their earned benefits.

The American Legion believes that every effort should be made to ensure the New GI Bill education benefits are delivered without problems or delays. Veterans are unique in that they volunteer for military service; therefore, these educational benefits are earned as the thanks of a grateful Nation. The American Legion believes it is a national obligation to provide timely oversight of all veterans' education programs to assure they are administered in a timely, efficient, and accurate manner.

GAO report entitled "VA Student Financial Aid; Management Actions Needed to Reduce Overlap in Approving Education and Training Programs and to Assess State Approving Agencies" (GAO–07–384) focuses on the need to "ensure that Federal dollars are spent efficiently and effectively." GAO recommends VA require State Approving Agencies (SAAs) to track and report data on resources spent on approval activities, such as site visits, catalog review, and outreach in a cost-efficient manner. The American Legion agrees. GAO recommends VA establish outcome-oriented performance measures to assess the effectiveness of SAA efforts. The American Legion fully agrees. Finally, GAO recommends VA collaborate with other agencies to identify any duplicate efforts and use the agency's administrative and regulatory authority to streamline the approval process. The American Legion agrees. VA Deputy Secretary Gordon Mansfield responded at the time to GAO that VA would initiate contact with appropriate officials at the Departments of Education and Labor to help identify any duplicate efforts.

The American Legion strongly recommends SAA funding at $19 million in FY 2010.

MAKE TAP AND DTAP MANDATORY

The American Legion is deeply concerned with the timely manner in which veterans, especially returning wartime veterans, transition into the civilian sector.

The Department of Defense (DOD) estimates that 68 percent of separating active-duty servicemembers attend the full Transitional Assistance Program (TAP) seminars, but only 35 percent of Reserve components' servicemembers attend. The American Legion believes these low attendance numbers are a disservice to all transitioning servicemembers, especially Reserve component servicemembers. In addition, many National Guard and Reserve troops have returned from the wars in Iraq and Afghanistan only to encounter difficulties with their Federal and civilian employers at home, and the number of destroyed and bankrupt businesses due to military deployment is still being realized.

In numerous cases brought to the attention of The American Legion by veterans and other sources, many returning servicemembers have lost jobs, promotions, businesses, homes, and cars and, in a few cases, become homeless. The American Legion strongly believes all servicemembers would benefit greatly by having access to the resources and knowledge that TAP/Disabled Transitional Assistance Program (DTAP) provide. TAP/DTAP also needs to update their programs to recognize the large number of National Guard and Reserve business owners who now require training, information and assistance while they attempt to salvage or recover a business which they abandoned to serve their country.

The American Legion strongly recommends DOD require all separating servicemembers, including those from Reserve component units, participate in TAP and DTAP training not more than 180 days prior to their separation or retirement from the Armed Forces.

TAP Employment Workshops provided to transitioning servicemembers at most military installations in the United States as well as in eight overseas locations consist of two and one-half day employment workshops. The training helps servicemembers prepare a plan for obtaining meaningful civilian employment when they leave the military. The workshop focuses on skills assessment, resume writing, job counseling and assistance, interviewing and networking skills, labor market information, and familiarization with America's workforce investment system.

Studies show servicemembers who participate in TAP employment workshops find their first civilian job three weeks earlier than veterans who do not participate in

TAP. The Department of Labor's Veterans Employment Training Services (DOL-VETS) ensures every TAP participant leaves the program with a draft resume, a practice interview session, and a visit to their state job board.

VETS only received a modest 4 percent increase since 2002. Transition assistance, education, and employment are each a pillar of financial stability. They will prevent homelessness; assist the veteran to compete in the private sector, and allow our Nation's veterans to contribute their military skills and education to the civilian sector. By placing veterans in suitable employment quickly, the country benefits from increased income tax revenue and reduced unemployment compensation payments, thus greatly offsetting the cost of TAP training.

The American Legion recommends $404.2 million to DOL-VETS for FY 2010.

MILITARY OCCUPATIONAL SPECIALTY TRANSITION (MOST) PROGRAM

The American Legion supports legislation to reauthorize and fund $60 million for the next ten years for the Service Members' Occupational Conversion and Training Act (SMOCTA). SMOCTA is a training program developed in the early 1990's for those leaving military service with few or no job skills transferable to the civilian market place. SMOCTA was renamed the Military Occupational Specialty Transition (MOST) program in legislation proposed last year, but the language and intent of the program still apply.

If enacted, MOST would be the only Federal job training program designed strictly for veterans and the only Federal job training program available for use by state veterans' employment personnel to assist veterans with barriers to employment.

Veterans eligible for MOST assistance are those with a primary or secondary military occupational specialty that DOD has determined is not readily transferable to the civilian workforce, or those veterans with a service-connected disability compensation rating of 30 percent or higher. MOST is a unique job training program because there is a job waiting for the veteran upon completion of training.

The American Legion recommends reauthorization of MOST and $60 million in funding for the program.

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 Homeless Veterans Reintegration Program (HVRP) is a competitive grant program. Grants are awarded to states or other public entities and non-profit organizations, including faith-based organizations, to operate employment programs that reach out to homeless veterans and help them become gainfully employed. HVRP provides services to assist in reintegrating homeless veterans into meaningful employment in the labor force and stimulates the development of effective service delivery systems that will address the complex problems facing veterans. HVRP is the only nationwide program focused on assisting homeless veterans to reintegrate into the workforce.

The American Legion recommends $50 million for this highly successful grant program in FY 2010.

NVTI

The National Veterans' Employment and Training Services Institute (NVTI) was established to ensure a high level of proficiency and training for staff that provide veterans employment services. NVTI provides training to Federal and state government employment service providers in competency-based training courses. Current law requires all DVOPs and LVERs to be trained within three years of hiring. We recommend these personnel be trained within one year.

The American Legion recommends $4.2 million for NVTI in FY 2010.

VETERANS WORKFORCE INVESTMENT PROGRAM

VWIP grants support efforts to ensure veterans' lifelong learning and skills development in programs designed to serve most-at-risk veterans, especially those with service-connected disabilities, those with significant barriers to employment, and recently separated veterans. The goal is to provide an effective mix of interventions, including training, retraining, and support services, that lead to long term, higher wage and career jobs.

The American Legion recommends $20 million for VWIP in FY 2010.

EMPLOYMENT RIGHTS AND VETERANS' PREFERENCE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects civilian job rights and benefits of veterans and members of the Armed Forces, including National Guard and Reserve servicemembers. USERRA prohibits employer discrimination due to military obligations and provides reemployment rights to returning servicemembers. VETS administers this law; it conducts investigations for USERRA and Veterans' Preference cases, conducts outreach and education, and investigates complaints by servicemembers.

Since September 11, 2001, nearly 600,000 National Guard and Reserve servicemembers have been activated for military duty. During this same period, DOL-VETS provided USERRA assistance to over 410,000 employers and servicemembers.

Veterans' Preference is authorized by the Veterans' Preference Act of 1944. The Veterans' Employment Opportunity Act (VEOA) of 1998 extended certain rights and remedies to recently separated veterans. VETS has the responsibility to investigate complaints filed by veterans who believe their Veterans' Preference rights have been violated and to conduct an extensive compliance assistance program.

Veterans Preference is being unlawfully ignored by numerous agencies. Whereas figures indicate a decline in claims by veterans of the current conflicts compared to Gulf War I, the reality is that employment opportunities are not being properly publicized. Federal agencies, as well as Federal Government contractors and subcontractors, are required by law to notify the Office of Personnel Management (OPM) of job opportunities, but more often than not these job opportunities are never made available to the public. The VETS program investigates these claims and corrects unlawful practices.

The American Legion recommends $40 million for Program Management that encompasses USERRA and VEOA in FY 2010.

VETERAN-OWNED AND SERVICE-CONNECTED DISABLED VETERAN-OWNED SMALL BUSINESSES

The American Legion views small businesses as the backbone of the American economy. It is the driving force behind America's past economic growth and will continue to be the major economic growth factor as we move into the 21st Century. Currently, more than nine out of every ten businesses are small firms. They produce almost one-half of the Gross National Product. Veterans' benefits have always included assistance in creating and operating veteran-owned small businesses.

The impact of deployment on self-employed National Guard and Reserve servicemembers is tragic, with a reported 40 percent of all businesses owned by veterans suffering financial losses and, in some cases, bankruptcy. Many other small businesses have discovered they are unable to operate and suffer some form of financial loss when key employees who are members of the Reserve Components are activated. The Congressional Budget Office report, "The Effects of Reserve Call-Ups on Civilian Employers," stated that it "expects that as many as 30,000 small businesses and 55,000 self-employed individuals may be more severely affected if their Reservist employee or owner is activated." The American Legion supports legislation that would require the Federal Government close the pay gap between Reserve and National Guard servicemembers civilian and military pay and would also provide tax credits up to $30,000 for small businesses with servicemembers who are activated.

The Office of Veterans' Business Development within the Small Business Administration (SBA) is crippled and ineffective due to a token funding of $750,000 per year. This amount, which is less than the office supply budget for the SBA, is expected to support an entire nation of veterans who are entrepreneurs. The American Legion feels this pittance is an insult to American veterans who are small business owners. This token funding also undermines the spirit and intent of Public Law 106–50 that provides small business opportunities to veteran-owned businesses.

The American Legion strongly recommends increased funding of the SBA's Office of Veterans' Business Development to provide enhanced outreach and specific community-based assistance to veterans and self-employed members of the Reserves and National Guard. The American Legion also supports legislation that would permit the Office of Veterans Business Development to enter into contracts, grants, and cooperative agreements to further its outreach goals and develop a nationwide community-based service delivery system specifically for veterans and members of the Reserve Components.

The American Legion recommends $15 million in FY 2010 to implement a nationwide community-based assistance program to veterans and self-employed members of the Reserves and National Guard.

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, Public Law 102–590. The Grant and Per Diem Program is offered annually (as funding permits) by the VA to fund community agencies providing service to homeless veterans.

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 2010.

CONCLUSION

Mr. Chairman and Members of the Committee, The American Legion is impressed by President Obama's initial "top line" budget request. Like the rest of America, The American Legion waits to see the details, legislative initiatives and other specifics in the budget request he has promised to provide in April. The American Legion and VA Secretary Shinseki cannot over emphasize the importance of enactment of the Military Construction, Veterans' Affairs and Related Agencies Appropriations for FY 2010 before the start of the new fiscal year.

The American Legion would greatly appreciate support of this Committee for advance appropriations for VA medical care in FY 2010 and FY 2011 in the FY 2010 Budget Resolution and the Military Construction, Veterans' Affairs and Related Agencies Appropriations for FY 2010.

Once again, The American Legion can support President Obama's top line budget request; however, that support is contingent upon review of his budget request released in April:

- Increases funding for the Department of Veterans Affairs by $25 billion above baseline over the next five years.
- Dramatically increases funding for veterans health care.
- Expands eligibility for veterans health care to over 500,000 veterans by 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 areas.
- Invests in better technology to deliver services and benefits to veterans with the quality and efficiency they deserve.
- Provides greater benefits to veterans who are medically retired from service.
- 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, that concludes my testimony and The American Legion would welcome any questions you or your colleagues may have.

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

Now we will hear from Rick Weidman.

STATEMENT OF RICK WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Mr. WEIDMAN. Thank you for the opportunity for Vietnam Veterans of America to present our views here this morning.

We have endorsed the *Independent Budget* and would like to associate ourselves with the figures you have heard here before, particularly the construction figures.

In the last decade we have approached looking at the health care budget for VHA working off of a per capita and looking at the Cen-

ter for Medicare and Medicaid Services inflation figure, which currently is figured at 3.6 percent. Therefore, we came up with $1.4 billion just for inflationary increases with no increase in the number of persons served; and an additional $2 billion for increased numbers that we will see over the coming years, for expanding the organizational capacity, and front-loading the services in the primary health care clinics before letting people into the system—back into the system—which they legitimately should have access to. But we need to front-load the services and get the teams in place before they come because otherwise we will end up in the same situation that we were in the Fall of 2002, where we had extremely long waits, and it was just an unacceptable situation across the board.

VVA also believes that we should get serious about funding for research and development at VA, so we are recommending $750 million this year with a commensurate increase in each of the next 4 years to bring it to well over a billion dollars.

The reason for that is that DOD does not look at any of the environmental injuries to veterans. They do not do any longer-term epidemiological studies on any group, and NIH refuses to do, across the board, any veteran-specific studies. We only know of one specific study that recently was funded by earmark, I believe, and that is a head injury study at NIH. Otherwise, NIH does not even take veteran status and exposures that veterans may have as a possible confounding variable that is required to be looked at in all their research; therefore, calling into question much of their research particularly on things that veterans are prone to having.

So, we strongly recommend that if we are going to go down this road of NIH continuing to pay no attention whatsoever to the problems of veterans, then we need to get serious and increase that budget at VA significantly over the next 5 years.

In regard to IT, we believe that we need to get really serious about that and rebuild, provide at least a billion dollars specifically for IT in the next year to start to do two things. One is to build the platform on which the Veterans Benefits Administration will have their system, as they design it. We agree with Secretary Shinseki that you need to straighten out the business processes before you automate it because if you do not straighten those out, then you just go wrong faster.

And second is the terrific system, the VistA system, is going to need a modern platform. We need to start the process in that. We hope that General Shinseki is successful in negotiating with Secretary Gates to share the cost of that new platform and have a single unified medical record. But, in any case, we need to look forward to that.

Specifically, we would also argue that we need to specifically fund outreach. The veterans still do not know about the services that are rendered to them or their health care maladies. As a result of that, VBA recently announced the formation of the Veterans Health Council, which is a partnership working with private civilian health care, diseases and groups, and the American Academy of Ophthalmology, the American Psychological Association, Men's Health Network, Easter Seals, et cetera, to get the word out.

This would be an ongoing effort over the next 3 years to educate the civilian medical system in the wounds, maladies, injuries and conditions that veterans are subject to, partly to be preventive health care measures that can be taken by early intervention. But, in addition to that, a lot of people are eligible for benefits who do not even know it, and VA continues to do a poor job of outreach.

But there needs to be a specific budget. When it is everybody's responsibility, it ends up being nobody's responsibility.

