U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2012

HEARING

BEFORE THE

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

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WEDNESDAY, FEBRUARY 17, 2011

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

The Committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Bilirakis, Lamborn, Roe, Benishek, Buerkle, Denham, Flores, Huelskamp, Johnson, Runyan, Stutzman, Filner, Reyes, Michaud, Braley, McNerney, Donnelly, Walz, Barrow, and Carnahan.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. And I now turn the Committee's attention to today's scheduled budget hearing. Thank you very much.

As the Secretary and his folks make their way forward, I would like to add that we do have votes that are going to be called within the next few minutes. I apologize for that. We were hoping that we would be able to get the bulk of this meeting done without the interruption. But in order to get our business done, we need to have early votes today.

So I would ask folks when they do their opening statements this morning to please bear that in mind so that we can get to the Secretary for his opening statement, his testimony, and also for us to have the opportunity to ask questions.

Mr. Secretary, thank you so much for being here today, bringing your team to present the President's 2012 Budget for the Department.

I also recognize all the veterans service organizations (VSOs) that are represented here today and we look forward to working with each of the VSOs very closely and the U.S. Department of Veterans Affairs (VA) as we all work to improve the delivery of benefits and health care to those who have been in service to our country.

Everybody knows this is a tighter budget year and it is going to be very difficult to measure because right now we do not have a full appropriations for every VA account for the current fiscal year.

That being said, if the numbers in the House Continuing Resolution (CR) bill are carried forward, the President's budget is roughly a three and a half percent increase in discretionary spending rel-

ative to the current spending, needless to say, this is a much more measured increase.

I think what is important for us to all remember is it is not necessarily the percentage of the increase, but it is, in fact, whether we are meeting our obligations to American veterans and to the taxpayers of this country. And to that end, I have a couple of observations that I just want to bring forward.

First, I am interested in learning how this budget will chart a path to address the broken disability claims system. Staffing compensation since the late 1990s has tripled. Numerous information technology (IT) tools have been utilized. There have been different organizational models attempted and nothing has appeared to work. And so I want to know what this budget will do in taking a new approach to meeting this challenge.

Second, I am interested, as you and I have already discussed, Mr. Secretary, how this budget is prioritized to meet the needs of the family caregivers of the severely wounded Iraq and Afghanistan veterans. The reaction to the initial plan, as most of us have seen, has been negative. And I want to explore ways we might be able to refocus resources for this important, very important initiative.

Third, I want to know what energy went into eliminating wasteful, redundant spending. The bipartisan Deficit Reduction Commission suggested that every agency, VA included, step up to the plate to meet the challenges of eliminating wasteful and redundant spending.

Mr. Secretary, I have to say when I look at this budget and I see that it proposes a funding level for the Office of the Secretary that is 41 percent higher than 2009 levels, 50 percent higher for the Office of Congressional and Legislative Affairs, 96 percent higher for the Office of Policy and Planning, and 140 percent higher for the Office of Public and Intergovernmental Affairs, it does raise questions and red flags.

Also, there is some curious budgeting mechanisms that have been requested and put in place, the contingency fund that is in there is one. I want to know how Congress can appropriate money for this contingency fund how exactly it will be used.

Also, the budget proposes that we appropriate money that you can save through management efficiencies so that it can carry that money forward into another fiscal year. These are new concepts and I think each Committee Member is anxious to get details on those.

Look, we are acutely aware of the fiscal and economic crisis that this country faces, a debt of $14 trillion, a deficit this year of $1.55 trillion, and unemployment hovering at just under 10 percent on the average and with veterans, a higher number than that. We have work to do. Together we have work to do.

I want to borrow a quote from recent history because it touches on the challenges that we face in finding a balance between meeting our obligations to veterans and keeping in mind fiscal limitations. "The Committee Members have kept in mind the fiscal limitations within which we must operate if we are to get Federal spending under control and thereby reduce the Federal deficit and debt. We believe that the government can be fiscally responsible

while still fulfilling its commitments to the most deserving among us, including our Nation's veterans. We are also mindful that uncontrolled Federal spending threatens the long-term health of the Nation's economy and in turn could adversely affect the provision of veterans' benefits. Thus, we recognize those who have worn the uniform in defense of the Nation seek, as we do, to protect the health of the Nation's economy."

You might think that comes from a tea party group. It really does not. This was a letter that was sent in 1997 signed by every Member of the Senate Veterans' Affairs Committee both Democrat and Republican, including the current Chairman of the Senate Veterans' Affairs Committee. Times are different. The deficit then was $128 billion. Now it is 10 times higher.

Moving forward, I think that every one of us can work together to find common ground on difficult choices that are ahead.

I would like to turn the microphone now over to the Ranking Member, Mr. Filner.

[The prepared statement of Chairman Miller appears on p. 52.]

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman.

If I may spend 2 minutes on something we did last week because I think you and this Committee ought to be congratulated.

I have been in politics for over 30 years and I have never seen such a quick and profound reaction to a hearing than we had from JPMorgan Chase. We had a hearing that you called, Mr. Chairman, on some of the actions taken by JPMorgan Chase that were adverse to both the law and to the interest of our fighting troops.

They responded within a few days. They have lowered their interest rate below what is required by law. They made all active duty eligible even though they did not have a loan before they were on active duty. If they foreclosed on people improperly, they are giving the homes debt free, I mean, no payments to the servicemembers. They formed a Veterans Advisory Council. They are hiring veterans. They are making a thousand homes available over the next few years to our veterans.

The hearing was incredible. I appreciate what you have done, and I think we have helped a lot of servicemembers and made their lives more secure. So thank you, Mr. Chairman. It was an incredible response to a hearing.

Secretary Shinseki, thank you for being here. I do associate myself with the remarks of the Chairman. I am also looking forward to our *Independent Budget* panel. But, you know, Mr. Secretary, like the Chairman, I have questions regarding some of your assumptions and estimates. But if you tell me and tell this Committee that this is what you need to get the job done in this fiscal year, then I am going to offer you, and I hope we all do, our support and fight to get the funding levels that you say you need.

Like the Chairman, I have concerns about the contingency fund, the operational improvements that are built in there and whether they will work. But the bottom line is that we have to work with you to assure that all our veterans get the care they need.

I am looking forward to *The Independent Budget,* also. Many of you know that for years, I have been waving this around as my

Bible and we will continue to take what they have said very seriously. I hope you will be here to also hear that, Mr. Secretary. We look forward to your testimony.

I think we are having votes and probably we will come back afterward. It is up to you, Mr. Chairman.

[The prepared statement of Congressman Filner appears on p. 53.]

The CHAIRMAN. We have 11 minutes on the clock right now. I would ask the Committee, what is your pleasure? I know that everybody probably has a statement that they would like to read or present. Would you like to start that process or would you like to hear from the Secretary?

Guys, you want to go ahead and do your opening statements or let the Secretary begin?

Mr. JOHNSON. I would rather do our statements so he is not interrupted when he makes his.

The CHAIRMAN. Okay. Very well. We will recognize Mr. Lamborn for his opening statement.

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman. And I will make a very brief opening statement.

I want to thank you, Secretary Shinseki and Members of the panel, for your service and hard work on behalf of the men and women of our Armed Forces and veterans. Your tireless efforts have made it possible for our veterans and families to secure a better future in terms of health care and compensation.

I want to personally thank Secretary Shinseki for his personal involvement in bringing a community-based outpatient clinic (CBOC) and a veterans' cemetery to Colorado District 5. We look forward to hearing the results of these endeavors in the near future.

We also eagerly await the start of the new VA medical center in Denver and we are hoping that the level of funding will keep the construction on track. There are over 100,000 veterans in my district and they look forward to the new services that it brings to Colorado.

To the veterans' support organizations, I thank you for your work on behalf of veterans. Your advocacy gives millions of veterans a voice and a sounding board for many of their issues.

And, distinguished Members of the panels, I salute you and I look forward to your testimony today.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. Lamborn.

Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman.

Mr. Secretary and members of your team, welcome.

And I will just insert my statement for the record. Thank you.

[The prepared statement of Congressman Reyes appears on p. 53.]

The CHAIRMAN. Thank you very much.

Dr. Roe.

Mr. ROE. Welcome, General Shinseki. Look forward to your comments.

And I yield back.
The CHAIRMAN. Thank you very much.
Mr. Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman and Ranking Member, for having this hearing.

I, too, want to thank you, Mr. Secretary, for your unwavering support in service and commitment to our veterans of this Nation and everyone on this panel.

Looking at the Administration's budget, it actually reflects a lot of the shared priorities of Members of this Committee such as rural health, mental health, and homeless veterans' issues.

I do want to single out your commitment to investing in innovation and technology to better serve our veterans. I had an opportunity earlier this week to actually meet members of your staff that head up the VA information technology (IT) Program and am impressed with the exciting work that they are undertaking and want to thank you for moving forward in technology.

With that, Mr. Chairman, I yield back.
The CHAIRMAN. Dr. Benishek.

OPENING STATEMENT OF HON. DAN BENISHEK

Mr. BENISHEK. I just want to say that I am looking forward to working with you on this Committee. And I think we will be able to make some progress in the care of our veterans. And I think it is going to be an exciting time going forward.

And I would just like to yield back the remainder of my time.
The CHAIRMAN. Mr. Braley.

OPENING STATEMENT OF HON. BRUCE L. BRALEY

Mr. BRALEY. Thank you, Mr. Chairman.

As the Ranking Member of the Economic Opportunity Subcommittee, I am very excited about working with Chairman Stutzman on creating economic opportunities for veterans across the country. I think at a hearing like this, it is important to put a human face on what the Veterans Administration does.

I just want to share, especially with my new colleagues, this is a young family in Dubuque, Iowa, Andrew, Jenny, and Brody Connolly, who moved into a new home on November of 2010 with a specially adapted housing grant. Andrew served honorably in Iraq, came home with a service-related disability, and that program which we help oversee has made an enormous impact in their lives, especially with their profoundly disabled son, Brody.

This is the housewarming party that they had. And they are wearing sweatshirts, Mr. Chairman, that say this house was built on hope and love. That is what the VA does for people.

This is a young man from Dubuque, Iowa, Christopher Billmeyer, who lost both of his legs above the knee and is recovering at Bethesda right now.

This is another young man in my district, Staff Sergeant Ian Ralston, who went to school with my daughter, Lisa, and was paralyzed from the neck down because of an improvised explosive device (IED) explosion.

And this is why the Chairman's comment about the Caregivers and Veterans Omnibus Health Services Act is so important. We have thousands of disabled veterans who depend on those caregivers. And in rural places like Iowa, it is increasingly difficult to find qualified caregivers.

And I had the opportunity to speak with the Secretary about that. I look forward to his comments about what we will do together to get that program off the ground.

And I yield back.

The CHAIRMAN. Thank you very much.

Members, I am watching the clock, so we are in good shape. We are at 6 minutes right now.

Ms. BUERKLE.

OPENING STATEMENT OF HON. ANN MARIE BUERKLE

Ms. BUERKLE. Thank you, Mr. Chairman.

As a freshman Member of the Committee and as the Chair of the Subcommittee on Health, I take very seriously my responsibilities to ensure that the Department of Veterans Affairs is adequately funded to provide our veterans with the benefits that their service afforded them.

We are all aware of the current economic situation in our country, our $14 trillion debt, our unemployment rate. There is no doubt we have to take a critical look at how our country spends our tax dollars.

However, the laws providing care to our veterans were some of the first laws enacted by Congress and because our founding fathers understood and had the foresight that America's veterans deserve the gratitude of a grateful Nation and providing care and benefits for those who have proved so worthy will make our country stronger.

I hope that our hearing this morning will point the way towards close cooperation among all of us who advocate for our Nation's veterans to respond to their evolving needs and to those of their families.

Thank you, Mr. Secretary, for your service and for being here this morning.

Also, thank you to the veterans service organizations for being here as well.

I yield back.

[The prepared statement of Congresswoman Buerkle appears on p. 53.]

The CHAIRMAN. Mr. McNerney.

OPENING STATEMENT OF HON. JERRY McNERNEY

Mr. MCNERNEY. Thank you, Mr. Chairman.