Two last things, if I may. One is we would encourage much stronger oversight in the next year. Particularly, General Shinseki, we believe, has it right when he says that the main problem at VA boils down to leadership and accountability. We believe that that is accurate, that most of the laws that are in place are reasonable, and he has the statutory authority to do things and do them right, but oftentimes you cannot get the system to respond.

We believe that you do not go down and beat up the privates. What you do is hold management and the officers accountable, strictly accountable, and that has not been done.

Last but not least, one minor digression, if I may, and that is on the issue about whether or not there are enough clinicians in mental health and in PTSD programs. We have started to call into question that even though they have hired an additional 3,800 clinicians, whether or not it is adequate because we still discover and hear around the country that they are not doing the testing, as recommended by the Institute of Medicine report in June 2006, to accurately diagnose PTSD at the front end. If you do that at the front end, then it makes the adjudication of the PTSD claim much more speedy and accurate at the back end because you have already done the testing.

In regards to that, VA in 2002 developed a Best Practices Guide, but they continue to refuse to train their people on how to use it, either in the VBA or in the VHA, and this would significantly speed up adjudication. So, we ask the Committee to pay some significant attention, once again, to the organizational capacity when it comes to mental health.

Thank you, sir.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF RICK WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Chairman Akaka, Ranking Senator Burr, and distinguished Senators on the Committee, on behalf of Vietnam Veterans of America (VVA) National President John Rowan and all of our officers, Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify today regarding the President's fiscal year 2010 budget request for the Department of Veterans Affairs. VVA thanks each of you on this distinguished panel, on both sides of the aisle, for your strong leadership on issues and concerns of vital concern to veterans and their families.

I want to thank you for recognizing that caring for those who have donned the uniform in our name is part of the continuing cost of the national defense. Caring for veterans, the essential role of the VA and, for specific services other Federal entities such as the Department of Labor, the Small Business Administration, and the Department of Health and Human Services, must be a national priority. This is poignantly clear when we visit the combat-wounded troops at Walter Reed Army Medical Center and Bethesda Naval Hospital.

Mr. Chairman, VVA thanks you for sponsoring advanced Appropriations legislation in the Senate (S. 423). As you know, VVA and other major veterans' service organizations have been long-time supporters of legislation to achieve assured fund-

ing. When the VA budget is late 19 of the last 22 times, it is clear that there is a need for a new mechanism to correct the problems in the current system of funding. While VVA remains committed to the assured funding concept, we currently strongly support the Advanced Appropriations legislation contained in S. 423 as being so much better than what we currently have in place. As we have this discussion in regard to the FY 2010 budget for the VA, the readily apparent need for this legislation has never been more pressing. We look forward to working with you to ensure its enactment, as it will move us toward our common goal of predictable, fully adequate, and timely funding for VA health care that is sufficient to truly meet the needs of all veterans in vital need of such care.

OVERVIEW

Concerning the proposal at hand, the President's FY 2010 budget for the VA, VVA is pleased with the overall amount of the request, which is for a $5.5 Billion overall increase over the FY 2010 budget. It is unclear how much of that is slated for the Veterans Health Administration (VHA), and how much for other purposes given the sketchy outline of the VA budget thus far available. However, it is clear that the bulk of those funds needs to VHA to meet the rising needs of medical inflation continue the process of adding needed organizational capacity as the population served expands, and for modernizing equipment and facilities.

Using the Center for Medicare & Medicaid Services (CMS) figure of 3.6% inflation, that would mean that the Congress needs to add a minimum figure of about $1.4 Billion to VHA just to keep up with increases in fixed costs, even if no more veterans entered the system. Further, there is a need to "front load" staff to increase organizational capacity to be ready to handle additional numbers of veterans allowed to seek health care from the VHA as the system is re-opened to those who were frozen out of the system by the actions of the previous Administrations beginning in January 2003. There will be further increases of our youngest veterans from the current conflicts seeking services from VHA as well as more older veterans seeking services, particularly Vietnam veterans whose medical problems are now coming to the fore due to age and manifestation of long-term effects of exposure to Agent Orange and other herbicides and toxins in Vietnam and elsewhere during their military service.

While VVA is adamant that VA needs to allow these veterans to register and to receive health care, it needs to be done in a manner that avoids overwhelming the system all at once leading to long delays in receiving care. The system is in many cases too "thin" to be able to accommodate more people for more than a brief amount of time. VVA believes that these staff enhancements and increases in organizational capacity will require at least another $2 Billion for VHA to increase the size of permanent staff.

VET CENTERS

This would include significantly increasing the number of staff in the highly successful VA Vet Center (Readjustment Counseling) program to not just open and provide staff for new centers and to do rural outreach, as important as these two efforts are, but to enlarge the size of existing teams. Perhaps the most pressing need, beyond ensuring that staff members at Vet Centers are not so over-worked that they "burn out," is the need for more certified family counselors and more counselors professionally trained and certified to deal with military sexual trauma in veterans of both genders. The Vet Centers are our first line of defense against suicides, and we must make sure they have the organizational capacity to continue doing what they do so well on a long-term sustainable basis.

RESEARCH

VVA calls for an increased outlay for Research and Development. Traumatic Brain Injuries, or TBI, needs to be better understood for treatment to be more effective. Other mental health issues, too, that are afflicting too many of our returning troops, need to be better understood. Research, for which VA scientists and epidemiologists can be justifiably proud, benefit not only troops who are forever changed by their experiences in combat but the general populace as well. VVVA believes that we must become more serious about research at the VA, given that the National Institutes of Health (NIH) continues to totally ignore veterans and the long-term health effects of military service. Other than one head injury study, we know of no other NIH research project that even tangentially asks about military service and uses that as a variable (and possible confounder). VVA recommends that Research & Development be provided at least $ 750 million for FY 2010 and com-

mensurately large increases in the out years, so that over five years this activity is funded at least at the $1 Billion level.

For the first time in many years, VVA has NOT signed on to the Friends of VA Health Care & Medical Research (FOVA) although we strongly believe that there needs to be a significant increase in R&D funding. VVA did not sign on to FOVA because of a required pledge not to push for any earmarks in Research & Development funds. It would be irresponsible of VVA to sign this pledge and not seek ear marks given that we have been unable to discover ANY research programs into the long-term health effects of Agent Orange and other toxins, despite repeated inquiries to the current Undersecretary for Health and the current occupant of the office of Director of Research & Development, as well as the previous two occupants of the office of Secretary of Veterans Affairs. Obviously we need ear marks for research into the environmental wounds of Vietnam, as well as into the deleterious health effects of service in other periods of time and theaters of operation, such as the first Gulf War. It would be a betrayal of our members and their families if we did not urgently seek ear marks for further research into the terrible health long-term effects of exposure to the herbicides and other toxins (including pesticides, PCBs, etc.) used in Vietnam during the war.

This lack of such research projects is compounded by VHA's adamant refusal to obey the law and complete the replication of the "National Vietnam Veterans Readjustment Study" (NVVRS) as a robust mortality and morbidity study from the only existing statistically valid random sample of Vietnam veterans in existence. Frankly, this study in needed not only to document the long-term course of Post Traumatic Stress Disorder, but also to document physiological problems in this population (which we know to be many). Their refusal says a great deal about their bias and determinedly continued willful ignorance.

Mr. Chairman, VVA thanks this Committee and the Appropriations Committee for using the power of the purse in the FY 2008 and FY 2009 Appropriations act to compel VA to obey the law (Public Law 106–419) and conduct the long-delayed National Vietnam Veterans Longitudinal Study. VVA asks that you schedule a hearing and/or a Members briefing for the second half of March for VA to outline their plan as to how they are going to complete this much needed study for delivery of the final results to the Congress by April 1, 2010, as a comprehensive mortality and morbidity study of Vietnam veterans, the last large cohort of combat veterans prior to those now serving in OIF/OEF.

VVA is concerned that previous leadership at VA felt they were above the law and ignored this mandate, and were unapologetic about being scofflaws. We hope this provision will again be included in the Appropriations act and that General Shinseki will see to it that VA obeys the law and gets this done on his watch.

Further, VVA strongly urges the Congress to mandate and fund longitudinal studies to begin virtually immediately, using the exact same methodology as the NVVRS, for the following cohorts: a) Gulf War of 1991; b) Operation Iraqi Freedom; and c) Operation Enduring Freedom.

Please take action now so that these young veterans are not placed into the same predicament Vietnam veterans find ourselves today.

Further, the continued refusal of VHA to take a complete military record as part of the electronic medical records means that there is no way to do needed epidemiological research on veterans who use the VA system that looks into exposures they may have been subject to in military service, depending on the branch of service, when, where, and MOS. Further, this would enable mortality studies based on when and where one served for those who have already died. It's almost as if our government does not want to know about these ailments so that it won't be burdened with Dependency Indemnity Compensation (DIC) payments.

VVA asks that $25 million be specifically designated for replication of the NVVRS, $20 million for research into the health care effects of Agent Orange and other toxins, $15 million to the Medical Follow Up Agency (MFUA) at the Institute of Medicine (IOM) at the National Academies of Sciences, to finish translating all of the data from the now closed Ranch Hand Study into modern computer language and properly catalogue it to make this data accessible to credentialed researchers. This potentially enormously valuable trove of research data should not be allowed to perish for want of these minimal funds.

In 2009, VA and DOD is supposed to complete the pilot of a new disability evaluation system for wounded returnees at major medical facilities in the Washington, DC, area, and expand it to most other large military medical centers. We hope that what results from this effort "to eliminate the duplicative and often confusing elements of the current disability process of the two departments" will lead to less confusion and a single, viable disability rating determined by the VA. However the process is currently not working as it is supposed to work. VVA repeatedly brought

this to the attention on the former Secretary of Veterans Affairs and the current Undersecretary for Benefits and his staff since last November. There is a real need for joint oversight of this process by the Veterans' Affairs Committee and the Armed Services Committee to ensure that wounded and ill soldiers are treated fairly in their waning days of military service.

We are also concerned that there still will not be enough resources to deal with the flood of troops and veterans returning to our shores and presenting with a range of mental health issues. The VA ramped down for several years the numbers of mental health professionals it employed. Now, seeing the error of its ways, it is hurriedly hiring clinicians. The question is: Will there be enough of them to meet the challenge? Will those staff be properly trained to deal with the needs of veterans with heavy combat trauma and other problems?

Much more attention needs to be devoted to continuing medical education, particularly for mental health providers and for primary care physicians and other clinicians. One of the best kept secrets at VA is the existence of the Veterans Health Initiative (VHI) curricula about the wounds, maladies, illnesses, and conditions endemic to military service depending on when and where one served. (www.va.gov/vhi) VHA apparently makes no systematic effort to utilize this tool to better educate these clinicians who can and will do an even better job if properly trained and supported. As Secretary Shinseki has repeatedly stated, what is lacking is primarily a matter of leadership and accountability. We hope and trust that he can and will meet that lack, particularly if the rest of his team gets on board quickly.

MENTAL HEALTH—NEED TO RESTORE ORGANIZATIONAL CAPACITY FOR SUBSTANCE ABUSE TREATMENT

VVA urges that language be inserted in the Appropriations bill the Congress to express concern that substance use disorders among our Nation's veterans is not being adequately addressed by the Veterans Health Administration (VHA). The relatively high rate of drug and alcohol abuse among our Nation's veterans (much of which is self-medication to deal with untreated PTSD), especially those returning from service in Operation Enduring Freedom and Operation Iraqi Freedom, is causing significant human suffering for veterans and their families.

These folks can and will be stronger for their experience if we only will deliver the effective care they need when they need it in a way they will accept.

Further delay in moving to restore effective mental health and substance abuse services will lead to poorer health and more acute health care utilization in the out years, not to mention economic opportunity cost to the Nation and needless suffering by these veterans, and their families.

Last year, VVA urged the Congress to direct the Secretary to make concerted efforts to reduce the overall incidence of drug and alcohol abuse and dependence among enrollees in the Veterans Health Administration by meeting the performance measurements included in "A Comprehensive VHA Strategic Plan for Mental Health Services," VA's current and adopted plan to reform its mental health programs, with the hallmark of recovery. To its credit, VA has developed a strategy to "restore VHA's ability to consistently deliver state-of-the-art care for veterans with substance abuse disorders," as a milestone within that reform plan, but to date has yet to fulfill the promise of its commitment to recovery, and establishing the goal of every veteran being able to obtain and sustain meaningful employment at a living wage as the ultimate goal for all VA mental health programs, including its substance use disorder programs. It should now no longer be a case of lacking resources, so we need much better oversight and accountability in the coming year. In addition it is clear that we need new leadership in the Mental Health area, as the Chairman has noted on several occasions. We hope Secretary Shinseki will heed the Chairman and others in this regard.

VVA urges the Congress to direct the Secretary to provide quarterly reports beginning with a baseline report by each Veterans Integrated Service Network (VISN) on the initiatives set forth in the VHA Strategic Plan for Mental Health Services, specifically to improve VA's treatment of substance use disorders. These reports will provide an ongoing indication of VHA's progress in the implementation of its adopted Strategic Plan as described in section 1.2.8 of "A Comprehensive VHA Strategic Plan of Mental Health Services," May 2, 2005. In addition to baseline information, at minimum these reports should include: the current ranking of networks on their percentage of substance abuse treatment capacity along with plans developed by the lowest quartile of networks to bring their percentage up to the national average; and, the locations of VA facilities that provide five days or more of inpatient/residential detoxification services, either on site, at a nearby VA facility, or at a facility under contract to provide such care; and, the locations of VA health care facilities

without specialized substance use disorder providers on staff, with a statement of intentions by each such facility director of plans to employ such providers or take other actions to provide such specialized care.

The decade long diminishment of VA mental health programs that we experienced in the 1990s did level out by 2001, and VA all too slowly started to rebuild capacity that has been accelerated in recent years. However, we must continue to restore capacity to deal with mental disorders, particularly with Post Traumatic Stress Disorder and the often attendant co-morbidity of substance abuse. In particular, substance abuse treatment needs to be expanded greatly, and be more reliant on evidence based medicine and practices that are shown to actually be fruitful, and be held to much higher standards of accountability, as noted above. The 21-day revolving door or the old substance abuse wards is not something we should return to, but rather treatment modalities that can be proven to work, and restore veterans of working age to the point where they can obtain and sustain meaningful employment at a living wage, and therefore re-establish their sense of self-esteem.