On Monday night, I had the honor of having dinner with two severely-wounded veterans, one with a traumatic brain injury (TBI) that is very similar to the injury that Ms. Gifford suffered in January. He was recovered, did not have much use of his right side. And so when I shook hands with the left side, he was very excited. But he is absolutely determined to get to college and learn history so that he can teach high-schoolers about our Nation's history. That

is why I am here today. That is why this Committee is so important.

So thank you for your work and thank all the Members for working together to serve our veterans.

The CHAIRMAN. Mr. Denham.

OPENING STATEMENT OF HON. JEFF DENHAM

Mr. DENHAM. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Filner, thank you for holding this hearing. I think that this will most likely be the most important hearing that we hold this year. I do not say that lightly because I know that we are going to be addressing a number of very, very important topics for our veterans.

But at a time when we are going to see more veterans return home than we have since Vietnam, we had better be prepared to be able to fulfill our commitment to our servicemembers and make sure that the benefits that they so deserve are there and available.

With that, I also want to welcome Secretary Shinseki. Thank you for spending a lot of your time with various new Members. We certainly appreciate your openness.

Also, I am impressed with your plan to reduce the backlog of disability claims in my district especially. It is one of the top casework issues that we have and probably one of the most important. Our disabled veterans, we need to make sure as Members of Congress that they are receiving the benefits that they need and deserve and at the same time, the process that you are putting in place or that you put in place not only will better serve those veterans, but, as I understand, reduce costs as well.

So, you know, again with the budget, you know, we are looking at reducing spending in every area of the budget. I believe that there is justification here for an increase, but that also comes with a great deal of responsibility, oversight. We want to make sure that the money that is allocated goes exactly where it is needed and that is to our huge influx of veterans that will be coming home, many of which have suffered different issues than previous veterans. Whether you have lost a home, you know, maybe a relationship, or a job, we need to be prepared not only with economic development but those health benefits and making sure that we can reintegrate them back into civilian life.

Thank you.

The CHAIRMAN. We are down to 2 minutes, so we will recess at this point. We have 14 votes. They are going to be 2-minute votes, so we will return as quickly as we can.

The Committee stands in recess.

[Recess.]

The CHAIRMAN. Bear with us for just one more second. The Ranking Member is here and he will be right with us.

Again, Mr. Secretary, we apologize for the votes, but thank you for coming today.

And on the first panel, we are going to hear from the Honorable Eric Shinseki, Secretary of the United States Department of Veterans Affairs. The Secretary is accompanied by the Honorable Robert Petzel. He is the Under Secretary for Health for the Veterans Health Administration (VHA); Mr. Michael Walcoff, Acting Under

Secretary for Benefits in the Veterans Benefits Administration (VBA); Steve Muro, the Acting Under Secretary for Memorial Affairs in the National Cemetery Administration (NCA); and the Honorable Roger Baker, Assistant Secretary for Information and Technology and Chief Information Officer; and, finally, W. Todd Grams, the Acting Assistant Secretary for Management.

Mr. Secretary, as usual, your written statement will be made a part of the record and you are now recognized.

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

Secretary SHINSEKI. Thank you, Chairman Miller.

Ranking Member Filner, other distinguished Members of the House Committee on Veterans' Affairs, thanks for this opportunity to present the President's 2012 budget and 2013 advanced appropriation request for the Department of Veterans Affairs.

I will just speak in general to the Members of the Committee. It was helpful for me to meet with so many Members of this Committee prior to the hearing. I did not get to visit every Member because of schedule alignments, but I assure you that I will follow-up and complete those visits.

Members were generous with their time, Mr. Chairman, and I appreciate it very much.

This Committee's support for our Nation's veterans has been unequivocal and unwavering. I have said that before. I say it again. And that support has never been more necessary or appreciated.

Let me also acknowledge, as you did, the representatives from some of our veterans service organizations in attendance today. They provide insights into veterans' needs and how VA might consider better addressing them. Those insights are always helpful to our workforce, our great folks who come to work each and every day to serve veterans, but there is more that we can all do to even better serve them within the resources we have. And we are always open to new ideas here.

Mr. Chairman, thank you for introducing the members of the VA leadership team who are here with me. I will just point them out, Roger Baker on the extreme left; Todd Grams, our Chief Financial Officer (CFO) here; I think most know Dr. Petzel, our Chief Medical Officer, Under Secretary for Health; Mr. Mike Walcoff from Veterans Benefits; and Steve Muro from our National Cemetery

Administration, who is also the President's nominee to fill the position of Under Secretary for NCA.

Thank you for accepting my written statement, Mr. Chairman.

Let me just say that the VA budget is large and complex, and I think you alluded to that in your opening comments, important enough to be sure because it cares for those who have safeguarded the Nation so that others can do what Americans do best and that is out-create, out-work, and out-produce the rest of the world.

Maybe the economy has lost a bit of sparkle for the moment, but I trust the instincts, the ingenuity, the intelligence, and the intellectual power of the American people. Less than 1 percent of our citizens who serve in the military enable the rest of us, the rest of the Nation to unleash the economic engine to do what we have historically done and that is win.

And when members of the military transition back into their communities to add their time and talent to that economic engine, VA's mission is to care for those who have borne the battle and their spouses and orphans as President Lincoln reminded us 146 years ago now.

And to do that, VA is a large integrated health care system, perhaps the largest in the Nation. It is also our largest national cemetery system with credentials as the top-performing institution in the country over the past 10 years as reflected in the American Customer Survey Satisfaction Index.

VA also manages the country's second-largest education assistance program. It guarantees nearly 1.4 million individuals home loans at zero down payment with the lowest foreclosure rates in all categories of mortgage loans.

Finally, VA is the eighth largest life insurance entity in the country with a 96 percent customer satisfaction rating.

Why is the VA enterprise so large and complex? Mr. Chairman, I would just offer simply because in times past, those who wore the Nation's uniforms were often unable to either acquire or afford these services on their own.

Our mission—to provide or arrange for the care of veterans who need us once the uniforms come off—is rooted in President Lincoln's promise of 1865. We deliver on the promises of presidents and fulfill the obligations of the American people through those who have borne the battle.

Today, the Nation's military remains deployed in two different operational theaters, conflicts that have been underway for most of the past decade in Afghanistan and Iraq. And we are all very familiar with the results that we see as our youngsters come home.

The burden on our magnificent all-volunteer force and their families in accomplishing every mission without failure, without fanfare, or complaint has been enormous. VA's requirements have grown over that time as we address long-standing issues from past wars and watch the requirements for those fighting the current conflicts grow significantly.

These numbers will continue to rise, perhaps for several decades, after the last American combatant departs Iraq and Afghanistan and we must be prepared to absorb them.

This budget request is the Department's plan for meeting our obligations to all generations of veterans effectively, accountably, and efficiently.

At present, about 8.3 million veterans depend on VA for medical care and benefits, but over 22 million veterans and another 35 million spouses and adult children see themselves as veterans, a part of veterans' families whether or not they visit one of our medical centers or apply for benefits.

Lots of people are counting on us to get things right for veterans. We need your continued support, Mr. Chairman, and I look forward to working with you to serve them.

To resource VA's efforts, the President's budget request would provide $132.2 billion in 2012, almost $61.9 billion in discretionary resources, and $70.3 billion in mandatory funding. Our discretionary budget request represents an increase of $5.9 billion or 10.6 percent over the 2010 enacted level.

Since I appeared before this Committee last year, we have published and implemented our strategic plan to continue transforming VA into an innovative 21st Century organization that is people-centric, results-driven, and forward-looking.

Our 2012 and 2013 budget plans are based on four goals in that strategic plan. First, continue improving the quality and accessibility of VA health care, benefits, and services; second, increase veterans' satisfaction with the care and services we provide them now; third, raise readiness to continue the provision of care and services at a time of crisis; and, finally, improve VA internal management systems.

Achievement of these goals mandates our constant and consistent good stewardship of the financial resources entrusted to us by the Congress both in the current constrained fiscal environment and during less stressful times.

We have designed management systems and initiatives to maximize efficiency and effectiveness and eliminate waste, including VA's project management accountability system, P–M–A–S, PMAS as it is often referred to, a new acquisition strategy to make more effective use of our IT resources.

Second, VA's transformation 21 total technology, T4. T4 consolidates our IT requirements into 15 prime contracts and leverages economies of scale to save time and money, enabling greater oversight and accountability.

Our strategic capital investment plan, S–C–I–P, SCIP, defines and assesses VA's capital portfolio and enables improved efficiency of operations.

Last November, we launched two on-line metric systems, one called LinKS, standing for Linking Information, Knowledge, and Systems, LinKS, and the other one Aspire. Together these systems allow VA to transparently increase our quality of health care against private sector benchmarks.

VA successfully remediated three of four long-standing material weaknesses in 2010 and earned our 12th consecutive clean audit opinion on our consolidated financial statements.

Finally, we have implemented Medicare standard payment rates and consolidated contracting requirements to reduce cost and waste within the system.

A recent independent study, which covered a 10-year period, found that VA's health IT investments between 1997 and 2007 were $4 billion while savings from those investments were more than $7 billion. More than 86 percent of the savings resulted from the elimination of duplicated tests and reduced medical errors.

Furthermore, reduced workload and lowered operating expenses were additional byproducts resulting in cost savings.

The 2012 budget continues to focus on our three key transformational priorities: expanding veteran, family, and survivor access to benefits and services; reducing and ultimately eliminating the claims backlog; and ending veterans' homelessness by 2015, three visible and urgent issues for VA.

A comprehensive review is underway to reuse VA's inventory of vacant or under-utilized buildings to house homeless and at-risk veterans and their families where practical.

Congress allocated $50 million to renovate unused VA buildings and VA has identified 94 sites with the potential to add approximately 6,300 units of housing through public and private ventures using VA's enhanced use lease authority.

The enhanced use lease legislative authority is scheduled to lapse at the end of calendar year 2011, this year, and its reauthorization is needed to continue to increase housing for homeless veterans and their families.

The most flexible and responsive housing option remains the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD–VASH) voucher on which we work quite closely with the Department of Housing and Urban Development. Both Secretary Donovan and I endorse the importance of this joint effort to care for our homeless veterans. Right now our only option is the HUD–VASH voucher for housing veterans with families.

As advocates for veterans and their families, VA is committed to providing the very best services to all veterans. I will do everything possible to ensure that we wisely use the funds that Congress appropriates to VA to improve the quality of life for veterans innovatively and transparently as we deliver on the enduring promises of presidents and the obligations of the American people.

Again, thank you for this opportunity to appear before this Committee. And I look forward to your questions, Mr. Chairman.

[The prepared statement of Secretary Shinseki appears on p. 54.]

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

And with the Members' indulgence, I know we did not finish opening statements. But in view of the fact the Secretary has had to wait during our votes, I would like to ask if we can go ahead and continue on and everybody will have an opportunity if they wish to have their opening statements.

Mr. Secretary, one of the first things the leadership did in this new Congress was to require a 5 percent budget cut on our staffs and Committees, including this one, as a matter of fact. And in looking in the budget, I see tremendous increases and I alluded to them in my opening statement.

So, you know, I think the thing this Committee wants to know is, number one, does the agency understand, and I know you do, but explain to us, that you understand the current fiscal condition

that this country is in? And these increases that are being made to support staff that do not directly impact the veterans and their benefits, just explain to us why such large increases.

Secretary SHINSEKI. Thank you, Mr. Chairman.

Let me call on our Chief Financial Officer to provide some details on some of the offices you covered. I will speak about the Office of the Secretary and then I will wrap up at the end.

Mr. GRAMS. Thank you, Mr. Chairman.

The increases that you are referring to I believe are in the staff offices at the Department level at the VA. In total, those increases from 2011, which we are assuming a freeze under a Continuing Resolution until we actually see what comes out of that, to the request in 2012 is about 13 percent.

Half of that increase is for the President's initiative. It is about $24 million to strengthen and enhance the acquisition workforce. And this is part of a government-wide initiative that is across all departments, not only in the VA.

This is important to us because part of our plan for decreasing waste and getting more efficient and having savings lies in our ability to reduce the spending in the $16, $17 billion that we have every year in VA acquisitions.

Of the remaining increases in the staff offices that are left, it is around 6 or 7 percent. Those increases are to help us strengthen and finish up the requirements of Homeland Security HSPD–12, which relates to the safety and security of our employees as well as the veterans who come to our facilities.

We are also looking to enhance our General Counsel's office so that we can more timely publish regulations and deal with issues in front of the U.S. Court of Appeals for Veterans Claims (CAVC).

There are also increases requested in our ability to do modeling and data analysis so that we can better project future needs of veterans and then also provide better oversight as we go forward.

Secretary SHINSEKI. Mr. Chairman, I think one of the points you made was the Office of the Secretary also showed an increase. That increase is $834,000, about a 9 percent increase.

There was an arrangement where in the past, people have been detailed from outside the office to work in the Office of the Secretary and so they are paid for elsewhere and, yet, they work in my location. I ended that this year. I said if they are going to work in my office, we are going to pay for it and that is what you see reflected here, so that accountability for how that money is being spent is properly accounted.

I would say when we get around to talking about things like the savings we are generating, some of this overhead, if you will, is designed to drive the better results of our expenditure funds and we can demonstrate what savings we have been able to realize.

The CHAIRMAN. Mr. Grams, you, I think, were talking about expected CR levels off 2011. And if we go back to 2009, I think the number is 33½ percent increase from 2009.

Mr. Secretary, if we go back to 2009 with the Office of the Secretary, we have seen a 41 percent increase. So while the numbers may appear small as compared to the line in the CR, we are still talking about an increase on top of a very large increase; is that correct?

Mr. GRAMS. Yes, sir. I think there has been growth through 2009. When you look at the Office of the Secretary, and it relates to what the Secretary said earlier in terms, let's say, straightening out who is detailed or who is actually on the Secretary's rolls, which is what he was referring to, my understanding is that, I believe it was in 2009, there was a decision made to put certain organizations in the Office of the Secretary that had previously been in some of the other Assistant Secretaries' offices. And that is part of the growth from 2009 through 2012 as well.

The CHAIRMAN. Okay. Thank you.

I see my time is expired. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman.

Mr. Secretary, you rightly pointed out the importance of the HUD–VASH Program. The HUD–VA Supported Housing Program provides permanent housing and ongoing treatment service to hard to serve homeless veterans with chronic mental illness, substance abuse, and other disabilities. And you pointed out how important this is.

The Continuing Resolution that is on the floor that was sponsored by the majority party eliminates the HUD–VASH Program for the rest of this fiscal year.

Do you have the numbers of how many veterans that might cut off from vouchers? Do you have any numbers there that can help us?

I may propose an amendment later on today that tries to restore that funding, but I think it is disgraceful that it was eliminated from the budget.

Secretary SHINSEKI. Congressman Filner, I believe that the allocation for this year would have been about 10,000 which is the number of HUD–VASH vouchers we have been provided in the past, but that exact number is——

Mr. FILNER. Okay. Again, you and the Administration have devised what you called a zero tolerance for veterans' homelessness over the next 5 years. That is the disgrace of having those who have served our Nation on the streets without getting the kind of help you want to eliminate. I greatly applaud you for that and we are going to try to do everything we can to support that.

But when one of the cornerstones of that program, the HUD–VASH Program, is cut, it makes it that much more difficult. I am sorry that it is going ahead in the CR. I hope the Senate does not accept that.

The CHAIRMAN. Will the gentleman yield time?

Mr. FILNER. Yes.

The CHAIRMAN. Actually, the HUD–VASH Voucher Program is not being eliminated from the CR; is that correct, Mr. Secretary?

Secretary SHINSEKI. I am not current.

The CHAIRMAN. Well, as I understand, there are, I think, 30,000 that were already done. You have 19,000 that have already been allocated. I think there are 11,000 out there that have not been and they are still in the CR. So, again, I think the important thing is they are not being eliminated.

Mr. FILNER. I do not know how you could say that, if I can reclaim my time. If you eliminate the funding, how many vouchers are left? We are talking, of course, for the remainder of the fiscal

year. Those that you have said were allocated were not. But the funding is zeroed out. So how do you expect any vouchers to be given out later?

The CHAIRMAN. There will be 11,000 vouchers still left to be issued.

Please continue. And that was on my time.

Mr. FILNER. But the funding has been zeroed out, so I am not sure how we reconcile that. We will try to figure that out.

But in any case, I think it is disgraceful that we are moving in that direction. These are folks, again, who have served our Nation.

The one subject that has concerned us over the years, Mr. Secretary, is the elimination of the claims backlog. You have taken an approach since you have been Secretary to get the numbers down by force, by hiring—you have hired, I do not know, over 10——

Secretary SHINSEKI. Brute force.

Mr. FILNER. Brute force. You have hired over 10,000 new people, roughly that, and, yet, we have not brought down the backlog at all. It has increased. I do not know if you want to try to defend that brute force. You know, you are not an Army Secretary anymore. You are into peaceful stuff.

But it seems, and just for the new Members here, I have advocated a brute force approach that eliminated the backlog rather quickly by using the so-called Linda Bilmes approach to mainly recognize the claims if they have been prepared with a veterans service officer.

I am thinking of a compromise where you do not need to comment on now, but you might think about, that we do the Bilmes approach maybe for a year or two. Similar to the way an organization that wants to reduce its overhead so they buy out people and let them retire early. If we buy out or give an offer of a buy-out and say it offers people 30 percent, which is a little bit above the average of their disability, and they will not go further in the system, but they get their check now, we might eliminate half a million of those claims right away.

I think we ought to figure out an outside the box thinking of going after those claims. We are never going to do it by this brute force. I do not know, over 10,000 new hires and we have not broken into backlog that at all.

I think we are going to have to cut the backlog down as far as we can go with one swift buy-out and then take all the new things that you have been developing in the last couple of years to speed things up. You can start from a base of somewhere near zero, and you may be able to keep up with it.

I do not want to give up on all those new things that you have been doing, but I do not think we are ever going to get it down to a reasonable number unless you take a meat ax on the brute force approach. I cannot think of the right metaphor here.

Secretary SHINSEKI. May I comment?

Mr. FILNER. Please.

Secretary SHINSEKI. We look at every opportunity to take on a new idea. And you and I have discussed this before, Congressman Filner, and I am happy to continue this. We will look at this option you offer us.

May I just call on a couple of our folks here to give you an update on where we are with regard to the investments we have made here? I will call, first of all, on Mike Walcoff to talk about the business processes we are doing and then on Roger Baker for the IT piece of this.

And very quickly, please.

Mr. WALCOFF. Thank you.

Mr. Filner, there certainly has been very generous support from Congress over the last several years and we have hired a number of people. The number when you look at our compensation and pension (C&P) workforce, has gone from about 7,500 in 2005 to around 14,000 now. So that gives you some idea. It is a pretty big increase.

And I believe that the hiring of those people has made it so that the elimination of the backlog is a reasonable goal. Through efforts to address not only people but also our process as well as technology, our production over the last year went over a million for the first time. We had an increase of 10 percent in production for 2009.

The receipts, however, were 1.2 million. They went up 18 percent last year and 14 percent the year before. So the question is, how do we eliminate that. And the fact is that there are problems with our capabilities that we have to address, and the things that we are doing to address that involve technology.

The Veterans Benefits Management System, which is our paperless system, we need to complete development of that. This is going to improve our efficiency. It is going to improve our quality and it is going to improve our timeliness.

The veterans relationship management initiative is going to make it so that veterans can communicate with us on their terms. And the Virtual Lifetime Electronic Record (VLER) Project, the development with VA and U.S. Department of Defense (DoD), is the third piece of the technology that we really need in order to eliminate that backlog.

The good news is that in 2012, this budget year, we will get to the point where we are producing more cases than we are getting in. And that is the beginning of the elimination of the backlog.

The other thing that is going to happen in 2012 is we begin rolling out the Veterans Benefits Management System (VBMS) so that paperless technology begins going to our regional offices.

Secretary SHINSEKI. Secretary Baker.

Mr. BAKER. Just quickly, Congressman Filner, I would tell you that the VBMS Program is on track. We are using the very successful techniques that we use to deliver the new GI Bill system on time to meet the VBMS system. And so we look forward to deploying that in conjunction with VBA. It will take technology to break the back of the backlog.

Mr. FILNER. My time is up and I will yield back. I just want to say for all of the freshmen, if we look at the transcripts from this hearing over the last 10 years, over 20 years, we have heard the exact same issues. We are going to break the back next year, we are going to break the back. So I hope you are right, but I do not see it happening.

Secretary SHINSEKI. Mr. Filner, I share your frustration. I do not take it lightly. But in the past, I think we have said that for the

first time in this year, 2011, a 27 percent increase to the VBA budget gives them the resources to go get the tools. And we are on the verge of getting those tools. I will continue to look at this option of how to cut back on the processing time and perhaps see how the Linda Bilmes model fits.

Mr. FILNER. Yes.

Secretary SHINSEKI. We are in a big numbers game. When we arrived 2 years ago, we produced 977,000 decisions and everybody was celebrating. We got a million claims in. And as Mr. Walcoff just suggested, last year——

Mr. FILNER. Make up for it.

Secretary SHINSEKI [continuing]. We exceeded a million and got a million two in. So we are in a numbers game and——

Mr. FILNER. Okay. Will the Chairman allow me just 1 more minute.

Another issue that I don't have the exact numbers, if somebody has it please tell me. This Nation has been saying for the last year or two, it is time to say welcome home to our Vietnam vets who we never really welcomed home as a Nation.

There must be hundreds of thousands of them that have Agent Orange claims that get sicker fighting the VA bureaucracy than they did from the original illness probably. I believe we ought to think about saying thank you and welcome home finally by granting these Agent Orange claims, get those out of the system.

It is another way to break the back. I do not know how many you have. I would guess a couple hundred thousand, but I do not know for sure. But I would ask the Committee to think about finally saying welcome home to the Vietnam vets.

Do you have any numbers there?

Secretary SHINSEKI. I can provide numbers——

Mr. FILNER. Okay.

Secretary SHINSEKI [continuing]. From where we are in processing claims of Vietnam veteran Agent Orange claims. We have a count and we are pushing them out just not as fast as we would like.

[The VA subsequently provided the following information:]

> As of April 4, VA has received over 189,000 Agent Orange claims based on the newly established presumptive conditions. Of the approximately 93,000 previously denied claims from Veterans with Vietnam service (*Nehmer* claims), 26,955 claims have been completed thru April 4. Of the nearly 60,000 claims received from October 2009 announcement through publication of the final rule, 45,787 claims have been completed thru April 4. VA was required to hold all claims based on the new Agent Orange presumptive disabilities until publication of the final regulation and expiration of the 60-day Congressional review period on October 30, 2010.

Mr. FILNER. I thank the Chairman for his indulgence.

The CHAIRMAN. Thank you very much.

And very quickly, Mr. Grams, again, in the CR, is it your understanding that the HUD–VASH has been zeroed out?

Mr. GRAMS. I have not personally seen the legislation, sir. What I have been advised——

The CHAIRMAN. You are the CFO.

Mr. GRAMS. I am.

The CHAIRMAN. Okay. I will answer for you.

Mr. GRAMS. Okay.

The CHAIRMAN. It has not been zeroed out. And I would like to ask my colleague to provide me where it has been. The baseline is 30,000. Those that are in the system stay in the system. There are 11,900 left. Those can still be allocated. We have been told that that is more than enough. I say more than enough. More than what VA can actually handle between now and the end of the fiscal year.

So with that, Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

Secretary Shinseki, we had a really good visit in my office recently. You gave me the courtesy of giving me a personal call. And we were able to talk about a lot of issues.

So with that in mind, Mr. Chairman, and for the sake of time, I will yield back.

The CHAIRMAN. Mr. Reyes.

Mr. REYES. Thank you, Mr. Chairman. And may I say it is good to be back on the Committee.