VVA also urges that additional resources explicitly be directed in the appropriation for FY 2009 to the National Center for PTSD for them to add to their organizational capacity under the current fine leadership. The signature wounds of this war may well be PTSD and Traumatic Brain Injury and a complicated amalgam of both conditions. VVA believes that if we provide enough resources, and hold VA managers accountable for how well those resources are applied, that these fine young veterans suffering these wounds can become well enough again to lead a happy and productive life.

Up until recently, VA has not made enough progress in preparing for the needs of troops returning from Iraq and Afghanistan—particularly in the area of mental health care. In addition to the funds VVA is recommending elsewhere, we specifically recommend an increase of an additional $500 million dollars over and above the $3.9 Billion that VA now says they will allocate to assist VA in meeting the mental health care needs of all veterans. These funds should be used to develop or augment with permanent staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as PTSD teams and substance use disorder programs at VA medical centers and clinician who are skilled in treating both PTSD and substance abuse at the CBOC, which will be sought after as more troops (Including demobilized National Guard and Reserve members) return from ongoing deployments. VVA also urges that the Secretary be required to work much more closely with the Secretary of Health and Human Services, and the states, to provide counseling to the whole family of those returning from combat deployments by means of utilizing the community mental health centers that dot the Nation. Promising work is now going on in Connecticut in and possibly elsewhere in this regard that could possibly be a model. In addition, VA should be augmenting its nursing home beds and community resources for long-term care, particularly at the state veterans' homes.

To allow the staffing ratios that prevailed in 1998 for its current user population, VA would have to add more than 15,000 direct care employees—MDs, nurses, and other medical specialists—at a cost of about $2 billion. This level, because the system can and should be more efficient now, would allow us to end the shame of leaving veterans out in the cold who want and are in vital need of health care at VA, and who often have no other option.

BLIND AND LOW VISION VETERANS NEED MUCH GREATER RESOURCES AND ATTENTION

The President's request contains a significant reduction in the efforts to strengthen services for blind veterans. With the number of blind and very low vision veterans of the Nation's latest wars in need of services now, VVA strongly recommends the Congress explicitly direct an additional $35 million for FY 2010 to increase staffing and programming at the VA's Blind and Visually Impaired Service Centers, and to add at least one new center.

Further, VVA recommends that the Congress directs the Secretary to implement an employment and independent living project modeled on the highly successful "Project Amer-I-Can" that so successfully placed blind and visually impaired veterans into work and other situations that resulted in them becoming much more autonomous and independent. That program was a cooperative venture of the New York State Department of Labor, the Veterans Employment & Training Service (VETS), and the Blind Veterans Association.

In a system in which so much of the infrastructure would be deemed obsolete by the private sector (in a 1999 report GAO found that more than 60% of its buildings were more than 25 years old), this has and may again lead to serious trouble. We are recommending that Congress provide an additional $1.5 billion to the medical facilities account to allow them to begin to address the system's current needs. We

also believe that Congress should fully fund the major and minor construction accounts to allow for the remaining CARES proposals to be properly addressed by funding these accounts with a minimum of the remaining $2.3 billion.

HOMELESS VETERANS

As we all know, homelessness is a significant problem in the veterans' community and veterans are disproportionately represented among the homeless population. While many effective programs assist homeless veterans to become productive and self-sufficient members of their communities and Congress must ensure that the Department of Veterans Affairs has adequate funding to meet the needs of the over 154,000 homeless veterans who served this country so proudly in past wars and veterans of our modern day war. VVA recommends the following in VA FY 2010 budget for homeless programs.

HOMELESS PROVIDER GRANT AND PER DIEM PROGRAM

The Department of Veterans Affairs Homeless Grant & Per Diem Program has been in existence since 1994. These programs address the needs of homeless veterans and support the development of transitional, community-based housing and the delivery of supportive services. Because financial resources available to HGPD are limited, the number of grants awarded and the dollars granted are restrictive and hence many geographic areas in need suffer a loss that HGPD could address.

The Consolidated Appropriations Act of 2008, Public Law 110–161 provides $130 million, the fully authorized level, to be expended for the GPD program. Based on GAO's findings and VA's projected needs for additional GPD beds, VVA that for FY 2010 a $200 million authorization is required. An increase in the funding level for the next several years would help ensure and expedite VA's program expansion targets. It would provide critical funding for service, or drop-in, centers—the primary portal that links veterans in need with the people who can help them. It would guarantee continued declines in veteran homelessness, and provide for scaling back the funding as warranted by the VA's annual Community Homelessness Assessment, Local Education and Networking Group (CHALENG) reports.

The VA provides grants to VA health care facilities and existing GPD recipients to assist them in serving homeless veterans with special needs including women, women who have care of dependent children, chronically mentally ill, frail elderly and terminally ill veterans. Initiated in FY 2004, VA has provided special needs funding to 29 organizations totaling $15.7 million. The VA Advisory Committee on Homeless Veterans 2007 report states the need and complexity of issues involving women veterans who become homeless are increasingly unexpected. Recognizing women veterans are one of the fastest growing homeless populations, the Committee recommended future notices of funding availability target women veteran programs including special needs grant offerings. Public Law 109–461 authorizes appropriations of $7 million for FY 2007 through FY 2011 for special needs grants.

VVA estimates approximately $45 million will be needed to adequately serve 7,500 or more clients in HUD-VASH housing units. Rigorous evaluation of this program indicates this approach significantly reduces the incidence of homelessness among veterans challenged by chronic mental and emotional conditions, substance abuse disorders and other disabilities.

VVA also strongly urges you to actively help us seek an appropriation for the full $50 million authorized for the Homeless Veterans Reintegration Program (HVRP) for FY 2010.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) continues to not only need additional resources and enhanced accountability measures, but a total paradigm shift and retooling of the business processes.

COMPENSATION & PENSION

VVA recommends adding one hundred staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional $80 million dollars specifically earmarked to create "express lines" at all VARO and not just the ten pilot sites, for additional training for all of those who touch a veterans' claim, institution of a competency based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and state employees, and any others who might presume to at any point touch a veterans' claim.

VOCATIONAL REHABILITATION

Last year (and the year before that), VVA recommended adding an additional two hundred specially trained vocational rehabilitation placement specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. VA only added 60 such counselors. It still remains clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

It is clear VA needs to add several hundred of these employment placement specialists for disabled veterans specifically called for in past years' funding measures, and there is clearly a need for additional training to ensure they are effective in assisting disabled veterans, particularly profoundly disabled veterans, to obtain decent jobs.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much greater accountability to the VA Vocational Rehabilitation process is essential if we as a nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

COMPUTERIZATION OF THE CLAIMS PROCESS

VVA agrees with Secretary Shinseki's statement that computerization in and of itself will not fix the mess in the Compensation & Pension program, but rather to re-think and straighten out the business processes first before we "put garbage in to get garbage out." While the Secretary and his new team figure that out, VVA also believes that Congress needs to set aside funds for putting all of the VBA records into digital form. This is essentially an investment in computer infrastructure every bit as important as buildings. We do not know what that figure is, but we have to believe there are existing platforms that can be adapted for this use that are already successfully being used in other branches of the Federal Government.

ACCOUNTABILITY AT THE VA

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It is certainly better than it used to be, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind of system that it can be with existing resources, and even largely the same personnel as they currently have on board. It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

The almost quarter of a million VA personnel consist of fine hard working people who are by and large committed to doing a good job for the veterans whom they serve. What is needed is leadership that is worthy of those fine workers, and a better system of accountability (especially for managers) and the system will work much better.

Thank you again, Mr. Chairman, for allowing VVA to be heard at this forum. We look forward to working with you and this distinguished Committee to obtain an excellent budget for the VA in this fiscal year, and to ensure the next generation of veterans' well being by enacting S. 423 at the earliest possible time. I will be happy to answer any questions you or your colleagues may have.

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

This question has been mentioned quite often in today's hearing, and this question is for the entire panel. There is clear opposition to any proposal to allow VA to bill insurance companies for care for veterans' service-connected injuries. Assuming Congress does not move forward with this proposal, how would you suggest covering the resulting gap?

Mr. Blake?

Mr. BLAKE. Mr. Chairman, I would suggest that, first off, this is money that should never have been considered in the first place. My sense is that it is included in the inflated estimate for the budget submission that we have seen so far, but we do not know the details.

The best way to answer that question is to say that since we are going to assume that this is money that is not going to be collected, that real dollars will have to be appropriated to offset that gap. I do not know any other way you could solve that gap.

Chairman AKAKA. Mr. Baker?

Mr. BAKER. I would have to agree with Mr. Blake, 100 percent on that.

Chairman AKAKA. Mr. Kelley?

Mr. KELLEY. I am in concurrence with Mr. Blake also.

Chairman AKAKA. Mr. Cullinan?

Mr. CULLINAN. Mr. Chairman, I would certainly agree with Mr. Blake and have to add that this proposal strikes at the very heart of the philosophy and moral obligation this Nation has to care for its wounded warriors.

With respect to making up any gap, we would think that some dollars would flow from third-party connections from the Category 8 veterans that will be coming into the system, who are more inclined to have insurance and also tend to use the services less. They are inexpensive, relatively speaking. The rest would have to be appropriated dollars.

Chairman AKAKA. Any further comment, Mr. Robertson?

Mr. ROBERTSON. Yes, sir. The American Legion—when eligibility reform was passed back in 1996, we were a strong advocate of allowing VA to bill Medicare for the treatment of non-service-connected medical conditions for Medicare-eligible patients. Clearly, over half of the VA patient population is Medicare-eligible, and the idea was that whoever would be brought into the system that was not entitled to care would pay through either co-payments and third-party reimbursements from their private insurance.

That is where I think a critical mistake was made because we are subsidizing Medicare by billions of dollars. As Mr. Cullinan said, comparing Medicare to VA is apples and oranges. They are simply an insurance company. They are not a health care provider, and VA is the best health care provider in the country.

There is no incentive for fraud, waste and abuse in billing Medicare. This would be straight up and down. This is a reasonable charge. Reimburse us for those allowable conditions.

So I think that there is literally billions of dollars that are being missed that would help the system and would take care of these extra costs of bringing this group of patients in, especially if they are Medicare-eligible—the Priority Group 8s.

Chairman AKAKA. Mr. Weidman, any further comment?

Mr. WEIDMAN. This proposal is so wrong in so many ways, it is hard. It would take a long time to elucidate them, but I will say that it does bear in mind the old sardonic cartoon of the real GI Bill which is what veterans have to pay for having been disabled in service to country.

Chairman AKAKA. You have all heard the Secretary, and we have heard your testimony. I am trying to reach into your mental capacity here, and what I am asking for is what is missing? What is missing?

We are slightly disadvantaged because of the lack of budgetary information at this point. But in looking at the Administration's

priorities as outlined in the documents we do have, think about it. What do you think is missing?

Mr. ROBERTSON. Well, the one area dealing with concurrent receipt, which is really a DOD funding issue and should not be in this part of the budget because it is the DOD military retirement pay that is offset. I did not understand that one to begin with.

Another area, I just want to mention one thing about the outreach. I think that just about everybody sitting at this table has community-based organizations, chapters, posts, lodges, et cetera. Speaking for the American Legion—and I know that the other groups are there with us when we do this—we have been connecting with the National Guard and Reserve, and I think that there is a great deal of outreach that is being done by the veterans service organizations that we are probably not getting credit for, both with the active duty military, the Guard and Reserve, and even the veterans that are in our communities. We are trying to beat the drum.

If you do recall when eligibility reform did initially kick in, we went out and we brought people to the VA system that had never been there before. And we told them: Trust us. It is a great system. You are going to be happy.

The results were they came back and said, enough, enough, enough.

So, as far as outreach, we are going to be in there, cheering for the Secretary. If he will give us the snowballs, we will throw them.

Chairman AKAKA. Any other comment?

Mr. WEIDMAN. There are couple things that come to mind, Mr. Chairman.

The first is something that nobody has been talking about, but our Alaska State President, Ric Davidge, and folks in Alaska have been working on a paper—when it is ready we will certainly share with you and your distinguished colleagues as well as staff—on a distinction between rural and remote. There are sections of Vermont that are very rural, but it is not remote like an outer island from the big island. It is not remote like many of the places in Alaska where you cannot drive to either.

So we need to look at this problem and delineate between remote and rural and just change our paradigm and the way in which we think about that in the future.

The other thing I think is not apparent in there, and that is no earmarks in the research budget. VVA, for the time in recent years, refused to join with the Friends of VA Medical Care and Research, not because we disagree with them, but because you have to pledge to have no earmarks.

There is not a single Agent Orange study funded by the VA currently out of R&D, not one. There is the National Vietnam Veterans Readjustment Study. They refused to obey the law and do the replication even though they have been, again, ordered to do so in the Appropriations Act that you passed on time. And so, we would ask that you include that again.

Last but by no means least, when it comes to Agent Orange, we need the funding for a medical follow-up agency at the Institute of Medicine—about $15 million—to not only translate that into modern computer language, the Ranch Hand data, but to do some re-

search organization to find out how can we best make that available to independent scientists and research institutions.

Agent Orange is not mentioned anywhere in this document, and I am willing to bet when they publish the big one it will not be mentioned anywhere in there. This is unacceptable to Vietnam Veterans of America. We are the largest cohort of veterans living today. We are 60 percent of all living veterans. And our folks are increasingly getting ill from the long-term effects of, we believe, Agent Orange; and there is substantial scientific evidence to that fact, but none of that research is being done by VA.

In fact, none of it is being done in the U.S. It is being done in Europe, it is being done in Asia, and it is being done in Australia and New Zealand, but not in the USA. We think this is wrong. You cannot throw away a generation as concerned as we are with the young people coming home.

Thank you.

Mr. BLAKE. Mr. Chairman, could I take one quick shot at that?

Chairman AKAKA. Mr. Blake.

Mr. BLAKE. I would suggest that probably the most glaring omission from any statement in the budget is any mention of advance appropriations as a policy, given the fact that then Candidate Obama affirmed his support for this and even went so far as to say he was going to propose it in his budget; and that Secretary Shinseki at least initially supported it before you during his confirmation hearing, yet seems to have backtracked since then. I would say that that is probably the most glaring omission in the priorities discussion of the budget.

Chairman AKAKA. Thank you.

Mr. Baker?

Mr. BAKER. The DAV completely agrees. Advance appropriations is the thing missing.

Thank you.

Chairman AKAKA. Any other comments on what is missing?

Mr. CULLINAN. I will simply have to agree with Mr. Blake and Mr. Kerry Baker.

Chairman AKAKA. Well, I want to thank you very much for your testimony and also your responses. I think we have covered a huge area, and I thought I would end this hearing by asking you what you think was missing from what has been said today.

I want to thank you so much for participation in our efforts to help our veterans across the Nation. It is an effort that, of course, the Congress, the Administration, and the VSOs have been a huge part of. We do not want you to ever forget that you are part of this partnership, and we are looking forward to further hearings on other issues as well as coming together to try to find the best ways to improve the quality of service to our veterans.

So, in closing, again, I want to thank all of you for appearing today. We are just beginning our work on the VA budget, and your input has been very much appreciated. I think you know that we have a deadline this Friday with the Budget Committee on this particular issue.

So, again, thank you very much.

This hearing is now adjourned.

[Whereupon, at 11:56 a.m., the Committee was adjourned.]

A P P E N D I X

The Independent Budget

Critical Issues Report

For Fiscal Year 2010

As the global war on terrorism enters its eighth year and the conflict in Iraq approaches its seventh year, servicemen and -women continue to experience traumatic effects as they place themselves in harm's way. Since fighting began in Iraq in March 2003 and in Afghanistan in October 2001, more than 4, 000 service members have made the ultimate sacrifice and more than 40,000 others have been wounded. The sacrifices these brave soldiers, sailors, airmen, marines and coast guard members have made will leave them dealing with a lifetime of visible and invisible wounds. It is for these men and women and the millions who came before them that we set out each year to assess the health of the one federal department whose sole task it is to care for them and their families.

The Independent Budget is based on a systematic methodology that takes into account changes in the size and age of the veteran population, cost-of-living adjustments, federal employee staffing, wages, medical care inflation, construction needs, the aging health-care infrastructure, trends in health-care utilization, benefit needs, efficient and effective means of benefits delivery, and estimates of the number of veterans and their spouses who will be laid to rest in our nation's cemeteries.

Whereas *The Independent Budget for Fiscal Year 2010* will be released in February 2009 concurrent with the release of the President's proposed budget for the Department of Veterans Affairs (VA), this Critical Issues report is designed to alert the Administration, Members of Congress, VA, and the public to those issues concerning VA health care, benefits, and benefits delivery that we believe deserve special scrutiny and attention. We are releasing this report now as a guide to policy makers so they can produce a budget for FY 2010 that is more likely to correct existing problems and to better position VA to successfully meet the challenges of the future. We also hope that this document will provide direction and guidance for the new Administration and new Members of Congress.

As it becomes more and more likely that the global war on terrorism will be long, with dangers from unexpected directions and enemies who are creative and flexible in planning and executing attacks on our citizens and on our friends, our nation must continue to provide for those who serve in our defense. Additionally, we must be cognizant of the current fiscal realities in a time of turbulent and rapidly fluctuating economic conditions that may compel veterans of past service to seek VA care and benefits for the first time.

With this reality ever present in our minds, we must do everything we can to ensure that VA has *all* the tools it needs to meet the challenges of today and the problems of tomorrow. Our sons, daughters, brothers, sisters, husbands, and wives who serve in the darkest corners of the world, keeping the forces of anarchy, hatred, and intolerance at bay, need to know that they will come home to a nation that respects and honors them for their service, while also providing them with the best medical care to make them whole, the best vocational rehabilitation to help them overcome employment challenges created by injury, and the best claims processing system to

deliver education, compensation, and survivors' benefits in a minimum amount of time to those most harmed by their service to our nation.

We are proud that *The Independent Budget* has gained the respect that it has over its 23-year history. The co-authors of this important document—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States—work hard each year to ensure that *The Independent Budget* is the voice of responsible advocacy and that our recommendations are based on facts, rigorous analysis, and sound reasoning.

We hope that each reader approaches this Critical Issues report with an open mind and a clear understanding that America's veterans should not be treated as the refuse of war, but rather as the proud warriors they are.

Sincerely,

James B. King
National Executive Director
AMVETS

David W. Gorman
Executive Director
Disabled American Veterans

Homer S. Townsend, Jr.
Executive Director
Paralyzed Veterans of America

Robert E. Wallace
Executive Director
Veterans of Foreign Wars
of the United States

CRITICAL ISSUE 1
Sufficient, Timely, and Predictable Funding for VA Health Care

VA must receive sufficient funding for veterans health care and Congress must reform the funding process to ensure sufficient, predictable, and timely VA health-care funding.

With the end of the 110th Congress nearing, it is important to review and assess its efforts to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs (VA), particularly the health-care system. The actions of Congress reflect the highest highs and the lowest lows of the current funding process. Although the new leadership in Congress elevated veterans issues to the top of the priority list, Congress still faced a significant struggle to get its appropriations work done on time. Political wrangling continued to deadlock the federal budget process, and, in turn, complicate funding for veterans health care.

Despite recent historic funding increases, today's VA health-care budget process itself has basically paralyzed VA officials from more properly managing, planning, and operating the VA system. Not knowing when or what level of funding it would receive from year-to-year, or how Congress would deal with policy proposals directly affecting the budget, severely impairs VA's ability to recruit and retain staff, contract for services, procure equipment and supplies, and conduct planning and administrative matters. Congress can fully solve this problem only by enacting real reform that results in sufficiency, predictability, and timeliness of VA health-care funding.

For more than a decade, the Partnership for Veterans Health Care Budget Reform (Partnership), made up of nine veterans service organizations,* has advocated for reform in the VA health-care budget process. The Partnership has worked with both House and Senate veterans' leaders to craft legislation that would change VA's health-care funding process from a discretionary to a mandatory system. If enacted, such a change would be intended to guarantee that VA health-care funding would be sufficient, timely, and predictable. This would guarantee funding is available on time every year, with automatic adjustments to account for medical inflation and enrollment changes. However, despite the fact that legislation has been introduced in recent years to shift VA health-care funding to a mandatory status, to date Congress has not shown interest in moving this legislation forward.

As a result, the Partnership worked with the Senate and House Committees on Veterans' Affairs this year to develop an alternative proposal (S. 3527/H.R. 6939) that would change the VA's medical care appropriation to an "advance appropriation," guaranteeing funding for the health-care system up to one year in advance of the operating year. In fact, with bipartisan cosponsors, Senate VA Committee Chairman Daniel Akaka (D-HI) introduced S. 3527 and House VA Committee Chairman Bob Filner (D-CA) introduced H.R. 6939. Had this proposal already been in effect, Congress would have recently completed the FY 2010 appropriations bill for VA health care, and the FY 2009 appropriations for VA health care would already have been approved well in advance of the start of the fiscal year. This alternative proposal would ensure that the VA received its funding in a timely and predictable manner. Furthermore, it would provide an option *The Independent Budget* veterans service organizations (IBVSOs) believe is politically more viable than mandatory funding, and is unquestionably better than the current process.

Moreover, to ensure sufficiency, our advance appropriations proposal would require that VA's internal budget actuarial model be shared publicly with Congress to reflect the accuracy of its estimates for VA health-care funding, as determined by the Government Accountability Office (GAO) audit, before political considerations take over the process. This feature would add transparency and integrity to the VA health-care budget process.

Although members of both committees appear to have serious questions about how best to address the recurring funding problems for VA's health-care system, it is clear that the current process must be reformed in a manner that meets three key tests: *sufficiency, timeliness, and predictability*. Most important, as long as VA's health-care system remains part of the current annual discretionary funding process, it will remain vulnerable to unrelated budget and partisan politics that threaten the quality of care for veterans.

As in years past, the FY 2008 appropriations process was not a seamless and efficient process. The IBVOS were very disappointed when for the 14th time in the past 15 years, VA did not receive its appropriation prior to the start of the new fiscal year on October 1. Although the appropriations bill was eventually enacted, it included budgetary gimmicks that *The Independent Budget (IB)* has long opposed. The maximum appropriation available to VA would match or exceed the IB's recommendations; however, the vast majority of this increase was contingent upon the Administration making an emergency funding request for the additional money Congress approved. Fortunately, the Administration recognized the importance of this critical funding and triggered its release to VA. This emergency request provided VA with $3.7 billion more than the Administration had sought for VA in FY 2008.

The process leading up to FY 2009 was equally challenging. For the second year in a row, VA received historic funding levels that matched, and in some cases exceeded, the recommendations of the IB. Moreover, for only the second time in the past 21 years, VA received its budget prior to the start of the new fiscal year on October 1. However, this funding was provided through a combination continuing resolution/omnibus appropriations act. The underlying military construction and Veterans Affairs appropriations bill for FY 2009 was not actually completed by Congress in the regular order. While the House passed the bill in the summer, the Senate never brought its bill up for a floor vote. This fact serves as a continuing reminder that, despite excellent funding levels provided over the last two years, the larger appropriations process is completely broken.

Although significant strides have been made to increase the level of VA health-care funding during the past several years, the inability of Congress and the Administration to agree upon and enact veterans health-care appropriations legislation on time continues to hamper and threaten VA health care. When VA does not receive its funding in a timely manner, it is forced to ration health care. Much-needed medical staff cannot be hired, medical equipment cannot be procured, waiting times for veterans increase, and the quality of care suffers. Equally disturbing are reports that VA, following the close of FY 2008 is retaining as much as $800 million because VA was unable to spend it in time, despite the fact that thousands of veterans are waiting or unable to receive care.

Only through a comprehensive reform of the budget and appropriations process, such as advance appropriations, will Congress be able to ensure the long-term viability and quality of VA's health-care system. A review of the past two budget cycles makes it evident that even when there is strong support for providing sufficient funding for veterans medical care programs, the systemic flaws in the budget and appropriations process continue to hamper access to and threaten the quality of VA's health-care system.

On February 4, 2008, the President's budget submission for the Department of Veterans Affairs for FY 2009 was released, which included a total funding request of $41.2 billion for VA medical care, an increase of $2.1 billion over the FY 2008 funding level. This request included $38.7 billion in discretionary funding and $2.5 billion in medical care collections. *The Independent Budget for Fiscal Year 2009* recommended approximately $42.8 billion in total funding for medical care—an increase of $3.7 billion over the FY 2008 approved funding level and approximately $1.6 billion over the Administration's request. This funding recommendation would allow VA to reduce waiting times for medical services and keep up with the increasing demands placed on the system by returning and transitioning veterans.

In the end, Congress provided approximately $43 billion for total medical spending in VA. This included $40.5 billion in discretionary budget authority and an additional $2.5 billion in medical care collections. While the IBVSOs have long opposed the use of collections in establishing the operating budget of VA, we recognize that a significant amount of funding is available to VA each year due to these collections. However, we would urge Congress to review the actual collections rates that VA achieves each year if it continues to use collections to increase the VA's operating budget. Our own analysis suggests that VA has only collected about 79 percent of its estimated collections rates dating back to FY 2004. This would suggest that VA will likely only collect approximately $2.0 billion for FY 2009, even though VA will credit its estimate of $2.5 billion to offset budgetary needs.

The IBVSOs contend that despite the recent increases in VA health-care funding VA does not have the resources necessary to remove the prohibition on enrollment of Priority Category 8 veterans, who have been blocked from enrolling in VA since January 17, 2003. In response to this continuing policy, the Congress included additional funding to begin opening VA health-care system to some category 8 veterans. In fact, the final approved FY 2009 appropriations bill includes approximately $375 million to increase enrollment of category 8 veterans by 10 percent. This will allow the lowest income and uninsured category 8 veterans to begin accessing VA health care. *The Independent Budget* provided a cost estimate for the total cost to reopen VA's health-care system to all category 8 veterans. We estimated that such a policy change would cost approximately $1.4 billion in the first year, assuming that about 375,000 such veterans would enroll in and use the system. This cost estimate is a total cost that does not reflect the impact of medical care collections. We believe that it is time for VA and Congress to develop a workable solution to allow all eligible category 8 veterans to begin enrolling in the system.

In its FY 2009 VA budget submission, the Administration once again included policy proposals to increase prescription drug copayments from $8 to $15 for a 30-day supply and an enrollment fee for category 8 veterans that earn $50,000 or more annually that would range from $250 to $750. VA estimated that these proposals would generate $2.3 billion in receipts to the Treasury

over five years; however, there would have been no guarantee that the funds would be used to improve or expand the delivery of health-care services to veterans. *The Independent Budget* opposes proposals requiring veterans to pay more for their own care, particularly when such revenues may not even be used for veterans health care. As it had done numerous times in previous years, Congress roundly rejected these proposals this year.

Recommendation:

- Congress should reform VA's medical care appropriation to give it an advance appropriation status, to provide funding for veterans health care one year or more in advance of the operating year. This would ensure funding becomes timely and predictable, without converting it to mandatory status or requiring it to meet Congressional PAYGO rules for mandatory accounts.

- Congress should require VA's internal budget model to be shared publicly to provide accurate estimates for VA health-care funding, with the information audited by the GAO.

- The Administration and Congress must provide sufficient funding for VA health care to ensure that all eligible veterans are able to receive VA medical services without undue delays or restrictions. When VA has calcuated the cost to reopen the system to all veterans, it should receive full funding to accommodate Priority Category 8 veterans who choose to use the VA system for their health-care needs.

**The Partnership for Veterans Health Care Budget Reform is made up of The American Legion, AMVETS, Blinded Veterans Association, Disabled American Veterans, Jewish War Veterans of the USA, Military Order of the Purple Hart of the U.S.A., Inc., Paralyzed Veterans of America, Veterans of Foreign Wars of the United States, and Vietnam Veterans of America.*

CRITICAL ISSUE 2
The Challenge of Caring for Our Newest War Veterans

The Departments of Defense (DOD) and Veterans Affairs (VA) face unprecedented challenges in meeting the needs of a new generation of war veterans and their families, including those who suffer from post-combat deployment readjustment challenges and reveal cognitive impairments as a result of traumatic brain injury.