Mr. Secretary, this goes back along the same lines what the Ranking Member was talking about. You and I have discussed this many times, including before I temporarily left the Committee. The issue pertains to DoD and VA's inability to establish a system, an electronic system that facilitates the transfer of records. Records pertaining to whatever claims an individual may have when they come out of active duty and become part of the VA system.

We had Secretary Gates in our Armed Services Committee yesterday and I mentioned it to him, encouraging him to work with you to finally establish a system that, as the Ranking Member and the Chairman have said, is seamless in terms of how we handle a servicemember's information.

We know when individuals are going to end their service. We know that in many cases, at least, well at least in El Paso and Fort Bliss, areas that, as you know, I represent, many soldiers will be going to the VA. It would be very helpful and it would likely save money, to be able to settle on a system, which would allow the VA and the DoD to talk to each other.

We still have, as Mr. Filner mentioned, we still have many Vietnam veterans, and I am particularly sensitive because I am a Vietnam veteran, that are still struggling with the claims under Agent Orange and others. It seems to me, for the sake of being able to provide better service, there ought to be a better way for the VA and the DoD to computerize and at least serve those veterans that are coming out of Iraq and Afghanistan and other parts of the world.

And I know, believe me, I appreciate your efforts. You are, I think, our best champion in terms of taking care of veterans. But can you speak to the point of creating a singular digital network?

Secretary SHINSEKI. Absolutely, Congressman. I am going to call on Mr. Baker for a technical update. But let me just say that, and I mentioned it before this Committee before, 2 years ago as I was waiting to be sworn in, both Secretary Gates and I, we shook hands and agreed that we were going to go to work on this seamless transition, of which the electronic health record was a key part.

Following that, in April of 2009, the President stood on the stage with both of us and said we are going to develop something call

LVER, the virtual lifetime electronic record, which has a medical piece and a personnel piece, in order to get to this seamless transition we all talk about.

What it is for me is when a youngster raises his right hand and takes oath of office upon entering the military, Air Force, Navy, whatever, with this system, a duplicate record will be created in VA so as that individual is deployed, gets sick, is promoted, goes to school, all of that is being replicated in VA.

And when the uniform comes off, if that individual chooses not to come and enroll with us right away, which is a choice, we will at least have captured the key data so that when they do come back, if they do, 20 years later and say there is something wrong here, we have a way to establish identity and tie it to an event that might have occurred during their service. This is the intent.

I just met with Secretary Gates again the first week in February. We renewed our pledge to go after the single electronic health record.

I think in Chicago where VA and the DoD have combined our efforts to produce an integrated hospital with the Navy and VA, we have an opportunity to do a proof of principle to put in place an electronic health record that both sides would use and then find out whether it serves, and what needs to be done to improve it.

I am out of time here. Mr. Chairman, may I have just a minute to provide an update on the electronic health record?

The CHAIRMAN. Yes, sir.

Mr. BAKER. Thank you, Mr. Secretary. I will make this quick.

We have, over the last year, made great progress on the President's virtual lifetime electronic record initiative and I will just highlight two things for you in that program.

The first is DoD and VA are jointly moving forward as the implementers of the nationwide health information network, which will then tie the private sector and other Federal agencies like the Social Security Administration into the provision of information that will let us provide better service at the benefits end as an example there.

We have also moved forward with a single, common Web portal for servicemembers. As the Secretary referenced, when they raise their right hand and are sworn in, now in their left hand, they are handed the log-in to that Web portal. That stays with them through their lifetime. Whether they are a servicemember or a veteran, all of the information about their service is put on to that portal. And so everything new we bring in is brought together there so they can constantly have access to it as can we so as to provide that information.

Those are the sort of things that we are doing inside the lifetime electronic program to achieve the President's vision of that lifetime electronic record.

As the Secretary said, the most substantial thing we can do to make that happen is a single common electronic health record system with DoD. We are close at this point. The Secretary and Secretary Gates have driven the two Departments to come to that agreement. We have had a lot of work over the last 4 or 5 months to come to agreement on what that is.

I believe that will happen with strong guidance from the secretaries in the next month or two and that will be a very substantial push forward on the LVER front.

Mr. REYES. Can I just ask one follow-up? When you say close, what does that mean and, secondly, of the whole realm, what percentage is computerized as you describe it right in your records?

Mr. BAKER. As to the percentage computerized, I believe that anyone who is seen now has a large percentage of what they do computerized.

The issue you spoke to—going back to Vietnam-era vets—is primarily paper and the records that come out there are then dealt with from a paper standpoint. That is why the Veterans Benefits Management System is so important to this. It is bringing them in, even if we get them as paper, bringing them in, turning them into electronic and turning them into data that we can really use when we access those.

As to the definition of close, we have recently had a series of meetings at the highest levels to make that decision and determine what the path forward will be.

I believe that the two departments have never had a greater opportunity to nail this down and nail it shut. And I believe that it should happen in the next month or two to come to final agreement that this is where we are going, we will have a single record, and it will be along this path.

Mr. REYES. Thank you.

The CHAIRMAN. Dr. Roe.

Mr. ROE. To continue with what Congressman Reyes was talking about you know you are a freshman Congressman when you go to Great Lakes, Illinois, in January for your Codel. We went there at Great Lakes where the Navy trains their folks. And it was a VA and the military had a hospital there. This was over a year ago.

The Secretary and I talked about this. Thank you for coming by the other day, and we had a great conversation. The problem with it was, as you were pointing out, I am a physician and here we have a troop over here and we have two sets of medical records. The DoD and VA systems cannot talk to each other. A lot of smart people have tried. We spent $10 billion and they still cannot talk to each other.

I was on the Oversight and Investigations Subcommittee at that time. I want to go back and revisit that because that was over a year ago and they were supposed to make the systems able to talk to each other.

To Congressman Filner's point, we have heard this before. I really thank the Secretary, and I agree, somebody has to blink and there is going to have to be one record because right now with two, we will be sitting here 20 years from now doing the same thing. So great point that you made. And we will talk about this after.

And I know Mr. Baker is as good as there is in technology. I do know that. He is spot on. But somebody, either the Secretary of the VA or Secretary Gates, is going to have to make a decision and pick one record, a winner or a loser, and then go with it. And people are going to have to deal with it. Otherwise, we will be sitting here 10 years from now and spend another $10 billion. I think the point that the Chairman made is a very good one.

In the county I live in, we have just cut 5 percent of our county budget. In the State I live in, Tennessee, we have a $1 billion budget hole that Congress running this Committee has cut 5 percent.

And I was looking at the amounts of money we have spent on VA, which is a good thing, the Post-9/11 G.I. benefit, but we have gone in fiscal year 2008 from $90 billion to $126 billion this is a substantial increase in spending in the VA. And I think the thing that I am most concerned with is if we are getting a bang for our buck. And I will give just an example.

I saw there was another $6 million in funding included in the budget for the the Vision Center of Excellence. We heard all the testimony in the last year or two about the Vision Center of Excellence, and I still do not know whether it works or not. I do not have a clue.

So I would like to see that brought up. And when we spend this money, are we getting value for the money. I think that was the thing. And I think everybody wants that. Do we have metrics out there we can measure and are we getting value for our money?

Secretary SHINSEKI. Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary and Dr. Roe.

The Vision Center for Excellence, as I hope everybody knows, is a VA/DoD enhanced care initiative. We have spent in the VA about $1.5 million and are in the process of executing an obligation for the remaining $5.4 million of the initial commitment that was made in support of this through fiscal year 2014.

That total commitment was $6.9 million. The staffing that we are supporting there are deputy directors, some vision rehabilitation analysts, and an administrative assistant that provides support.

They have developed their eye injury registry. They continue to expand their capabilities to store data, keep track of the transit of the veteran, of combat soldiers that are injured, veterans and their transition from that status into our organization.

And I do believe that we are getting value for the limited amount of money we are spending there, Dr. Roe.

Mr. ROE. And we will have time for that later.

Another thing that I have noticed in my home area where our VA hospital is, we have the CBOCs, which I think are a tremendous asset. I cannot say enough good things about the CBOCs. I think they need to be expanded. Certainly in this budget, I do not know whether you can, but I think they should be.

But in most of our CBOCs that we have, there are waiting lists for veterans to get in. One in Morristown, Tennessee, has over 500 veterans who cannot get in that CBOC. They still have to go to the main VA not near their home. And Knoxville, Tennessee, has huge waiting lists as well.

The other question, and, again, my time is running short, and I am in a rural district like Mr. Michaud is, we both serve rural areas, we have $250 million last year that was supposed to be spent on rural access to care, I guess, I do not know how it was spent. And that is what I would like to know. I did not see the value in my local district about how that $250 million in rural health was spent.

And I do not know whether you did, Mike or not.

Dr. PETZEL. That is an excellent question. As Congress has generously over the last several years given us $250 million a year to spend on rural initiatives and a good portion of that money went to support new CBOCs, Congressman, a good portion of that money went for telehome health, that is where we put tools into the home, connect them directly to the medical professionals.

Mr. ROE. Can a Veterans Integrated Services Network (VISN) director request money from this $250 million for a CBOC because those are great investments?

Dr. PETZEL. Oh, absolutely. The way this was done in the first 2 years is that we sent out a request for proposals to every one of the networks. They came back to us with proposals on how they would like to spend that rural money. We funded it. We kept track of how the money was spent. And, again, telehealth, telemedicine, transportation networks, new CBOCs, all of those things were included in the grants.

Mr. ROE. My time is expired, but I would like to talk further about that, and I yield back.

Secretary SHINSEKI. Congressman Roe, I will close the loop with you. I mean, we owe you a sharper point on the pencil here on specifically CBOCs if you are talking about if we have that many veterans waiting to get in. We will find out what was requested and how it was addressed.

The CHAIRMAN. Mr. Michaud.

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

And, Mr. Secretary, I have several questions and actually part of it was what Mr. Roe has talked about. And the problem when you look at the rural health initiative, if they are able to get money for a CBOC, the problem comes in the maintenance of those CBOCs. I do not think you can get those operating funds out of the rural health and that is where the problem comes in.

A couple of questions and I will ask them in the order that hopefully you can answer them in because of the time limit.

Last year, as you know, I raised serious concerns about the VA implementing the regulations with the new payment schedule for State veterans' nursing homes. These payment rates actually have put some State veterans' nursing homes in a financial liability situation where they have actually stopped taking veterans, especially for those veterans' homes that are States that have high Medicare, Medicaid patients.

This year, the VA is implementing new regulations that may have similar impact on veterans in need of dialysis care, especially those living in rural areas. I understand that the patient access issues were raised at the stakeholders during the regulation process. I would like to better understand VA's plans to address the access issue as it relates to the dialysis.

The second question, you mentioned in your testimony that, and Congress is concerned, about the resources we are giving. We are trying to make sure we, you know, make the best of whatever dollars that we do give. You point out in your written testimony a method by which you can save millions of dollars eliminating redundant evaluations. I was just kind of curious if you could elaborate a little about that.

Another question would come up over and over again when you look at the Veterans Equitable Resource Allocation (VERA) model as far as the VISN distributing money within a VISN, a big issue that has come up over and over again, for instance, the increased funding we have given veterans for mileage reimbursement.

For instance, Togus gets $1.5 million, $1.6 million from the VISN to reimburse veterans in Maine. However, it costs between $5 and $6 million. So, automatically, a health care facility in a rural area is operating in the red because of the model that is given them as they distribute the money.

And my last question, you mentioned earlier the strategic capital investment planning process. Does that process take into consideration where you might have some facilities that are on the historic list and they might not be able to actually renovate the facilities as need be? So those are my four initial questions.

Secretary SHINSEKI. Mr. Michaud, let me ask Dr. Petzel to address the State veterans' homes arrangements and then the rural aspects of this.

Mr. MICHAUD. Yeah. But, actually, it was on the dialysis issue.

Secretary SHINSEKI. And dialysis as well.

Mr. MICHAUD. Yes.

Dr. PETZEL. Thank you, Mr. Secretary.

Congressman Michaud, what the Congressman is referring to is that we are going to a reimbursement system for fee-basis dialysis that uses a Medicare rate and there was some thought that there were some providers who would not be willing to accept the Medicare rate and would not be willing to participate.

We did a survey. We looked. We did not find anyone at the level of providing services in a town was threatening to do that. We left open the possibility that if there are existing contracts, those can stay in place and we will use those rates. And if we need to contract above the Medicare rate in an ongoing fashion in order to get the services, we will do that.

We absolutely share your concern and we do not want any veteran in rural America or any place that needs dialysis not to have access to that.

Secretary SHINSEKI. State veterans' homes.

Mr. MICHAUD. The second one was on the savings, limiting redundant evaluations. Can you elaborate.

Secretary SHINSEKI. Evaluations, redundant evaluations.

Dr. PETZEL. Are you talking about Integrated Disability Evaluation System (IDES) or are you talking about the Disability Evaluation System that we are doing in DoD?

Mr. MICHAUD. No. I thought you were looking at doing some work with Centers for Medicare and Medicaid Services (CMS). Well, CMS, actually, they evaluate nursing homes. And it is my understanding that VA also evaluates nursing homes. You have a check-off list and I think there is only eight questions difference between what CMS does and the VA does. And I was wondering what is happening in that effort.

Dr. PETZEL. We are trying to accommodate ourselves, Congressman, to the CMS process. We do not want to have redundant evaluations that basically are finding the same things using almost, as

you point out, virtually the same tool. And that is being worked through.

But then my hope is that in the not too distant future, we will have that settled and we will be using the same tool or we will be relying on CMS evaluations and not having to do our own. That is an excellent idea.

Mr. MICHAUD. Okay. Thank you.

And the VERA model, have you looked at that as far as the inequities in rural areas?

Secretary SHINSEKI. VERA, like any model, responds to quality input. And I must say when you get into the rural area, they are unique and we have to be sensitive to this. But the VERA model responds to use. A number of people come in and establish a pattern of requirement. Then the VERA model will respond to that.

And the challenge to the rural areas is dispersion. It is hard to get to see that population. And we need to be sensitive to this, Mr. Michaud, and figure out a way to see whether or not we have tweaked the model sufficiently.

Mr. MICHAUD. Well, I mean, it gets back to Mr. Roe's concern and my concern is, the VERA model is there, but if we are required by law that we reimburse veterans with 41 cents a mile and you have a rural area that are getting reimbursed a mile, but they only get from the VISN office a third of what it actually costs to provide the service, it puts an inequity upon that health care facility.

As I mentioned earlier, Maine, we spend between $5 and $6 million at Togus. They only get $1.5 million. They are at a disadvantage. Rural areas are getting hurt. The model is right, but they are not getting the money for it and, therefore, they have to actually cut back on services in rural areas, which actually could hurt when you look at CBOCs and funding those programs in rural areas because they are not getting the adequate funding that they are supposed to get.

Dr. PETZEL. Congressman Michaud, just to respond to that question. We have established a different mechanism for distributing money from the networks to the facilities. VERA takes the money from Central Office and distributes it to the network. We have a different model with much more flexibility in it that distributes money from the network to the individual medical centers.

I will talk with Dr. Mayo Smith on the opportunity for them to do what they need to do to accommodate that discrepancy. I certainly do not want a medical center in Maine or any other rural area to be disadvantaged because the veterans have larger travel distances and there is a larger travel bill for those people. So we will look into that, sir.

The CHAIRMAN. Ms. Buerkle.

Ms. BUERKLE. First of all, I want to start by saying that several weeks ago when I was in the district, I had the pleasure of touring our VA hospital. Syracuse, New York has a very large VA facility there. And Mr. Cody took me on a tour. I had the pleasure of meeting the senior staff there. And I just want to tell you the senior staff and Mr. Cody, it is apparent to me that this is just not a job. It is a mission to them. The facility was topnotch. We had an excellent tour.

And, most importantly, when I had the opportunity to talk to patients, they were pleased with their care, the services they were receiving. And I think you should know that it was a very positive meeting and we look forward to working together.

Also, several weeks ago when we met in my office, one of my concerns that we discussed was the payment methodology issue, the inconsistencies and the various reimbursement formulas that were a little confusing because there was no consistency.

I see here in your testimony that you are going to apply the Medicare payment methodology, which will be a more—it will be more consistent and it will be less confusing for everyone. You talk about saving $275 million in 2011 and then $315 million in 2012. But this system has not been put in place yet is my understanding. You are just rolling out.

And so I would like to ask you to explain to us how you, you just made this decision in February, how you would expect that we would have that much of a savings in 2011 when it has not been implemented yet.

Secretary SHINSEKI. Fair enough. It is a fair question. We just put it in place this month and the system is running. And the estimates are that we are going to achieve those outcomes. They are estimates. We will have to see how we progress here to see whether we achieve those savings. We are pretty comfortable. It is a conservative model.

Ms. BUERKLE. Do you have a time table for when all the hardware and all the software will be and you will be able to do the automatic payments and get away from the manual?

Mr. BAKER. I do not off the top of my head have that one. We just had a review and I am trying to recall that, but we will have to get back with the specifics on the date for that. It is in the near term, but I do not have the specific dates in my head.

Ms. BUERKLE. Thank you.

The other question I had was with regards to the Caregiver Assistance Program. I have heard from veterans, and you rolled out a plan last week. Can you just talk to us a little bit about your expectation for the program and how many veterans you would anticipate and families being eligible for that program and then beyond that, if you think that that number is consistent with the number Congress intended?

Secretary SHINSEKI. First, Congresswoman, I regret the delay that occurred in transmitting the implementation plan to the Congress. There was an expectation it would be here November. Did not get here until February. All kinds of reasons why all those things happened that way. They are my responsibilities. And so I apologize for that.

Let me just assure you that even as the legislation was being crafted, we began in a parallel way in VA writing what we thought were going to be potential regulations that we might need. At the time, our proposal was to use, in trying to get the payments going as quickly as possible, an existing mechanism that is there today called Aid and Attendance. And we have been using Aid and Attendance for eight decades now and providing that kind of support to veterans.

Our position did not prevail and so we were required to create a new payment methodology. This time, for the first time in my understanding, we provide this support directly to the caregiver. We have never done that before. And so we are in the process of creating regulations that do not exist.

And, unfortunately, the regulation process is a long and involved one and requires legal review. Congress has an opportunity to review it as well. We put our thoughts out for public comment and stakeholders have an opportunity to make comment. And then we have to address each one of them. So it is an involved process which we were hoping to avoid.

That said, we are going as fast as we can. What we were asked to do was to look at the Iraq and Afghanistan population and address the caregiver requirements there. As we did that, we came to understand because we held sensing sessions with veterans' caregivers and others, including DoD, that there was some interest in caregivers of previous generations, World War II and Vietnam, whose families have been dealing with the same problems for decades.

And we are trying to write a regulation that meets the immediate requirement and that is to get payments going to the Iraq and Afghanistan veterans and caregivers and, yet, keep the opportunity open that if Congress says there is a better way to do this that we can also address the requirement over time.

A good policy we arrive at here would also have the capability of addressing veterans and caregivers of the next or yet to be determined conflict in the future. So it is an issue of fairness. We are trying to get it right. And then we will await the comments from folks that suggest that we ought to, you know, look more closely at this.

I think we have established a population for the immediate requirements of the Iraq and Afghanistan population. I think that number is about 840, I think, is my understanding. But that is a start point. That number is subject to review. And we are, as I say, going as fast we can. We would like to turn this quickly.

Ms. BUERKLE. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Carnahan.

Mr. CARNAHAN. Thank you, Mr. Chairman.

I first want to say it is a pleasure to join this Committee and take a special assignment here for this Congress. And I want to thank you and Ranking Member Filner for coming to St. Louis last year when we were looking at issues at the Cochran VA Medical Center. So it is great to be here with you.

I took this assignment because in my district, we have a number of great facilities, the VA facility there at Jefferson Barracks, really the national treasure there, the national cemetery which we take great pride in.

And, Mr. Muro, we look forward to working with you.

But the number one reason that I am on this Committee right now is to work with turning around Cochran.

And I appreciate our discussions we have been able to have, Mr. Secretary. And as we wait for some of the national investigations that are going on with the administrative investigative board, the

Inspector General, the U.S. Government Accountability Office (GAO) to really pull together those results to really engage with our veterans there locally, to engage with the employees.

I had a great conversation with the Director there, Rima Nelson, this past week about how to put that together in a turnaround plan. We want to work with you to help do that.

So we look forward to doing that. And I really want to be sure that we can address some of these negative issues that have come up in substance, but also in perception of the community and veterans.

So I wanted to ask, you know, how we can work together, how these resources are going to help focus on those needs there, and how you all are going to focus some of the leadership of the Department to do that.

Secretary SHINSEKI. Let me call on Dr. Petzel and then I will wrap up.

Dr. PETZEL. Thank you, Mr. Secretary.

Thank you, Congressman Carnahan. We are also concerned about St. Louis.

I want to first say that we are very supportive of the present Director, Rima Nelson. She has done an excellent job since she acquired that job, first of all as an acting, and then was given it permanently just around the time that the initial problem occurred with the dental processing.

She has put together with our help and cooperation a four-part plan that is going to, we believe, turn St. Louis into one of our quality and safety and satisfaction leaders. It involves what we would call tiger teams composed of people from the medical center, from the network surrounding, and with national support to look at patient satisfaction, to look at employee satisfaction, to look at quality and safety issues within the medical center, and then finally to develop a process of continuous improvement where they are continuously evolving and improving.

Since Ms. Nelson arrived there, the employee perceptions of the medical center have changed dramatically. There is no question that 2 or 3 years ago employees did not feel their voices were heard. They did not feel as if when they had a problem to bring forward, it was being listened to and acted on. And now that has changed dramatically.

Ms. Nelson has set up a process, several processes, in fact, where employees can both meet with her regularly and can go through a number of different pathways to make their concerns known and feedback provided for them to see what has actually happened as a result of what they said.

The union is very supportive of her. The veterans service organizations in the community are supportive of what is happening there right now. And I am very optimistic that over a period of time, it does not happen over night, but over a period of time, this is going to be one of our leading hospitals, sir.

Secretary SHINSEKI. Congressman, you have my assurance that we are going to get Cochran where it needs to be and both Dr. Petzel and I are committed to doing that with you and anyone else who has veterans that come to Cochran for care.

The first incident that occurred about a year ago was a failure in leadership in my opinion, not the leadership at the director level, but inside the dental department. That individual has been replaced.

This latest event where a nurse in the surgical ward saw spots on an instrument and did what we would expect anyone to in that position, called it to the attention of her superiors and they suspended surgery until they could figure out what caused them.

What is clear is that it is not a result of unsanitary conditions. It is not blood. It is not pathogens. It is not tissue. Discoloration on the instrument, we are still investigating exactly what caused them. We think there may be a chemical basis for this. As soon as we have that answer, we will begin surgeries again.

Mr. CARNAHAN. Great. Thank you.

And I see I am out of time, but if I could indulge just one 15-second comment. The other issue just is critical. And we recently lost one of our veterans who served on my veterans advisory panel back home from suicide. And the dramatic rise we have seen in suicides nationally among our veterans, I hope that we can all again redouble our commitment and our focus to those issues because it has really been a national problem. And I hope that these additional funds for mental care and so forth within the VA can really help turn that around.

Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

And thank you, Secretary, for being here today and being by my office earlier in the week. And we discussed there that Pratt, Kansas, was selected as one of the sites for the pilot program you are calling Project Arch. And I know Pratt is scheduled to be up and providing services hopefully by mid 2011.

Is VA on track to meet that targeted date?

Dr. PETZEL. Congressman, thank you very much for the question.

As you pointed out, Project ARCH was passed by Congress and there are five sites that we are beginning a pilot in each one of them. And Pratt, Kansas is indeed one of them. These are on track. We are calling this phase one. These are all on track to be hopefully up and running by the end of fiscal year 2011.

We will evaluate those initial efforts and then begin based on the evaluation to open up other sites in those five networks that are part of the pilot. The networks, just for your information, Network 1, northern Maine; Network 6, Virginia; Network 15, Kansas; Flagstaff, Arizona, Network 18; and Billings, Montana, Network 19.