Since October 2001, approximately 1.7 million military service members have deployed to Iraq and Afghanistan in Operations Enduring and Iraqi Freedom (OEF/OIF). Because many service members participate in multiple deployments, they are subjected to a number of serious threats including mortar attacks, suicide bombs, and exposure to repeated blasts from improvised explosive devices (IEDs). Current studies indicate that multiple exposures to IED blasts and the stress of these deployments in general are exacting a toll on the fighting force resulting in a variety of seemingly "invisible" wounds, including post-traumatic stress disorder (PTSD), major depression, and cognitive impairments due to milder forms of traumatic brain injury (TBI). Military medicine has advanced to unprecedented levels of excellence that have resulted in a 90 percent survival rate among wounded veterans.[1] However, within the DOD and VA health-care systems gaps remain in the recognition, diagnosis, treatment, and rehabilitation of these less-visible injuries.

The DOD and VA share a unique obligation to meet the health-care and rehabilitative needs of veterans who have been wounded during military service or who may be suffering from post-deployment readjustment problems as a result of combat exposure. Without question, both agencies have done an extraordinary job in treating those who have suffered the most grievous polytraumatic injuries. But these deployments are also causing heavy casualties in what are considered the invisible wounds of war—PTSD, depression, substance-use disorders, family disruptions and distress, and a number of other social and emotional consequences for those who have served. The DOD, VA, and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of the newest generation of combat veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older veterans who served and were injured in earlier military conflicts. Congress must also remain apprised of how VA spends the significant new funds that have been provided and earmarked specifically for the purpose of meeting post-deployment mental health and physical rehabilitation needs.

The *Independent Budget* veterans service organizations (IBVSOs) are grateful that VA has adopted the principles of the President's New Freedom Commission on Mental Health. The commission's ultimate goal is the eradication of the stigma that surrounds mental health challenges and the opportunity for full recovery for people facing those challenges. The commission's framework for achieving this important goal should be the guiding beacon for VA

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[1] *Projecting the Costs to Care for Veterans of U.S. Military Operations in Iraq and Afghanistan: Hearing before the House Committee on Veterans Affairs*, 110th Cong., 1 (2007) (Testimony of Matthew Goldberg, deputy assistant director for National Security, Congressional Budget Office).

mental health planning, programming, budgeting, and clinical care for veterans of OEF/OIF service and of all military service periods. Optimal recovery is also the goal for those with severe physical injuries.

The RAND Corporation Center for Military Health Policy Research recently completed a comprehensive study titled *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* RAND found that the effects of TBI are still poorly understood, leaving a gap in knowledge related to how extensive the problem is or how to handle it.[2] The study evaluated the prevalence of mental health and cognitive problems of OEF/OIF service members; the existing programs and services available to meet the health-care needs of this population; the gaps that exist in these programs and what steps need to be taken to improve these services; and the costs of treating or not treating these conditions.

The study found rates of PTSD, major depression, and probable TBI are relatively high when compared to the U.S. civilian population.[3] RAND estimated that approximately 300,000, of the 1.64 million OEF/OIF service members who had been deployed as of October 2007, suffer from PTSD or major depression, and that about 320,000 individuals experienced a probable TBI during deployment.[4] Additionally, about one-third of those previously deployed have at least one of those three conditions, and about 5 percent report symptoms of all three.

According to RAND, 57 percent of those reporting a probable TBI had *not* been evaluated by a physician for brain injury. About 53 percent of those who met the criteria for PTSD or major depression had sought help from a physician or mental health provider in the past year.[5] It was noted, however, that even when individuals sought care, too few received *quality* care—with only half having received what was considered minimally adequate treatment. A number of barriers to care were identified by survey participants as reasons for not getting treatment. RAND concluded that there is a need for increased access to confidential, evidenced-based psychotherapy and that the prevalence of PTSD and major depression will likely remain high unless efforts are made to enhance systems of care for these conditions.[6]

Finally, the study evaluated the costs of these mental health and cognitive conditions to the individual and society. Suffering from these conditions can impair relationships, disrupt marriages, affect parenting, and cause problems in children of veterans.[7] RAND determined the estimated financial costs associated with mental health and cognitive conditions related to OEF/OIF service would be substantial ($4 billion to $6 billion over a two-year period for PTSD

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[2] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at XX (T. Tanielian & L. Jaycox eds., 2008).

[3] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research , at xxi, (T. Tanielian & L. Jaycox eds., 2008)

[4] *Ibid.*

[5] *Ibid.*

[6] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research, at XXII (T. Tanielian & L. Jaycox eds., 2008).

[7] *Ibid.*

and major depression, and $591 million to $910 million for TBI within the first year of diagnosis).[8]

Military service personnel who sustain catastrophic physical injuries and suffer severe TBI are easily recognized, and the treatment regimen is well established. However, DOD and VA experts note that TBI can also be caused without any apparent physical injuries if a person is in the vicinity of these powerful detonations. Symptoms can include chronic headache, irritability, behavioral disinhibition, sleep disorders, confusion, memory problems, depression, and other behavioral conditions.

Emerging literature (including the RAND study) strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other mental health conditions. Additionally, TBI and PTSD can be co-existing conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. The IBVSOs believe VA should conduct more research into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. The medical and social histories of previous generations of veterans could be of enormous value to VA researchers interested in the likely long-term progression of brain injuries. Likewise, such knowledge of historic experience could help both DOD and VA better understand the policies needed to improve screening, diagnosis, and treatment of mild-to-moderate TBI in combat veterans of the future.

The VA's Office of the Inspector General (OIG) issued an initial report on July 12, 2006, focused on the *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report found that better coordination of care between DOD and VA health-care services was needed to enable veterans to make a smooth transition. The OIG Office of Health Care Inspections conducted follow-on interviews to determine changes since the initial interviews conducted in 2006. OIG concluded that three years after completion of initial inpatient rehabilitation many veterans with TBI continue to have significant disabilities and—although case management has improved, it is not uniformly provided to these patients.[9]

Although the DOD and VA have initiated new programs and services to address the needs of TBI patients, and progress is being made, gaps in services are still troubling. The authors of *The Independent Budget* remain concerned about whether VA has fully addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact on both veterans *and* their families.

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[8] *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery, Executive Summary,* RAND Center for Military Health Policy Research , at XXIII, (T. Tanielian & L. Jaycox eds., 2008).

[9] *Follow Up Health Care Inspection: Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation,* VA Office of Inspector General Report No. 08-01023-119 at 8, (2008).

While a miraculous number of our veterans are surviving what surely would have been fatal wounds in earlier periods of warfare, most now survive but some grievously disabled and require a variety of intensive and even unprecedented medical, prosthetic, psychosocial, and personal supports. Eventually most of these veterans will be able to return to their families, at least on a part-time basis, or be moved to an appropriate therapeutic residential setting—but with the expectation that family members will serve as lifelong caregivers and personal attendants to help them substitute for the dramatic loss of physical, mental, and emotional capacities as a consequence of their injuries. Immediate families of newly and severely injured veterans face daunting challenges while serving in this unique role. They must cope simultaneously with the complex physical and emotional problems of the severely injured veteran, deal with the complexities of the systems of care that these veterans must rely on, while struggling with disruption of their family life, interruptions of personal goals and employment, and often the dissolution of other "normal" support systems most people take for granted.

The IBVSOs believe that a strong case management system is necessary to ensure a smooth and transparent handoff of severely injured and ill veterans and their family caregivers between DOD and VA programs of care. This case management system should be held accountable to ensure uninterrupted support as these veterans and family caregivers return home and attempt to rebuild their lives. A severely injured veteran's spouse is likely to be young, have dependent children, and reside in a rural area where access to support services of any kind can be limited. Spouses must often give up their personal plans (resign from employment, withdraw from school, etc.) to care for, attend, and advocate for the veteran. They often fall victim to bureaucratic mishaps in the shifting responsibility for conflicting government pay and compensation systems (military pay, military disability pay, military retirement pay, VA compensation) that they must rely upon for subsistence in absence of other personal means. For many younger, unmarried veterans who survive their injuries, their primary caregivers remain their parents, who have limited eligibility for military assistance and have virtually no current eligibility for VA benefits or services of any kind.

Both the DOD and VA health-care systems have limited authorization or capacity to provide mental health and relationship counseling services to family members—an important component of the rehabilitation process for veterans and their families. However, the IBVSOs have been informed by a few local VA officials that they are providing a significant amount of training, instruction, counseling and other services to spouses and parents of severely injured veterans who are already attending these veterans during their hospitalizations at VA facilities. These officials are concerned about the possible absence of legal authority to provide these services, and that scarce resources are being diverted to these needs without recognition of their cost within VA's resource allocation system. Thus, medical centers devoting resources to family caregiver support are penalizing themselves in doing so, but they clearly have recognized the urgency and validity of this need.

The Independent Budget veterans service organizations believe Congress should authorize, and VA should provide, a full range of psychological counseling and social support services as an earned benefit to family caregivers of severely injured and ill veterans. At a minimum this benefit should include relationship and marriage counseling, family counseling, and related assistance for the family coping with the stress and continuous burden of caring for a severely

injured and permanently disabled veteran. Also, we believe VA should establish a new national program to make periodic respite services available to all severely injured veterans.

Another issue having an impact on service members, veterans, and their families is substance use disorder. There are multiple consistent indications from both the DOD and VA that the misuse of alcohol and other substances will continue to be a significant problem for many OEF/OIF service members and veterans. An untreated substance use disorder can result in a number of health consequences for the veteran and family, including a marked increase in health-care expenditures, additional stresses on families, social costs from loss of employment and additional, avoidable costs to the legal system. We urge VA and the DOD to continue research into this critical area and to identify the best treatment strategies to address substance abuse and other mental health and readjustment issues collectively.

Over the past decade VA drastically reduced its substance use treatment and related rehabilitation services; however, it now appears some progress is being made in restoring them in the face of increased demand from veterans returning from OEF/OIF. We urge VA to closely monitor the implementation phase of its newly approved Uniform Mental Health Services policy to ensure a full continuum of care for substance use disorders and include additional screening in all its health-care facilities and programs—and especially in primary care. Congress must provide continued oversight to ensure these specialized programs are fully restored, readily accessible, and focused on meeting the unique needs of this population.

The IBVSOs are pleased that VA has developed a comprehensive strategy to address suicides and suicidal behavior in the veteran population, but we encourage Congress to provide oversight to ensure proper focus and attention are paid to this issue. It is clear that without proper screening, diagnosis, and treatment, post-deployment mental health problems can lead distressed individuals to attempt to take their own lives. Ready access to robust mental health and substance abuse treatment programs, which must include screening and early intervention, are critical components of any effective suicide prevention effort.

VA operates a network of more than 190 specialized PTSD outpatient treatment programs throughout its system of care, including specialized PTSD clinical teams and/or a PTSD specialist at each VA medical center. Additionally, Vet Centers, which provide readjustment counseling in 232 community-based centers, have reported rapidly growing enrollments in their programs. Although VA has announced plans to increase the number of Vet Centers, the IBVSOs believe that currently operating Vet Centers must also bolster their staffing to ensure that all the centers can meet the expanding caseload—now including not only traditional counseling but outreach, bereavement counseling for families of active duty service personnel killed in action in Iraq and Afghanistan, and counseling for victims of military sexual trauma.

The numbers of women now serving in our military forces are unprecedented in U.S. history. Today, women are playing extraordinary roles in the conflicts in Iraq and Afghanistan. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers and military police officers and serve in other military occupational specialties that expose them to the risk of injury and death. To date, more than 100 women have been killed in action, and women have suffered grievous injuries including multiple amputations. The current rate of enrollment of

women in VA health care constitutes the most dramatic growth of any subset of veterans. According to VA, since 2002, 41 percent of women who deployed in OEF/OIF and have since discharged from military service have enrolled in VA health care.

Because of the expanded roles of women in the military and their broadened exposure to combat, as well as the potential for them to carry the dual burden of combat experience and sexual assault, and given the sheer numbers of women enrolling in VA health care, we encourage VA to continue to address, through its growing treatment programs and expanded research initiatives, the unique health-care needs of women veterans.

Recommendations:

- The DOD and VA must invest in research for individuals who suffer from post deployment mental health challenges and TBI, to close information gaps and plan more effectively. Both agencies should conduct more research into the consequences of TBI and develop best practices in its screening, diagnosis, and treatment.

- VA should work more effectively with the DOD to establish a seamless transition of early intervention services to obtain effective treatments for war-related mental health problems, including substance use disorders, in returning service members.

- Congress should formally authorize, and VA should provide, a full range of psychological and social support services, including strong, effective case management, as an earned benefit to family caregivers of veterans with service-connected injuries or illnesses, especially for brain-injured veterans.

- The VA system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all its positive benefits, becomes VA's guiding beacon.

- VA should initiate surveys and other research to assess the variety of barriers to VA care for OEF/OIF veterans, with special emphasis on reservists and guardsmen returning to veteran status after combat deployments; rural and remote veterans; and female veterans. These surveys should assess barriers among *all* OEF/OIF veterans—not only the subset who actually enroll or otherwise contact VA for health care or other services.

- The DOD and VA must increase the number of providers who are trained and certified to deliver evidenced-based care for post-combat PTSD and major depression.

- The DOD and VA should amend current policies to encourage service members and veterans to seek the care they need without fear of stigma.

- VA should promote and expand programs for the care and treatment of the unique needs of women veterans with a focus on new women veterans who have served in Iraq and Afghanistan.

- The President and Congress should sufficiently fund DOD and VA health-care systems to ensure these systems *adapt* to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of previous generations of veterans with PTSD and other combat-related mental health challenges.

CRITICAL ISSUE 3
Maintain VA's Critical Medical Facilities Infrastructure

The Independent Budget ***veterans service organizations (IBVSOs) are concerned that the Department of Veterans Affairs (VA) has made attempts to back away from the capital infrastructure blueprint laid out by the CARES process and that its plans to begin widespread leasing of inpatient services through the "Health Care Center Facilities" program might not serve the best interests of veterans.***

With the completion of the Capital Assets Realignment for Enhanced Services (CARES) process, VA had a clear blueprint for the future—a comprehensive listing of necessary projects, including renovations and new construction that would bring VA infrastructure into the 21st century. So far, VA has completed 5 of those projects, with another 27 under construction.

Despite this progress, challenges remain. These projects, as well as the CARES-identified projects in the planning stage, still require at least $2.2 billion in future funding. At a March 24, 2008, briefing to several veterans service organizations, VA officials explained that between FY 2003 and FY 2009, the difference in the department's capital needs and what Congress had appropriated was a shortage of nearly $5 billion. Further, VA estimated that its future capital needs would be approximately $2 billion per year over the next five years.