Mr. HUELSKAMP. Thank you.

How quickly do you think you will be able to provide an assessment of how that is working?

Dr. PETZEL. The plan is that 6 months into the operating pilot, we would assess the impact, assess the cost, and make decisions about whether or not we are going to proceed with other sites and, if so, where.

Secretary SHINSEKI. By this fall, we expect to have the analysis done.

Mr. HUELSKAMP. Okay.

Secretary SHINSEKI. We have set aside sufficient funds to do this.

Mr. HUELSKAMP. In addition to that, I appreciate that answer and look forward to hopefully the success of that pilot program.

In addition, just in general, how does this budget assist veterans in rural areas that have limited access to facilities? How does this initiative protect those veterans in that situation?

Dr. PETZEL. That is an excellent question. I come originally from Minneapolis where I ran a network that was incredibly rural, and I have great empathy for the inability that we have sometimes to reach people in these remote communities.

First of all, there is a 69 percent increase in the amount of telemedicine and telehealth money that we are spending. We believe that telehome health particularly is the wave of the future in terms of reaching the particular remote areas. The ability to monitor patients at their home, have a television, computer connection with them, the instruments to measure their blood pressure, their EKG, their heart rate, is going to be a major modality for reaching rural America.

Secondly, there is again $250 million worth of rural health money that is going to be used for pilot projects, perhaps a clinic in Tennessee.

And then the third component of this is contracting and fee basis. In many communities, we just are not able to provide VA owned and operated facilities. And we use fee-basis care quite substantially, $4 billion of it actually each year, to try and reach remote rural areas.

While we are trying to get and will get a handle on our fee-basis cost and expenditures, I am expecting that there will be an increase in our use of this modality in the rural parts of this country.

Mr. HUELSKAMP. And how is the provider response to the fee basis that you mentioned? A lot of folks involved in that or——

Dr. PETZEL. I think it is excellent. When we use fee basis in the community, we are working with the other community providers. We are not a competitor. We are not seen as a competitor by them. We are seen as a partner. So it is often very successful.

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

Secretary SHINSEKI. Congressman, I would just add on fee basis, non-VA care where we pay a fee for care downtown, in 2011, based on what comes out of the CR, we had estimated $4 billion going into caring for veterans who get their care in other than VA facilities, about a million people.

And then in the rural discussion we just had prior to that, there are about three million veterans who live in these rural and highly rural areas and the challenge for us is how do we ensure that one of those rural veterans has the same opportunity as someone living in, you know, suburbs of Washington, DC, to have their health care needs met. And it is something we pay attention to.

Mr. HUELSKAMP. Thank you, Mr. Secretary. I appreciate that recognition.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you to you and your team for being here with us today.

I am very grateful to the brave men and women who have served our country and I believe that our veterans, as I had mentioned to you, are the segment of our society that most deserves our sincere gratitude and assistance. So I applaud what you and your team are trying to do.

The Department of Veterans Affairs has the most important and singular responsibility of caring for our Nation's veterans and that is a promise that we made to them for their sacrifice to our country and for the cause of freedom.

In turn, it is the role of the Congress to ensure that the VA is both effectively carrying out that responsibility and that it has the funding necessary to fulfill that promise.

It is also our responsibility to ensure that veterans returning home are made aware of the benefits that they are entitled to and that they receive the necessary assistance to ease their transition back into civilian life and the workforce.

We have, in that regard, a very difficult task ahead us to create a budget that holds spending in line in order to bring down the national debt while simultaneously providing veterans with the quality health care benefits and services they deserve.

In order to efficiently provide these services, we must also ensure that programs provided by the VA are not only cost effective but are managed with discipline and accountability. And I know your team is trying to do that.

I welcome this opportunity to discuss the budget the President has proposed and to work with your team and my colleagues to ensure that the needs of our veterans will be met in this upcoming fiscal year. So thank you again for being here.

The virtual lifetime electronic record, is there a timeline for achieving that? Is this an active program? I mean, what is the status of that?

Mr. BAKER. The VLER Program we break into four different what we call capability areas. Each one of those will have an initial operating capability by 2012.

So, for example, in the first area, which is health information for health purposes, we will have rolled out the nationwide health information network across the country at all VA facilities from an IT perspective by 2012. And the facilities will be implementing their connectivity to their local health information exchanges in that time frame. So each of them has an initial operating capability in the 2012 time frame.

As you can imagine, it is, inside of VA and DoD, what we call a pervasive program. It touches everything. So as an example, what we did very early on was agree with DoD that there would be a single identifier for every servicemember and it would be the DoD's Electronic Data Interchange Personal Identifier (EDIPI), getting into the vernacular, but the number that they issue that identifies every servicemember.

We have then also said that all of our databases will contain that identifier. It will take a long time to convert all of those databases to that, but the effect is that all of our applications, when they go to look for information for a veteran, can rely on that identifier being there to find the information on the veteran.

So a lot of capabilities that we have, if you will, kicked off and started to work on will take quite a number of years to really roll that through all of the various systems at agencies like the VA and the DoD.

Mr. JOHNSON. But is there a formal project manager that is overseeing this and is there a timeline and a project plan and a strategic plan to get from point A to point Z?

Mr. BAKER. Yes. There is a very detailed project plan on this one. It is actually in our vernacular called an operating plan. It is one of the major initiatives overseen by the deputy Secretary. So there is a detailed plan, detailed timelines. I am happy to provide that to you. It may be more than you want to read, but happy to provide it from that standpoint.

[The VA subsequently provided the following the operating plan entitled, "FY11–13 Virtual Electronic Record (VLER) Initiative Operations Plan," by the Office of Information and Technology, U.S. Department of Veterans Affairs, which will be retained in the Committee files.]

Mr. JOHNSON. Shifting gears just a bit, does the VA charge veterans for a service-connected visit such as an annual exam? I am not sure who should answer that.

Dr. PETZEL. Thank you, Congressman.

No. If a veteran is seen for a service-connected problem, they are not charged.

Mr. JOHNSON. They are not. Okay. Okay. All right. I think I have used up most of my time.

Thank you, Mr. Chairman.

The CHAIRMAN. You have 17 seconds left.

Mr. JOHNSON. I am good. Thank you.

The CHAIRMAN. Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman.

And first of all, I would like to thank Secretary Shinseki for, first of all, his service and also service to our vets as well as everybody that is here today.

I appreciate your visit as well a couple of weeks ago. I thoroughly enjoyed it and appreciate the information that you were able to get to us as well as getting to know you and looking forward to working with you in the future.

We have almost 51,000 plus veterans in my district back in Indiana and it is a privilege to serve them. And I know that in these tough economic times, it is those folks who are willing to serve us that I believe should be standing in the front of the line for taxpayer dollars because they were willing to put their life on the line as well as those who are serving us currently.

So I am looking forward to working with you in the future. Our visit a couple of weeks ago answered a lot of questions for me, but I did want to just kind of follow-up with a proposal out of the budget.

In the Fort Wayne facility there in Indiana, the northern Indiana facility, it looks like there are a couple of different options. And I do not know if you can share or give us any more details on what might possibly be coming out of it. I know that there are several alternative possibilities there.

Dr. PETZEL. Thank you, Mr. Secretary.

Congressman Stutzman, right now in the fiscal year 2012 budget, there is a proposal for leasing 27,000 net square feet in Fort Wayne for expansion of primary care, mental health, post-traumatic stress disorder (PTSD), substance abuse, and some ancillary services to take pressure off of the major facilities there.

Mr. STUTZMAN. Okay. I mean, as we know, that facility, it is an aging facility and one that we have tried to upgrade and even rebuild a new facility.

Looking down the road, is the facility going to be on the same campus? Is it going to be close in proximity to the campus and then how also does that relate to the mental health to the facility in Merriam as well which is just to the south of Fort Wayne? Is that going to be taking any services away from that facility and bringing it to Fort Wayne? Are these new services that are going to be provided in Fort Wayne?

Dr. PETZEL. Congressman, these are services that were formerly in the main building and are going to be done in a different setting. So these would be things that were already being done in that area, but we are going to do them in a new modern building in a different way to, again, relieve some of the pressure that is on the Fort Wayne facility.

I would have to get back to you about Marion, Indiana, and its relationship to this. I do not have that information at the tip of my tongue, but we can certainly get back to you about that.

[The VA subsequently provided the following information:]

> FY 2012 Budget included a proposal for leasing space for an expansion of primary care, mental health, PTSD, substance abuse and some ancillary services in the Fort Wayne area. At this time, it is unknown where the additional clinic space will be located. Congressman Stutzman was informed in a conference call on January 12, 2011, that a competitive solicitation will determine the location of the clinic.
>
> Fort Wayne, Indiana, is approximately 1 hour from Marion, Indiana. Moving the mental health clinic, PTSD clinic, substance abuse clinic, clinic based home care, telephone triage and fee services to an off-site location from the current Fort Wayne facility will not impact the Marion campus. No new services will be provided, however, access to Veterans for these services, as well as primary care will be improved as capacity for those services is increased.

Mr. STUTZMAN. Okay. All right. I appreciate that a lot. And we look forward to working with you some more on this and some of the ideas that have been proposed. And hopefully, you know, our office can be helpful and appreciate the information.

Dr. PETZEL. Absolutely.

Mr. STUTZMAN. Okay. Thank you, Mr. Chairman. I will just yield back.

The CHAIRMAN. Thank you very much.

Vice Chairman of the Committee, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Thank you, General. Thank you for your service to our veterans, and thank you for your entire service to our Nation.

We had an opportunity to talk about some of the local interests in my district yesterday, so I want to focus on this. I want to ask this question. It really does not pertain to the budget.

But are there any particular areas or employees maybe in vet clinics, CBOCs, hospitals if the veteran decided to enter to the fa-

cility to find out general information with regard to services and benefits? I know there is a lot of information—you can get on the Web site and also on the phone and ask particular questions. But maybe is there space available for certified veterans service officers to see veterans in any type of need——

Secretary SHINSEKI. Congressman——

Mr. BILIRAKIS [continuing]. And is it permitted?

Secretary SHINSEKI [continuing]. That is our intent. That has not been our history, but that is our intent. We are moving that way where our medical facilities also have a representative from our benefits administration who can deal with those questions.

Mr. BILIRAKIS. Is it a budget issue or——

Secretary SHINSEKI. It is not. It is culture. We grew up as two separate administrations and now we are forcing a marriage here. And so I would say in the future that you will probably look at collocation of our VBA and VHA facilities so that veterans have an opportunity to go to one location and take care of business——

Mr. BILIRAKIS. Very good.

Secretary SHINSEKI [continuing]. With ample parking, which is always an issue, ample parking. But these are plans that we are right now beginning to consider how we bring this about within the budgets we have.

Mr. BILIRAKIS. I appreciate that very much because sometimes a lot of times, they do not know where to turn to and——

Secretary SHINSEKI. Just let me call——

Mr. BILIRAKIS. Yes.

Secretary SHINSEKI [continuing]. Mr. Walcoff to add to that.

Mr. WALCOFF. Yes, sir. Just using Florida as an example, Veterans Benefits Administration is located in about 15 different places throughout the State. And in most of those places, we are located at a VHA facility. So when a veteran comes in for treatment, there is a VBA person right there to work with them.

Mr. BILIRAKIS. Very good. Common sense. Very good. Thank you.

Every day I hear from my constituents about difficulties and delays that are encountered in VA claims. You hear this all the time.

In your testimony, Mr. Secretary, you mentioned the accelerated claims process being used for the influx of new claims associated with the exposure to Agent Orange.

Is there a way to expand such an accelerated process to reduce the current system-wide backlog and then, if so, what is the timeline that we can anticipate realizing such an accelerated system and how do you plan to end the current backlog through the system that the system faces and what is your ideal turnaround time for claims processing and when do you think this goal may be realized?

Mr. WALCOFF. Yes, sir. We have several initiatives that are aimed at expediting the claims process. An example would be our benefits delivery at discharge initiative where we are located at bases when veterans are getting out. We take their application 60 days before they get out and have their claim adjudicated shortly thereafter from when they are discharged. We have several programs that are modeled like that.

In terms of what is our idea of how long it should take, our answer to that is we believe that no claim should take more than 125 days. And the primary way that we are going to get to that is through the technology that we are currently developing. The Veterans Benefits Management System, VBMS, is the key to us being able to eliminate the backlog. And we define that backlog as any case that is over 125 days.

Mr. BAKER. If I could just touch on your point about the Agent Orange fast-track system, we have had a good experience with that. The main focus there is on establishing what are called Disability Benefit Questionnaires (DBQs) or forms that ensure that the veteran has an opportunity to provide us all the information necessary to process the claim and it can then be processed automatically to the point of automatically generating a recommended adjudication for the adjudicator to then review.

My understanding is that to fully do the benefits, it would be about 79 of those DBQs, all of which need to go through the standard forms to be able to be put public. We are working those. It is an approach that we like and we believe is going to, in conjunction with VBMS, both turn all the paper we receive into electronic images, but even more importantly make certain that the originating information is electronic, making it even easier to deal with and more automatic.

I believe we said that we are going to put VBMS live in the 2012 time frame. We see adding more and more of those DBQs to the fast-track system as we go along. It is live today, as you know, working for Agent Orange.

Mr. BILIRAKIS. Thank you very much.

Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Benishek, do you have questions?

Mr. BENISHEK. Yes. I am sorry I missed quite a bit of the question and answering, but I do have some questions.

You may know I have spent quite a bit of time at a VA hospital and I have some concerns about the answers to the questions here. There were five answers reducing indirect costs, reducing the costs, you know, the answers to the, you know, how are you going to identify waste in that.

And it was two of the costs that are actually decreasing payments to the people that actually do the care or changing the mix of health care professionals to the veterans. In other words, to me, that means there are going to be less doctors and more, you know, adjunct personnel. So I just wondered how that relates to quality.

Similarly with the dialysis, implementing Medicare standard payment rates, which is obviously a decrease in the payment rate and how difficult it is to, you know, for dialysis to—that amount is not very much money to pay for dialysis. And that is sort of the standard of care. But dialysis payments are so low that it is just a bare minimum of what can be done to treat dialysis patients.

So I am just a little upset about the fact that, you know, the people that are actually providing the care are two of the ways of saving the money. And there is nothing in there about, you know, the ratio of people in the VA that do not actually care for patients, that

are a part of the administrative, bureaucratic side of the VA. It does not say anything about cutting those people.

You understand what I am saying?

Dr. PETZEL. Yes, Congressman, and let me respond to that, please.

First of all, we appreciate the fact that you did work at the Iron Mountain VA Medical Center. That is a good experience and hopefully it is going to be helpful for our interactions with the Committee.

First, the dialysis regulation, the rest of this country pays for dialysis using the Medicare rates almost exclusively. We are a relatively small portion, I believe it is less than 5 percent, of the total dialysis business that occurs in this country. And the rates that were previously being charged were sometimes two to two and a half times the Medicare rate.

We did not believe that was appropriate. And we think that the providers are able to survive, make a profit on the Medicare reimbursement rate. It means that veterans or the people that care for veterans are not paying anything more than the rest of the community is paying to provide those rates.

So I feel quite comfortable that this is a fair reimbursement and a fair way to do it. If we are not able, as I said earlier in response to another question, to provide the care using Medicare rates, we have the freedom and the flexibility to contract for higher rates.

So if there is a rural community where the provider refuses to take Medicare, then we are in a position to contract for a higher price.

In terms of the staff realignments, what we are doing with staff realignments is looking to see that the work is being done by the most appropriate person so that if a nurse's aide can do the work as opposed to a licensed practical nurse (LPN) and is trained to do that, they should be doing it. If an LPN can do some of the work that an RN was doing and is trained to do it, they should be doing that. Same thing applies to physicians. We certainly do not want physicians taking blood pressures, doing the other things that other people can do just as competently.

Mr. BENISHEK. I do not think physicians take blood pressures anymore. I am just saying——

Dr. PETZEL. I am just using this as an example, sir.

Mr. BENISHEK. I know, but that is a bad example. Would you rather see a doctor or a nurse when you go to see your health care provider? There is a certain something to that, don't you think?

Dr. PETZEL. Oh, absolutely. And we are not saying that there are not going to be physicians seeing the patients. We are saying that we are going to be using people that can do the tasks physicians are doing by using other people to do it in a more appropriate fashion.

Mr. BENISHEK. Oh, I understand that. But the point of my question was, you know, there were two things about patient care in the cost reduction and there was not anything about bureaucratic cuts. I mean, you know, reducing the cost by adopting uniform standards for administrative and support services, reducing the cost by——

Dr. PETZEL. The item there is all administrative costs. That is the indirect cost of care and we are reducing substantially the indirect costs of care.

Mr. BENISHEK. I just did not see anything about reducing the costs if an administration is adopting uniform standards. You know, reducing the cost of the administrative portion of the thing is my biggest concern, you know, the bureaucracy involved with running the system.

Secretary SHINSEKI. Congressman Benishek, in our tables here, we show a line for medical and administrative support savings. In the 2012, the estimate is $150 million. And I believe that is sort of the topic area you are looking in.

Mr. BENISHEK. Okay.

Secretary SHINSEKI. We are happy to provide more detail here for you.

[The VA subsequently provided the following information:]

> The cost savings of $150 million will be achieved by more efficiently employing the resources in various medical care, administrative, and support activities at each medical center and will be achieved by targeting the following areas to improve overall operational efficiency:
>
> - High missed outpatient appointments/no show rates
> - Observed to Expected Length of Stay
> - Diagnostic colonoscopy (CPT code 45378) cost per procedure
> - Cardiac catheterization cost per procedure
> - Primary care cost per encounter

Mr. BENISHEK. Well, I guess you understand the point of my question. I just see the bureaucratic side of the budget cut and the people that are actually delivering the care, those people should be the last people to be cut.

Dr. PETZEL. Right. I understand your concern.

The CHAIRMAN. Thank you.

Mr. Secretary, there are numerous questions that I think each of us will probably put together. We will do them collectively from the Committee to submit to you for the record.

Are there any other questions that people want to ask in the public forum?

[No response.]

The CHAIRMAN. If not, we thank you for being here and you are recognized again, Mr. Secretary.

Secretary SHINSEKI. Thank you, Mr. Chairman, for very, very helpful testimony.

We began with a discussion about overhead and staff and we never really got to talk about savings because part of the responsibility of having that kind of overhead is to have something to show for it.

We are estimating that this year, we will generate about a $1.1 billion in savings. What we would like to work on with the Committee is taking $600 million of that and reinvesting it in our 2012 budget, take the second $500 million and reinvest it in the 2013 budget so that with these monies, we are able to generate additional savings. And we are targeting with this carryover, this is the carryover discussion, we anticipate another $1.2 billion in 2012. And it is still a fuzzy estimate, but we are looking at about the same kind of savings in 2013.

We think this is the return on the investment for some of this additional overhead where we can put in place processes, business plans, and follow-up that are going to outlast everyone here at the table where the behaviors at VA are the ones that we would all expect about good business.

The CHAIRMAN. Again, Mr. Secretary, we thank you for your indulgence. We apologize again for the delay. Thank you for those people that were here with you to help in answering the questions. We appreciate that as well. Each of us on this Committee is dedicated to working with you to help those whom we are supposed to be serving from the veteran community. Thank you, sir.

And as the Secretary and his party depart, I would like to go ahead and invite the second panel to make their way to the table.

The second panel with us today includes Mr. Carl Blake, National Legislative Director of the Paralyzed Veterans of America (PVA); Mr. Raymond Kelley, the Director of the National Legislative Service for Veterans of Foreign Wars of the United States (VFW); Mr. Joseph Violante, the National Legislative Director of the Disabled American Veterans (DAV); Ms. Christina Roof, the National Acting Legislative Director for AMVETS; and Mr. Timothy Tetz, the Director of the National Legislative Commission for the American Legion.

As customary, each of your written statements will be entered into the record and you will each be recognized for 5 minutes. And I do not know who has been selected to go first, but you are on.

Mr. BLAKE. We did not select, but I am just going to go first, Mr. Chairman.

The CHAIRMAN. Mr. Blake.

STATEMENTS OF CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; JOSEPH A. VIOLANTE, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CHRISTINA M. ROOF, NATIONAL ACTING LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS); AND TIMOTHY M. TETZ, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AMERICAN LEGION

STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Miller, Ranking Member Filner, Members of the Committee, on behalf of the four co-authors of *The Independent Budget (IB),* I would like to thank you for the opportunity to be here to testify today. I will focus my comments on the health care budget of the VA for fiscal year 2012.

Before I begin the rest of my statement, I would just like to say thank you to your staff and to Ranking Member Filner's staff for giving us the opportunity last week to come over and sit down and talk about *The Independent Budget* in advance and sort of, you know, lay out what we are looking at going forward before the President's budget was actually released on Monday.

With that, Mr. Chairman, we are pleased that it appears that the fiscal year 2011 appropriations process may be actually nearing an end as last week, the House Committee on Appropriations intro-

duced H.R. 1. And as you well know, it is being considered on the floor as we speak.

While we have some minor concerns with the details of H.R. 1, we appreciate the needed increases in certain funding for the VA provided by the legislation and we hope the Congress will act on this legislation quickly.

Additionally, we appreciate the fact that the Appropriations Committee has outlined the advanced appropriations for fiscal year 2012. As you know, last year, the Administration recommended an advanced appropriation for fiscal year 2012 of approximately $50.6 billion in discretionary funding for VA medical care. The House Committee on Appropriations supported this recommendation in H.R. 1 as well.

When combined with the $3.7 billion for medical care collections previously projected, the total available operating budget recommended for 2012 is approximately $54.3 billion.

However, included in the President's budget request for fiscal year 2012, the Administration revised the estimates for medical care down by $713 million due to the proposed Federal pay freeze. That is something that we recognized in *The Independent Budget* and we chose to do so as well as part of our recommendations.

I would like to say that I believe that the Administration has offered a reasonable starting point, particularly for medical care, for the overall medical care budget. However, we do have some concerns about some of the proposals that are included in the fiscal year 2012 health care budget.

Of particular concern to *The Independent Budget* is the ill-defined contingency fund that would provide $953 million more for medical services for fiscal year 2012. Moreover, we are especially concerned that the VA presumes management improvements, something that harkens back to the gimmicks known as management efficiencies of the past, of approximately $1.1 billion to be directed towards fiscal year 2012 and fiscal year 2013.

The VA has explained that these management improvements provide $1.1 billion that the VA would like to carry over and, yet, if the VA is not authorized to carry over this additional money, its fiscal year 2012 budget request and 2013 advanced appropriations request will be insufficient to meet the health care demand of veterans it serves.

Finally, we have real concerns about the revised estimates and medical care collections from what was originally projected. In last year's advanced appropriations, as I mentioned, it was projected that they would collect $3.7 billion and now it appears that they are projecting only $3.1 billion.

Given the emphasis on medical care collections and ramping up through Consolidated Patient Account Center (CPAC) in recent years, we are just as curious, as I hope the Committee is, as to how these things have occurred like this.

Given this revision in estimates, the VA's budget may arguably be short $600 million additionally in budget authority for next year based on the consideration of those collections.

The Administration recommended, as I mentioned, $53.9 billion for total medical care funding for fiscal year 2012. *The Independent Budget* recommends approximately $55 billion for total medical

care. This includes approximately $43.8 billion for medical services. Our medical services recommendation includes $41.3 billion for current services, $1.1 billion for the increase in projected workload, and $1 billion for additional medical care program costs. Each of these areas is explained in more detail in my full written statement and in *The Independent Budget* for fiscal year 2012.

For medical support and compliance, *The Independent Budget* recommends approximately $5.4 billion and finally for medical facilities, *The Independent Budget* recommends approximately $5.9 billion.

While our recommendation does not include additional increases over and above the baseline for nonrecurring maintenance (NRM), it does reflect the fiscal year 2012 baseline of approximately $1.1 billion for NRM.