Given this fundamental mismatch between VA's infrastructure demands and funding, VA has begun studying the feasibility of establishing the "Health Care Center Facilities" (HCCF) program. In its HCCF study of replacing facility construction with leasing, VA may be signaling a push to circumvent the traditional construction process. VA's FY 2008 Asset Management Plan describes the HCCF studies as a "means of improving both the access and environment of care for its veterans. These studies will assist in determining whether VA should lease space in lieu of seeking construction funding to address the current and future *health-care* needs of veterans."

From a list of 75 potential projects, VA has narrowed down the number of sites that it would consider for this program to 22, and the FY 2008 Asset Management Plan explains that VA expects to have the site analysis finished during FY 2009, allowing the Department to move forward on a pilot program shortly after that point. VA claims it retains the authority to conduct this program within the context of its existing leasing authority, and without specific authorization by Congress to initiate the program.

On the face of it, having VA lease space is not necessarily a bad idea. It has the advantage of being able to be done quickly, especially when compared to the drawn-out major construction process. It also allows VA flexibility, and it has been particularly valuable in establishing community-based outpatient clinics (CBOCs) and Vet Centers.

Our concern with the HCCF model is that it is leasing in lieu of VA providing essential inpatient capacity. The leased VA facility would provide extensive outpatient services, including primary and specialty care services. Inpatient services, however, would be provided by local contract through an agreement with an affiliate or with a community hospital, privatizing many services that the IBVSOs believe VA should continue to provide.

When combined with the recent trend of VA Medical Centers dropping inpatient services, the IBVSOs are becoming increasingly concerned. In Salisbury, North Carolina, the Hefner VA Medical Center is terminating inpatient, emergency, and surgical services. Michigan's Iron Mountain VA Medical Center has stopped performing inpatient surgeries and downgraded the emergency services it provides. There is suggestion that VA will contract out for some inpatient services at the Beckley, West Virginia, facility as well. Other still-unidentified facilities may follow this pattern.

One example of what can go wrong when VA abandons its inpatient services can be found in Grand Island, Nebraska. In 1997, the Grand Island VA Medical Center closed its inpatient facilities, contracting out with a local hospital for these services. Recently, the contract between the local facility, St. Francis Hospital, and VA was canceled. Veterans needing VA inpatient services can no longer receive care locally. They must travel great distances to other VA facilities including the Omaha VA Medical Center. In some cases, when Omaha is unable to provide the necessary specialized care, VA is flying patients at its expense to other VA facilities, including to the St. Louis and Minneapolis medical centers.

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 IBSVOs also have increasing concern over the changing of plans for the Denver VA Medical Center. The initial plans for the replacement Denver center were part of the 2004 CARES commission recommendations. Congress authorized and appropriated funding for the project, but in April 2008 VA unveiled a revised plan that would dramatically change the size and scope of the project, taking it away from the blueprint CARES had laid out. Although VA has not identified it as one of its HCCF projects, it shares the characteristics of those proposals. VA's new proposal would shift its inpatient services to a shared facility built and maintained by the University of Colorado. VA would be responsible for a scaled-back outpatient clinic at the fringes of the Fitzsimons campus.

One example of the problems with the proposal in Denver pertains to the spinal cord injury/dysfunction (SCI/D) center. The new proposal inexplicably splits the SCI/D center into

two separate buildings with the outpatient clinic providing 18 beds and the University's inpatient tower providing another 12 beds. These two facilities are separated by a distance of close to a mile—making coordination of care between the two locations difficult, especially given the mobility problems these patients have and harsh winter weather conditions in the Rocky Mountains. Worse, the design splits support spaces for these beds in two. With separate locations, some VA will need to duplicate support services at each facility, but with half the space VA originally determined was required. With regard to VA requirements, efficient staffing for an SCI/D unit dictates a unit with a minimum of 30 contiguous beds. If a SCI/D center is to function properly, it must be colocated with a full-service hospital and an SCI/D outpatient clinic.

Paralyzed Veterans of America has traditionally had a strong working relationship with VA in developing these SCI/D centers, providing guidance and recommendations to optimize the care provided in a setting that is comfortable and efficient for the paralyzed patients VA serves. With regard to the planned change in the Denver project, veterans have not had a voice; therefore, VA may be making a major strategic error in establishing a suboptimal facility for this critical population of veterans.

We have a number of other questions regarding this project, many of which would apply to other potential HCCF projects. How would governance be handled, 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's space planning criteria and design guides be applied 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?

The IBVSOs would like to see some justification for the changes in scope of this project. The CARES study used comprehensive demographic and health utilization data to support its recommendations. We would like to know what other information was used to develop this revised plan, especially in light of Congress's recent reauthorization of the project and its appropriation of an additional $20 million in FY 2009. The IBVSOs believe the Denver project must immediately move forward as initially envisioned.

CARES provided a sound data-driven assessment of VA's infrastructure needs, and VA seems to be backing away from it toward a model that includes much more privatization of care. The IBVSOs will be watching the process carefully and insist that VA provide us specific information and reasons for any changes in plans that deviate from the CARES blueprint. Also, we believe Congress should examine VA's new HCCF plan to determine whether VA retains the legal authority to proceed without specific Congressional authorization.

Recommendations:

- VA must not move to a wide-scale leasing program that replaces critical inpatient capacity with contract or fee-basis care.

- VA must immediately move forward with the initial plans for the Denver VA Medical Center, as the IBVSOs believe that the revised blueprint would not serve the needs of veterans, especially with respect to the split SCI/D clinics.

- Congress must carefully examine VA's HCCF program and exercise its oversight authority to ensure that VA is caring for veterans in the best possible way.

CRITICAL ISSUE 4
Improvements Needed in the Claims Process

In order to make the best use of newly hired personnel resources, Congress must focus on the claims process from beginning to end. The goal must be to reduce delays caused by superfluous procedures, poor training, and lack of accountability.

During the past couple of years, the Department of Veterans Affairs (VA) hired a record number of new claims adjudicators. Unfortunately, as a result of retirements by senior employees, an increase in disability claims, the complexity of such claims, and the time required for new employees to become proficient in processing claims, VA has achieved few noticeable improvements.

The claims' process is burdensome, extremely complex, and often misunderstood by veterans and many VA employees. Numerous studies have been completed on claims processing delays and the backlog created by such delays, yet the delays continue. The following suggestions would simplify the claims process by reducing delays caused by superfluous procedures, inadequate training, and little accountability. Other suggestions will provide sound structure with enforceable rights where current law promotes subjectivity and abuses rights.

The subjectivity of the claims process results in large variances in decision-making, unnecessary appeals, and claims overdevelopment. In turn, these problems contribute to the duplicative, procedural chaos of the claims process. Congress and the Administration should seek to simplify, strengthen, and provide structure to the VA claims process.

In order to understand the complex, procedural characteristics of the claims process, and how these characteristics delay timely adjudication of claims, one must focus on the procedural characteristics and how they affect the claims process as a whole. Whether through expansive judicial orders, repeated mistakes, or variances in VA decision-making, some aspects of the claims process have become complex, loosely structured, and open to the personal discretion of individual adjudicators. By strengthening and properly structuring these processes, Congress can build on what otherwise works.

These changes should begin by providing solid, non-discretionary structure to VA's "duty to notify." Congress meant well when it enacted VA's current statutory "notice" language. It has nonetheless led to unintended consequences that have proven detrimental to the claims process. Many Court of Appeals for Veterans Claims (Court) decisions have expanded upon VA's statutory duty to notify, both in terms of content and timing. However, with the recent passage of P.L. 110-389, the "Veterans Benefits Improvement Act of 2008," Congress, with the Administration's support, took an important step to correct this problem. However, *The Independent Budget* veterans service organizations (IBVSOs) believe VA can do more.

The VA's administrative appeals process has inefficiencies. The delays caused by these inefficiencies force many claimants into drawn-out battles for justice that may last for years. Delays in the initial claims development and adjudication process are insignificant when compared to delays that exist in VA's administrative appeals process. The IBVSOs believe VA can eliminate some of the delays in this process administratively, and we urge VA to do so. For example, VA can amend its official forms so that the notice VA sends to a claimant when it makes a decision on a claim includes an explanation about how to obtain review of a VA decision by the Board of Veterans' Appeals (Board) and provides the claimant with a description of the types of reviews that are available.

Another problem that seems to plague the VA's claims process is its apparent propensity to overdevelop claims. One possible cause of this problem is that many claims require medical opinion evidence to help substantiate their validity. There are volumes of Veterans Appeals Reporters filled with case law on the subject of medical opinions, i.e., who is competent to provide them, when are they credible, when are they adequate, when are they legally sufficient, and which ones are more probative, etc.

There is ample room to improve the law concerning medical opinions in a manner that would bring noticeable efficiency to VA's claims process, such as when VA issues a Veterans Claims Assistance Act (VCAA) notice letter. Under current notice requirements and in applicable cases, VA's letter to a claimant normally informs the claimant that he or she may submit a private medical opinion. The letter also states that VA may obtain a medical opinion if VA decides to do so. However, these notice letters do not inform the claimant of what elements render private medical opinions adequate for VA rating purposes. To correct this deficiency, we recommend to VA that when it issues proposed regulations to implement the recent amendment of section 5103 that 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. We believe that if a claimant's physician is made aware of the elements that make a medical opinion adequate for VA rating purposes, and provides VA with such an opinion, then, VA no longer needs to delay making a decision on a claim by obtaining its own medical opinion. This would reduce the number of appeals that result from conflicting medical opinions—appeals that are ultimately decided in an appellant's favor—more often than not. If the Administration refuses to promulgate regulations that incorporate the foregoing suggestion, then Congress should amend VA's notice requirements in section 5103 to require that VA provide such notice regarding the adequacy of medical opinions.

Congress should consider amending title 38, United States Code, section 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 Department healthcare facility. Some may view this suggestion as an attempt to tie VA's hands with respect to its consideration of private medical opinions. However, it does not. The language we suggest adding to section 5103A(d)(1) would not 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.

We also believe that other procedures add unnecessary delays to the claims process. For example, we believe that VA routinely continues to develop claims rather than issue decisions even though evidence development appears complete. These actions result in numerous appeals and unnecessary remands from the Board and the Court. Remands in fully developed cases do nothing but perpetuate the hamster-wheel reputation of veterans law. In fact, the Board remands an extremely large number of appeals solely for unnecessary medical opinions. In FY 2007, the Board remanded 12,269 appeals to obtain medical opinions. Far too many were remanded for no other reason but to obtain a VA medical opinion merely because the appellant had submitted a private medical opinion. Such actions are, we respectfully submit, a serious waste of VA's limited and shrinking resources.

The suggested rulemaking actions and recommended changes to sections 5103 and 5103A(d)(1) may have a significant effect on ameliorating some problems. But to further improve these procedures, Congress should amend 38 U.S.C. § 5125. Congress enacted section 5125, for the express purpose of eliminating the former title 38, Code of Federal Regulations, section 3.157(b)(2), requirement that a private physician's medical examination report be verified by an official VA examination report before VA could award benefits. However, Congress enacted section 5125 with discretionary language. This discretionary language permits, but does not require, VA to accept medical opinions from private physicians. Therefore, Congress should amend section 5125 by adding new language that requires VA to accept a private examination report if the VA determines that the report is: (1) provided by a competent health-care professional; (2) probative to the issue being decided; (3) credible; and (4) otherwise adequate for adjudicating the claim.

The IBVSOs have consistently maintained that VA must invest more in training adjudicators and decision makers, and should hold them accountable for higher standards of accuracy. The 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 has not been a high enough priority in VA. We 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 only achieve such quality when 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 VA's problems with accountability are not isolated to the claims process. In fact, they begin in the VA training process. Essentially, there is no distinction between VA's claims process and its training program when distinguishing unsatisfactory performance and outstanding

performance. Both processes place too much emphasis on quantity rather than quality. It is simply the numbers game in full swing.

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 completed such testing.

In addition to training, accountability is a key to quality and therefore to timeliness. However, almost everything in VA is production driven. VA should base personnel awards as equally on quality as it places on production. Therefore, VA must implement stronger accountability measures for quality assurance.

Congress should require the Secretary to report on how the Department will establish a quality assurance and accountability program that will detect, track, and hold responsible those employees who commit errors. VA should generate the report in consultation with veterans service organizations most experienced in the claims process.

VA can engineer an effective accountability system that holds each employee responsible for his/her work as a claim moves through the system while it simultaneously holds all employees responsible. As errors are discovered, employees responsible for such errors must be held accountable. The IBVSOs recommend that this accountability be enforced by forfeiture of work credit.

Such a cumulative accountability system would eliminate potential abuse of the system through the proverbial "good-old-boy's" club. One employee is far less likely to cover for errors or look the other way from errors committed by a fellow employee if he or she knew his or her performance measurement was equally at risk. This type of system will ensure personal accountability at every stage in the claims process without seriously disrupting or dismantling VA's current performance measurement system.

Recommendations:

- VA should amend its notification forms to inform claimants of the procedures that are available for obtaining review of a VA decision by the Board of Veterans' Appeals along with providing an explanation of the types of reviews that are available to claimants.

- VA should issue proposed regulations to implement the recent amendment of 38 U.S.C. § 5103 as quickly as possible. The VA's proposed regulations should include provisions that will require VA to notify a claimant, in appropriate circumstances, of the elements that render medical opinions adequate for rating purposes.

- Congress should amend section 5103A(d)(1) to provide that when a claimant submits a private medical opinion that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request another medical opinion from a Department healthcare facility.

- Congress should amend title 38, United States Code, section 5125, insofar as it states that a claimant's private examination report "may" be accepted. The new language should direct that the VA "must" accept such report if it is: (1) provided by a competent healthcare professional, (2) probative to the issue being decided, (3) credible, and (4) otherwise adequate for adjudicating such claim.

- VA should undertake an extensive training program to educate its adjudicators on how to weigh and evaluate medical evidence. In addition, to complement recent improvements in its training programs, VA should 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 and under which VA will hold trainees accountable.

- Congress should require the Secretary to report 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. The VA should generate the report in consultation with veterans service organizations most experienced in the claims process. As errors are discovered, employees responsible for such errors must be held accountable by forfeiture of work credit percentage.

CRITICAL ISSUE 5
Seamless Transition from the DOD to VA

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that all service members separating from active duty have a seamless transition from military to civilian life.

As service members return from the wars in Iraq and Afghanistan, DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service to successfully integrate into the civilian community as veterans. Though improvements have been made, the transition from DOD to VA continues to be a challenge for newly discharged veterans. *The Independent Budget* veterans service organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

The problems with transition from DOD to VA were never more apparent than during the controversy that occurred at Walter Reed Army Medical Center in 2007. While much of the media coverage misrepresented the problems at Walter Reed as a problem with care for injured service members, the real problems reflected many of the administrative difficulties associated with transitioning from DOD to VA.

The Independent Budget continues to stress the points outlined by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) report released in May 2003, and reinforced by the President's Commission on Care for America's Returning Wounded Warriors in September 2007, as well as four other major studies[10] regarding transition of service members to veteran status. One of the 20 recommendations made by the PTF and those made by the President's Commission was for increased collaboration between the DOD and VA for the transfer of personnel and health information. Great progress has been made in this area by VA, however, this recommendation remains only partially implemented. A September 2008 Government Accounting Office (GAO) report noted that DOD and VA are not sharing all electronic health information and that information is still being captured in paper records at many DOD facilities.

Health Information

The IBVSOs believe the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and bidirectional, allowing for a two-way real time electronic exchange of health information and occupational and environmental exposure data. Such an accomplishment could increase health information sharing between providers, laboratories,

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[10]Veterans Disability Benefits Commission, DOD Task Force on Mental Health, Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, Task Force on Returning Global War on Terror Heroes.

pharmacies, and patients; help patients transition between health-care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our knowledge and understanding of the clinical, safety, quality, financial, and organizational value and benefits of health information technology (IT). Lessons learned from previous wars also indicate that the DOD must continue collecting medical and environmental exposure data electronically while personnel are still in theater and we applaud the DOD for doing so. But it is equally important that this information be provided to VA. Electronic health information should also include an easily transferable electronic DD214 forwarded from DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan as agreed to by both DOD and VA through the Joint Executive Council and overseen by the Health Executive Council is a progressive series of exchanges of related health data between the two departments culminating in the bi-directional exchange of interoperable health information. While this has occurred at several levels, the current need is for a common standard. In May 2007, DOD established a Senior Oversight Committee (SOC), chartered and co-chaired by the Deputy Secretaries of DOD and VA with the goal to identify immediate corrective actions and to review, implement and track recommendations from a number of external reviews. Due to the recognized need, one of the Lines of Action (LOA) identified to be addressed was DOD-VA Data Sharing. The SOC approved initiatives to ensure health and administrative data are made available. The September 2008 GAO report indicates that the DOD and VA have agreed to numerous common standards and are working with federal groups to ensure adherence and alignment with emerging standards.

For example, the DOD and VA are sharing selected health information at different levels of interoperability such as pharmacy and drug allergy data on nearly 19,000 patients that seek care from both agencies. Such information is computable to warn clinicians of a possible drug allergy with a to-be prescribed medication. The Laboratory Data Sharing Interface Project is a short-term initiative that has produced an application used to electronically transfer laboratory work orders and retrieval of results between the departments in real time. Nonetheless, questions remain regarding the extent to which the DOD and VA will achieve full interoperability by next year when both departments have not yet articulated an interoperability goal.

According to the GAO[11], the DOD-VA Information Interoperability Plan recently completed by the departments is supposed to address these and other issues, including the establishment of schedules and benchmarks for developing interoperable health record capability. However, although an important accomplishment, on preliminary review the plan's high-level content provides only a limited basis for understanding and assessing the department's progress towards full interoperability by the September 30, 2009 date mandated by the National Defense Authorization Act for Fiscal Year 2008. Moreover, when fully established, a new interagency program office is to play a crucial role in accelerating efforts. Unfortunately, this office is not expected to be fully operational until the end of this year, and some milestones in the office’s plan for achieving interoperability have yet to be determined.

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[11]GAO-08-954.

Care Coordination

Severely injured service members and veterans whose care and rehabilitation is being provided by both DOD and VA, or who are transferring from one health-care system to the other, must have a clear plan of rehabilitation and the necessary resources to accomplish its goals. In response to the provisions of VA's Office of Inspector General (VAOIG) recommendations in a 2006 report examining the rehabilitation of OEF/OIF veterans suffering from Traumatic Brain Injury (TBI), the under secretary for health stated, "…case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families." In October 2007, the DOD and VA partnered to create the Federal Recovery Coordination Program to improve care management by identifying and integrating care and services between DOD and VA health-care systems and subsequently served to satisfy provisions of the Wounded Warrior Act, title XVI of Public Law 110-181. With such resources as the newly developed Federal Individual Recovery Plan, National Resource Directory, Family Handbook, MyeBenefits, and Veterans Tracking Application, the IBVSOs are cautiously optimistic that these coordinators will be able to provide greater oversight for the seamless transition of severely injured service members. While there are only eight Federal Recovery Coordinators serving about 120 severely injured service members across military treatment facilities,[12] and one newly assigned at Dwight D. Eisenhower Army Medical Center, the President's Commission on Care of America's Returning Wounded Warriors reported that more than 3,000 seriously wounded veterans might need the assistance of these coordinators.

For those service members and veterans whose injuries allow for more outpatient recovery and rehabilitation, a more extensive network has been created spanning the entire VA health-care system.[13] VHA has assigned part-time and full-time social workers to major Military Treatment Facilities (MTF) to serve as VHA liaisons between the MTF and VHA facilities. Each VHA facility has selected a point of contact (POC) and alternate who work closely with the VA-DOD social work liaisons detailed to MTFs and the Veterans Benefits Administration (VBA) representatives to ensure a seamless transition and transfer of care. While this initiative pertains primarily to military personnel returning from Afghanistan and Iraq having served in Operation Enduring Freedom and Operation Iraqi Freedom, it also includes active duty military personnel returning from other combat theater assignments. It does not include active duty military personnel who are serving in non-combat theaters of operation.

Moreover, VA introduced the concept of transition patient advocates in March 2007 to focus specifically on the needs of severely wounded veterans from operations in Iraq and Afghanistan. VAOIG then issued a follow-up report (May 1, 2008, to assess the extent to which VA maintains involvement with service members and veterans who had received inpatient rehabilitative care in

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[12]Walter Reed Army Medical Center, Bethesda National Naval Medical Center, Brooke Army Medical Center, Naval Medical Center Balboa, as of this writing.

[13]VHA Directive 2006-017 April 3, 2006.

VA facilities for TBI. According to the report, VA case management was determined to have improved, while long-term case management is not uniformly provided for these patients, and significant needs remain unmet.

Disability Evaluation

The Independent Budget likewise concurred with the President's Commission recommendation that the DOD and VA implement a single comprehensive medical examination, and we believe that this must be absolutely done as a prerequisite of promptly completing the military separation process. However, we would like to reiterate our belief that if and when a single separation physical becomes the standard, VA should be responsible for handling this duty as VA simply has the expertise to conduct a more thorough and comprehensive examination as part of its compensation and pension process. Moreover, the inconsistencies with the Physical Evaluation Board (PEB) process from the different branches of the service can be overcome with a single physical administered from VA's perspective, and not DOD's. A pilot project launched by the DOD and VA in November 2007 for service members from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center has more than 200 participants and is a step toward developing this single separation physical. While this separation physical is targeted primarily at those considered for medical discharge from the military, it should be considered for all separations. According to the GAO, the DOD and VA have not finalized their criteria for expanding the pilot project beyond the original sites. The IBVSOs believe the DOD and VA need to expand the pilot to more sites in preparation to fully implement the program.

The problem with separation physicals identified for active duty service members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists, and in some cases reservists are not made aware of the option. Though the physical examinations of demobilizing reservists have greatly improved in recent years, there are still a number of service members who "opt out" of the physicals, even when encouraged by medical personnel to have them. Though the expense and manpower needed to facilitate these physicals might be significant, the separation physical is critical to the future care of demobilizing service members. We cannot allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War illnesses, particularly among our National Guard and Reserve forces. This would also enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service.

In the past several years, the DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. The Department of Labor's (DOL) Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) handled by the Veterans Employment and Training Service (VETS) is generally the first service a separating service member will receive. In particular, local military commanders, through the insistence of the DOD, began to allow their soldiers, sailors, airmen, and marines to attend well enough in advance to take greatest advantage of the program. The programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for

complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve, but challenges continue at some local military installations, at overseas locations, and with services and information for those with injuries. Disabled service members who wish to file a claim for VA compensation benefits and thus, other ancillary benefits, are dissuaded by the specter of being assigned to a medical holding unit for an indefinite period. Furthermore, there still appears to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature and quick processing time may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a VA spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP and it is critical that coordination be closer between the DOD, VA, and VETS to improve this disparity.

Though the achievements of the DOD and VA have been good with departing active duty service members, there is a much greater concern with the large numbers of Reserve and National Guard service members moving through the discharge system. Due to the number of troops that are on "stop-loss"—a DOD action that prevents troops from leaving the military at the end of their enlistments during deployments—large numbers of troops rapidly transition to civilian life upon their return. Both DOD and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the Global War on Terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. Unless these service members are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans benefits and services. Additionally, DOD personnel at these sites are most focused on processing soldiers through the site. Lack of space and facilities often restrict contact between demobilizing soldiers and VA representatives.

In October 2008, DOD released a new Compensation and Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces. This handbook is designed to help service members who are wounded, ill, and injured, as well as their family members, navigate the military and veterans disability system. The IBVSOs applaud this informative booklet as one more method for service members to understand the transition, but now it will be critical for DOD to ensure it gets into the hands of transitioning service members.

The IBVSOs believe the DOD and VA have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interfere with providing for service members who have chosen to leave military service. If we are to ensure that the mistakes of the first Gulf War are not repeated during this extended global war on terrorism, it is imperative that a truly seamless transition be created. With this, it is imperative that proper funding levels be provided to VA and the other agencies providing services for the vast increase in new veterans from the National Guard and Reserves. Servicemen and women exiting military service should be afforded easy access to the health care and benefits that they

have earned. This can only be accomplished by ensuring that the DOD and VA improve their coordination and information sharing to provide a seamless transition.

Recommendations:

- The DOD and VA must ensure that service members have a seamless transition from military to civilian life.

- The DOD and VA must continue to develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environmental exposure data. These electronic medical records should also include an easily transferable electronic DD214.

- The DOD and VA must fully establish the Joint Interagency Program Office with permanent staff and clear lines of responsibility and finalize the draft implementation plan with appropriate milestones and timelines for defining requirements to support interoperable health records.

- The DOD and VA must outline the requirements for assigning new or additional Federal Recovery Coordinators to military treatment facilities caring for severely injured service members in concert with tracking workload, geographic distribution, and the complexity and acuity of injured service member's medical conditions.

- The DOD and VA must develop a clear plan of rehabilitation for severely injured service members and veterans receiving care and must receive the necessary resources to accomplish these goals.

- In accordance with the recommendation of the FY 2008 National Defense Authorization Act and the recommendation of the President's Commission, the DOD and VA must implement a single comprehensive medical examination as a prerequisite of promptly completing the military separation process. Moreover, VA should be responsible for handling this duty.

- Congress and the Administration must provide adequate funding to support the TAP and DTAP programs managed by DOL-VETS to ensure that active duty, as well as National Guard and Reserve, service members do not fall through the cracks while transitioning.

CRITICAL ISSUE 6
Human Resource Challenges Facing the Department of Veterans Affairs

The Department of Veterans Affairs (VA) must strengthen, energize, and expand programs to recruit and retain highly qualified VA employees, particularly in the Veterans Health Administration (VHA), and must redouble its efforts to advance succession plans to welcome the next generation of VA employees.

Addressing human resource issues within VA has never been more urgent than today with the ongoing conflicts in Afghanistan and Iraq and the aging of both the veteran population and the "Baby Boomer" generation. Service members are returning from conflicts abroad and seeking services from VA, and, at the same time, veterans from previous wars, particularly veterans from the Vietnam era, are aging and their need for medical services and other VA benefits is steadily increasing. In this environment, sufficient staffing becomes more essential to ensuring that veterans receive adequate VA care.

VA's ability to sustain a full complement of highly skilled and motivated personnel will require aggressive and competitive employment hiring strategies that will enable it to successfully compete in the national labor market. VA's employment success within the VHA and Veterans Benefits Administration (VBA) will require constant attention by the very highest levels of VA leadership. Additionally, Members of Congress must understand the gravity of VA personnel issues and be ready to provide the necessary support and oversight required to ensure VA's success.

VA must prepare for future personnel challenges by refining human capital policies and procedures, specifically in the areas of recruitment, retention, and succession planning. The average age of a VA employee is nearly 50 years, and 41 percent of VA employees will be eligible for retirement by the year 2013. The estimated U.S. veteran population is 23,816,000, and 39 percent of the veteran population is 65 years of age or older. VA must create and implement a strategy that will focus on hiring, training, and retaining personnel to offset the changing demographics of the veteran population and the VA workforce. VA must work to ensure efficient, safe, and productive work environments that attract high caliber professionals to successfully execute the VA mission, caring for America's veterans.

Veterans Health Administration

The facilities of VA, like many other American health-care providers, are facing a looming and potentially dangerous shortage of available health-care personnel to meet the growing demands of sick and disabled veterans. The current documented national shortage of physicians, nurses, pharmacists, therapists of all disciplines, psychologists, and practitioners in several other professional disciplines is bound to impact the effectiveness of VA's recruitment and retention programs. VA estimates that 163,308 new hires will be needed to handle attrition and maintain VHA's workforce to 2013. VA must anticipate the effects of the national health-care workforce

shortage and work to provide competitive employment packages and a more preferred workplace to ensure veterans continue to receive high quality and effective VA health care in the future.

The dwindling supply of trained and qualified health-care professionals cannot keep pace with the national growth in demand for health care. VA has recognized that the employment market is extremely competitive for some positions and is working to provide innovative professional development opportunities and programs to attract some of the new employees it will need to care for veterans. However, recruitment, retention, and succession planning can be fully successful only with sufficient, timely, and predictable funding from Congress for VA's overall health-care mission. After years of reacting to the current erratic funding process, achieving effective health-care budgetary reform can provide VA the confidence it needs to more effectively recruit, develop, and retain its health-care workforce to meet the needs of our nation's veterans.

With regard to registered nurses (RNs) within the VA system, the United States is experiencing an unprecedented nursing shortage that is expected to continue well into the future.[14] The Health Resources and Services Administration (HRSA) projected in 2007 that the nation's nursing shortage will grow to more than 1 million nurses by the year 2020 and that all 50 states will experience shortages of nurses in varying degrees by the year 2015. According to projections from the U.S. Bureau of Labor Statistics (BLS) in the November 2005 *Monthly Labor Review*, 1,203,000 new RNs will be needed by 2014 to meet job growth and replacement needs. According to the July 2006 Aging Workforce Survey conducted by the Nursing Management organization, 55 percent of surveyed nurses reported the intention to retire between 2011 and 2020.[15] In addition to the need for 30,211 RNs by 2013, the VHA turnover rate for registered nurses in 2006 was 8.5 percent (full and part-time positions, not including trainees). VA must develop a recruitment strategy that provides employment incentives that attract and encourage nursing students and new nurse graduates to commit to VA employment. More specifically, VA must work to recruit and retain nurses that provide care in VA's specialized service programs, such as spinal cord injury/disease (SCI/D), blind rehabilitation, mental health, and brain injury using compensatory benefits, such as specialty pay.

With respect to VA physicians, at present, 130 VA medical centers have affiliations through which physicians represent half of approximately 100,000 VA health profession trainees. VA estimates that medical residents equate to approximately one-third of the total VA physician workforce. About 2,500 (16 percent) of VA physicians are currently eligible for voluntary retirement, and it is projected that by 2012, this number will grow to 2,909 (17 percent).[16] Notably, a 2007 survey assessed the impact of VA health profession training on VA physician recruitment. Prior to exposure to training in VA facilities, 21 percent of medical students and 27 percent of medical residents indicated they were "very" or "somewhat" likely to consider post-graduate VA employment. Following training at VA, these positive responses grew to 57 percent

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[14]Auerbach, Buerhaus, & Staiger, 2007.

[15]www.nursingmanagement.com.

[16]Department of Veterans Affairs, Veterans Health Administration Workforce Succession Strategic Plan FY 2008–2012.

of medical students and 49 percent of medical residents. Although current resignation rates among VA physicians remain stable, VA projects the number of voluntary retirements will rise over time. Thus through its training programs VA is well positioned to take advantage of a ready source of physician recruitment.

In 2004, Congress passed Public Law 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004. The act is partially intended to aid VA in both recruiting and retaining VA physicians (including scarce sub-specialty practitioners) by authorizing VA to offer highly competitive compensation to full time physicians oriented to VA careers. In the intervening years VA has implemented the act, but we believe the act may not have provided VA the optimum tools needed to ensure that veterans will have available the variety and number of physicians needed in their health-care system. For example, a recent review of offered VA physician position vacancies on usajobs.gov revealed the following: Bay Pines VA Medical Center is recruiting an orthopedic surgeon at a maximum salary of $175,000 while the national average income of orthopedists is $459,000. Indianapolis VAMC was seeking an emergency room physician at a maximum of $175,000 while the national average for this category is $216,000. The Greater Los Angeles VA system was offering a maximum of $270,000 for an anesthesiologist while the average income for anesthesiologists is $311,000. We urge Congress to provide further oversight and to ascertain whether VA has adequately implemented its intent or if VA may need additional tools to ensure full employment for qualified VA physicians as it addresses its future staffing needs.

Given the VHA's leadership position as a health system, it is imperative that VA aggressively recruit health-care professionals in addition to emphasizing the attractive opportunities within the VHA and work within established relationships with academic affiliates and community partners to recruit new employees. In order to make gains on these needs, VA must update and streamline its human resource processes and policies to adequately address the needs of new graduates in the health sciences, recruits, and current VA employees. Today's health-care professionals and other staff who work alongside them need improved benefits, such as competitive salaries and incentives, child care, flexible scheduling, and generous educational benefits. VA must actively address the factors known to affect current recruitment and retention, such as fair compensation, professional development and career mobility, benevolent supervision and work environment, respect and recognition, technology, and sound, consistent leadership, to make VA an employer of choice for individuals who are offered many attractive alternatives in other employment settings.

VA Human Resources Policies Are Outmoded

VA must work aggressively to eliminate outdated, outmoded VA personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment. It is reported that, on average, from the time a vacancy announcement is posted, appointment of a new employee within VHA consumes 90 days. In some professional occupations (especially physicians and nurses), many months can pass from the date of a position vacancy until the date a newly VA-credentialed and privileged professional caregiver is on board and providing clinical care to veterans. Its lack of ability to make employment offers and confirm them in a timely manner, especially to new graduates VA has helped train,

unquestionably affects VA's success in hiring highly qualified employees and has the potential to diminish the quality of VA health care. Hiring delays depress current workforce morale and lead to overuse of mandatory overtime for nurses and others, greater workplace stress and staff burnout. At all levels, VHA (especially including local facility managements) must be held accountable for improving human resources policies and practices. Congress should require VA to report its efforts to improve recruiting, retention, and environmental/organization practices to assure veterans that VA will be a preferred health-care provider in the future and will continue to provide veterans an effective health-care system to meet their specialized needs.

Succession Planning Needs Improvement

Improving VA recruitment and retention efforts and more focused succession planning could help offset the inevitable loss of VA's experienced personnel. The VHA has identified the top 10 occupations which make up approximately 44 percent of the future new hires needed to stem attrition between FY 2007 and FY 2013. VA must implement an energized succession plan in VA facilities that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures to bring the next generation of VA caregivers onboard.

As employees exit VA employment over the next few years, it is imperative for VA to conduct exit surveys without regard to time in service or reason for resignation. However, the opposite seems to be the case today. In 2007, VHA's exit survey rate dropped from 27 percent to 20 percent, the lowest in three years. Exit surveys in the top 25 critical VA occupations are particularly important to evaluate employees leaving these positions. With thorough surveys VA management can secure pertinent data to help refill positions as quickly as possible and to determine whether conditions of employment, human resources policies or other contributing factors to early departures of valued staff need revision. Exit surveys also provide valuable insight and information on the VA work environment and organizational culture. These are key elements to both retaining and recruiting high quality personnel in VA health care.

Existing VA loan repayment and scholarship programs were established by Congress to provide individuals interested in VA nursing with the financial support they need to enter and stay in the field. Both a recruitment and retention tool, the centrally funded Employee Incentive Scholarship Program (EISP)[17] pays up to $32,000 for health care–related academic degree programs, with an average of $12,000 paid per scholarship. Since its inception in 1999 through 2007, approximately 7,000 VA employees have received scholarship awards for educational programs related to Title 38 and "hybrid" Title 5-Title 38 VA occupations. About 4,000 employees have graduated from academic programs under these auspices. Scholarship recipients include registered nurses (93 percent), pharmacists, physical therapists, and other allied health professionals. A five-year VA analysis of program outcomes demonstrates this program's impact on VA employee retention. For example, turnover of nurse scholarship participants is 7.5 percent compared to a nonscholarship nurse turnover rate of 8.5 percent. Also, less than 1 percent of

[17]38 U.S.C. §§ 7671–7675. Established by Public Law 105-368, Title VIII, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and amended by Public Law 107-135, Department of Veterans Affairs Health Care Programs Act of 2001.

participating nurses left VHA employment during their service obligation period (from one to three years after completion of degree).[18]

The VA Education Debt Reduction Program (EDRP) provides tax-free reimbursement of existing education debt of recently hired Title 38 and hybrid employees. Centrally funded, the EDRP is the Title 38 equivalent to the Student Loan Repayment Program (SLRP) administered by the Office of Personnel Management (OPM) for Title 5 employees. More than 5,600 VA health-care professionals have participated in EDRP. The maximum amount of an EDRP award is limited by statute to $44,000 in exchange for five years of service. As education costs have risen, the average award amount per employee has increased over the years from about $13,500 in FY 2002 to more than $27,000 in FY 2007. While employees from 33 occupations participate in the program, 77 percent are from three mission critical occupations—RN, pharmacist, and physician. The rate of losses from resignation of EDRP recipients is significantly less than that of nonrecipients as determined in a 2005 study. For physicians the study found the resignation rate for EDRP recipients was 15.9 percent compared to 34.8 percent for non-EDRP recipients.[19]

Both the ESIP and EDRP initiatives need to be strengthened and expanded to new VA occupations, in particular among the 25 critical occupational categories that will be increasingly competitive as the health manpower shortage worsens. These programs have proven themselves to be cost-effective recruitment tools and to provide strong incentives for individuals to remain in VA employment rather than to go elsewhere.

Veterans Benefits Administration

Over the past two years, and with Congressional authorization, the Veterans Benefits Administration has hired a record number of new claims adjudication staff. Unfortunately, as a result of senior VBA officials retiring in the interim, an increase in disability claims received, rising complexity of such claims, and the time required for new employees to become proficient in processing accurate claims, VA has achieved little noticeable improvement in its claims work. The VBA has a major challenge ahead in completing complex training required to gain full productivity of several thousand new staff.

With the influx of these new benefits personnel, it is difficult for the IBVSOs as observers to predict that ongoing challenges faced by the VBA are still the result of staffing shortages. In fact, such is the size of the claims backlog that it would be naïve to expect an immediate reduction in the VBA workload. Such an expectation is defeated merely by the time required for new employees to gain necessary experience, and the drain on experienced employees who provide much of the current training to them. In order to make the best use of new resources, the VBA must focus on improving training and accountability while simplifying the claims process itself.

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[18]April 8, 2008, testimony of Marisa Palkuti, M. Ed., director, VA Health Care Retention and Recruitment Office.

[19]*Ibid.*

Many of the core human resource systems problems documented primarily for the VHA in this Critical Issue also pertain to VBA. As VA approaches solutions to its human resource challenges in the VA health-care system, it should also incorporate those solutions where applicable in the human resource policies and practices of the VBA.

Recommendations:

- VA must work aggressively to eliminate outdated, outmoded VA-wide personnel policies and procedures to streamline the hiring process and avoid recruitment delays that serve as barriers to VA employment.

- VA must implement an energized succession plan in VA medical and regional office facilities that utilizes the experience and expertise of current employees, as well as to improve existing human resources policies and procedures.

- VA facilities must fully utilize recruitment and retention tools, such as relocation and retention bonuses, a locality pay system for VA nurses, and education scholarship and loan payment programs as employment incentives, in both the VHA and VBA.

- VA must conduct improved exit surveys as employees terminate employment to secure pertinent data that will help refill positions in a timely manner and to determine if conditions of employment, human resources policies, or other contributing factors need revision.

- Congress must provide further oversight to ensure adequate implementation of Public Law 108-445.

- Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA's specialized services areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

- VA must develop a more aggressive recruitment strategy that provides employment incentives that attract and encourage affiliated health professions students, and new graduates in all degree programs of affiliate institutions, to commit to VA employment.

- Congress should improve the provisions of VA's Employee Incentive Scholarship Program (ESIP) and Education Debt Reduction Program (EDRP) and make them available more broadly to all VA employees. VA must become more flexible with its work schedules to meet the needs of today's health-care and benefits professionals and must provide other employment benefits, such as child care, that will make VA employment more attractive.

CRITICAL ISSUE 7
The National Cemetery Administration

The National Cemetery Administration must ensure that burial in a national or state veterans cemetery is an option available for all veterans and their family members and must provide a dignified setting with perpetual care that honors veterans and exhibits evidence of the nation's gratitude for their military service.

The Department of Veterans Affairs (VA) National Cemetery Administration (NCA) maintains more than 2.8 million gravesites at 125 national cemeteries and 33 additional installations in 39 states and Puerto Rico. Currently there are more than 17,000 acres within established NCA installations. Just more than half of this land is undeveloped. Including available gravesites and the undeveloped land there is a potential to provide more than 4 million resting places. In addition to the maintenance of these facilities, the NCA administers four programs: the State Cemetery Grants Program, the Headstone and Marker Program, the Presidential Memorial Marker Program, and Outer Burial Receptacle reimbursements.

The purpose of the national cemetery is to honor the memory of America's servicemen and -women. Many of our nation's cemeteries are steeped in history, and the monuments, markers, and memorials that stand represent the very foundation of our country. Our nation's burial grounds are a national treasure deserving of the utmost care and protection. To achieve this high standard of preservation the NCA faces serious challenges. The increase in the demand for interment and the need for continuous gravesite maintenance, including the repairs, upkeep, and other labor-intensive tasks involved in operating a cemetery, continue to rise. To meet these challenges, the NCA must have adequate funding to ensure it remains a world-class system that honors our veterans and recognizes their contribution and service to our nation. Therefore, *The Independent Budget* recommends a budget for the NCA that will both meet the growing demand and allow every man and woman who has worn the uniform of the United States armed forces to be treated with dignity and respect.

The 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, Missouri, 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.

The 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 into the 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 110,000 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.

In addition to the day-to-day operations to develop, maintain, and improve the NCA cemeteries, the NCA run State Cemetery Grants Program is vital in establishing and maintaining veterans' gravesites in areas in which the NCA cannot fully respond to the burial needs of veterans. This program assists states, by providing grant money to ensure veterans' burial needs are met in areas where there are no national cemeteries or the area is under represented due to the number of veterans who live in a given area. It is imperative that the State Cemetery Grants Program be funded at a level that ensures the states can continue to meet the needs of veterans who want to be buried closer to their homes and that meets the challenge of growing interest by states in providing burial services in areas not currently served.

In 1973 the 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 death, $300 for nonservice-connected 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 nonservice-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.

To ensure the National Cemetery Administration's capability to maintain our national cemeteries in a dignified and respectful manner, a comprehensive effort must be made to greatly improve the condition, function, and appearance of these cemeteries. To assist in restoring the national cemeteries *The Independent Budget* recommends to Congress the establishment of a five-year, $250 million "National Shrine Initiative" to restore the character of NCA cemeteries.

The NCA honors veterans with a final resting place that commemorates their service to the nation. 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.

Recommendations:

- Congress must provide adequate resources to ensure that the NCA remains a world-class operation that honors veterans and recognizes their contributions and service to the nation.
- Congress must fund the State Cemetery Grants Program at a level that ensures that states can meet the needs of veterans who want to be buried closer to their homes.
- Congress should increase burial benefits to cover the cost of burial more adequately and expand the eligibility for the plot allowance to all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime.
- The NCA must continue to identify sites for the addition of new national cemeteries in areas that remain underserved.

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