We are also concerned about the steep reduction in spending for medical and prosthetic research. *The Independent Budget* recommends $620 million, approximately $111 million more than the Administration's request. As you know, research is a vital part of veterans' health care and an essential mission for our national health care system.

Finally, Mr. Chairman, *The Independent Budget* is pleased to see that the Administration has proposed an increase in the medical care accounts for fiscal year 2013. However, we cannot emphasize enough that Congress must remain vigilant to ensure that the proposed funding levels for fiscal year 2013 are, in fact, sufficient to meet the continued growth and demand on the health care system.

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

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

STATEMENT OF RAYMOND C. KELLEY

Mr. KELLEY. Mr. Chairman, Members of the Committee, on behalf of the 2.1 million members of the Veterans of Foreign Wars and its auxiliary, I would like to thank you for the opportunity to testify today.

As a partner of *The Independent Budget,* the VFW is responsible for the construction accounts, so I will limit my remarks to that portion of the budget.

A vast growing and aging infrastructure continues to create a burden on VA's overall construction and maintenance requirements. These facilities are the instruments that are used to deliver the care to our ill and injured veterans. Every effort must be made to ensure these facilities are safe and sufficient environments to deliver that care.

A VA budget that does not adequately fund facility maintenance and construction will reduce the timeliness and quality of care to our veterans. This is why *The Independent Budget* partners are recommending an overall construction budget of $2.8 billion, $2.2 billion for the major construction accounts, $585 million for the four minor construction accounts.

Last fall, VA provided the IB partners with an overview of the strategic capital investment plan or SCIP. After this briefing and upon reviewing the VA's fiscal year 2012 budget submission, *The*

Independent Budget partners were pleased with the improved transparency of the capital planning.

The VA has advised *The Independent Budget* partners that SCIP is intended to identify capital acquisition needs ranging from non-recurring maintenance and leasing to major and minor construction projects to close the currently identified performance gaps. All tolled, these gaps will require between $53 billion and $65 billion in funding over the next 10 years.

However, at the Administration's requested funding level, it will take between 18 and 22 years to complete the current 10-year plan. Under-funding VA's capital plan in its infancy will only exacerbate their ongoing construction and maintenance needs.

We are happy to see the VA's fiscal year 2012 budget request for the medical facilities in New Orleans and Denver along with three other major construction projects will be fully funded. However, only 7 of the 23 partially funded major construction projects will continue to be funded in 2012, leaving over $4 billion remaining in partially funded projects dating back to fiscal year 2007.

These projects include improving seismic deficiencies, providing spinal cord injury centers, completing a polytrauma, blind and rehab research facility, as well as expanding mental health facilities. These projects have a purpose and should be funded as quickly as possible to fulfill the promise of care to our wounded and ill veterans.

VA is requesting approximately $545 million to continue construction on the seven existing projects and to begin work on four new projects. At this pace, VA will not reach its strategic capital investment 10-year plan. Therefore, the IB partners request that Congress provide funding of $1.85 billion for VHA major construction accounts. This will allow VA to complete all current partially funded major construction projects within 5 years, begin providing funding for 15 new projects, and fund the four currently partially funded seismic correction projects at a level that will have them completed within 3 years.

The IB partners are pleased with VA's funding request for VHA minor construction accounts. This level of funding will allow VA to fully fund more than 75 projects.

The Administration's request for managerial cost accounting (MCA) construction projects is nearly $80 million. The IB is requesting $161 million. This will allow MCA to complete nearly all of its minor construction projects and begin three major projects, expanding veterans' access to cemeteries in Hawaii, Florida, and Colorado.

The IB partners are also requesting an increase in funding for research facilities. Funding at a level of $150 million will allow work to begin on the five highest priority research facilities. Again, it is critical to the care of our veterans that we fully fund VA construction.

Mr. Chairman, thank you for the opportunity to testify today and I look forward to any questions you may have.

[The prepared statement of Mr. Kelley appears on p. 67.]

STATEMENT OF JOSEPH A. VIOLANTE

Mr. VIOLANTE. Mr. Chairman, Ranking Member Filner, Members of the Committee, on behalf of the Disabled American Veterans, I am here today to present the recommendations of *The Independent Budget* for fiscal year 2012 in the area of veterans' benefits.

Mr. Chairman, for fiscal year 2012, the IB recommends only modest increases in personnel levels for Veterans Benefits Administration. And those increases are targeted primarily at the Vocational Rehabilitation and Employment Service and the Board of Veterans' Appeals.

The Voc Rehab Program is one of the most important benefits provided to many disabled veterans. However, a 2009 study by GAO found that 54 percent of the VA regional offices reported they had fewer vocational rehab counselors than needed.

The current caseload target is one counselor for every 125 veterans, but the ratio is reported to be as high as one to 160. Therefore, the IB supports an increase of 100 new counselors and an additional FTEE dedicated to management and oversight of the growing number of contract counselors and service providers.

The Board of Veterans' Appeals' workload has consistently averaged about 5 percent of the total number of claims before VBA. So as claims rise, so, too, do the number of appeals. To meet the new demand and avoid creating an ever-larger backlog of appeals, the IB recommends funding increases for the board that are commensurate with increasing workload.

Mr. Chairman, the IB once again calls on Congress to completely end the ban on concurrent receipt for all disabled veterans and eliminate the SBP and DIC offsets for veterans' widows and dependents. Under current law, most service-connected disabled veterans who retire after a full career in the Armed Forces must forfeit a portion of their retirement pay before they can receive VA disability compensation rightfully due to them. This inequity unfairly penalizes a servicemember who pursues a career in the military.

A disabled veteran who elects to pursue a civilian career will be able to receive full VA disability compensation and full civilian retirement pay. Although Congress has addressed this inequity for veterans with disability ratings of 50 percent or greater, it is time to extend fairness to all veterans.

Similarly, when a disabled veteran dies of service-connected causes, their eligible survivors or dependents receive dependency and indemnity compensation or DIC. The benefit provides a modest support to compensate for the veteran's earnings loss due to disability. However, if the survivors are also eligible under the Survivor Benefit Program or SBP, they will have their SBP benefits reduced by the amount of DIC payments.

This fails to recognize that SBP is a separate and purchased program paid for by deductions from servicemembers' military pay. Surviving spouses of Federal civilian retirees who are disabled veterans can receive a DIC payment without any offset for their purchased Federal civilian survivor benefits. Congress should treat military widows equally by repealing the offset between DIC and SBP.

Mr. Chairman, VA is at a critical junction in its efforts to reform the outdated, inefficient, and overwhelmed claims processing system. Secretary Shinseki has made clear his intention to break the back of the backlog as a top priority. And while we welcome this goal, we would caution that eliminating the backlog is not necessarily the same goal as reforming the claims process system. To achieve real and lasting success, the VA must focus on creating a veterans benefits claims processing system designed to decide each case right the first time.

Undoubtedly, the most important new initiative underway is the Veterans Benefits Management System, VBMS, their new IT program being designed to provide a paperless and rules-based method of processing and awarding claims. We would urge Congress to carefully monitor and oversee this work and recommend considering an independent outside expert review of the VBMS. However, regardless of the IT solutions, VBA must ensure that they have a properly trained workforce and a comprehensive quality control system.

That concludes my statement and I would be happy to answer any questions from the Committee.

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

STATEMENT OF CHRISTINA M. ROOF

Ms. ROOF. Chairman Miller, Ranking Member Filner, and distinguished Members of the Committee, on behalf of AMVETS, I would like to thank you for inviting me and the representatives of the other member organizations that authored *The Independent Budget* to share with you our recommendations on the Department of Veterans Affairs' fiscal year 2012 budget.

We believe our recommendations to be the most fiscally responsible way of ensuring quality and protecting the integrity of the care and benefits our veterans' community receives.

As a partner of *The Independent Budget,* AMVETS devotes a majority of our time to the concerns and matters of VA's National Cemetery Administration as well as veteran entrepreneurship and Federal procurement. Today I will briefly speak to both issues.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the Armed Forces. As of late 2010, NCA maintained more than three million graves at 131 national cemeteries in 39 States and Puerto Rico.

With the anticipated opening of several new national cemeteries, annual interments are projected to increase to approximately 116,000 in 2013 and are projected to remain at this level through 2015.

The IB recommends a total operating budget of $275 million for NCA for fiscal year 2012. This is so that they may meet the increasing demands for interments, grave site maintenance and related essential elements of cemetery operations. This recommendation is based upon the immediate and increasing need for NCA services as well as the upkeep of these sacred grounds.

The State Cemeteries Program is currently facing the challenge of meeting the growing needs from States to provide burial services in areas not currently served by NCA. *The Independent Budget* thus recommends Congress appropriate $51 million for the State

Cemetery Grant Program (SCGP) for fiscal year 2012. This funding level will allow SCGP to establish new State cemeteries at the current rate of need and will provide burial options for veterans that otherwise would have no reasonable access to State or national cemeteries.

We call on the Administration and to you, the Congress, to provide the resources required to meet the critical nature of NCA's mission and to fulfill this Nation's commitment to all veterans who have served their country so honorably and faithfully.

AMVETS' second focus of the fiscal year 2012 IB is on veteran entrepreneurship and Federal procurement as it relates to service-disabled veteran-owned small businesses and veteran-owned small businesses. And while I will note that a majority of the preceding information is focused on policy rather than hard fiscal numbers, we believe that broken policies, duplication of efforts, and lack of oversight are key factors in determining a fiscally responsible budget and eliminating any unnecessary waste.

Supporting service-disabled veteran-owned small businesses and veteran-owned small businesses contributes significantly in sustaining a veteran's quality of life while also contributing to the success and ease of transitioning from active duty to civilian life.

Given the current state of the economy, now more than ever Federal agencies must be held accountable in meeting the 3-percent Federal procurement goal as outlined by Executive Order 13–360 and Section 36 of the Small Business Act. All Federal agencies must assist in the development and implementation of strong strategies and be held accountable to meeting the 3-percent goal.

Furthermore, Congress must ensure adequate resources are available to effectively monitor and recognize those agencies that are not meeting the 3-percent goal and hold them accountable for their failure.

Another critical part of protecting veterans in a successful Federal procurement system is to centralize the vendor verification system. Thus far, VA has been awarded $1.4 billion in Recovery Act funds to aid in the employment and contracting opportunities available to veteran-owned businesses. And according to VA, of the Recovery Act funds they have received, $538 million, of the $1.4 billion, have been used on awards to service-disabled-owned small businesses and veteran-owned small businesses.

However, we have serious concerns on how much of the awarded funds were actually awarded to legitimate veteran-owned businesses due to the lack of a solid verification process in place at VA.

In closing, I encourage each of the Members to review my full written testimony, which will outline all of our concerns and recommendations on veteran entrepreneurship, contracting, and the NCA.

Again, Chairman Miller and Members of the Committee, thank you for your time.

[The prepared statement of Ms. Roof appears on p. 86.]

STATEMENT OF TIMOTHY M. TETZ

Mr. TETZ. Good afternoon, Mr. Chairman and Ranking Member Filner and Members of the Committee. On behalf of the American

Legion, I would like to thank you for the opportunity to present our thoughts on the VA's 2012 budget.

You only have to open the newspapers to know we are all as a Nation deeply concerned with financial responsibility, making smart choices about how to spend money. The American Legion believes in making those smart choices, the right choices.

When I started to buy my first car, I remember my father speaking to me about how to make the right choices, being wise about spending. I was, of course, not really interested in hearing what he had to say. I was a young man and thinking more about what I wanted out of my car. Did I want the truck to feel with my attitude or did I want the sporty coupe to attract the ladies? Yet, the reality was I only had a limited amount of money, only so much to spend to meet all my needs, all of my desires. And I was too naive to understand factoring the cost of insurance, tires, maintenance, and other unforeseen hazards.

The Department of Veterans Affairs' approach to the 2012 budget is not much different than the car buying experience of a 21-year-old. They have tried to manage the reality today against the possibilities of tomorrow while listening to the veterans service organizations. And they have done a fairly admirable job.

The American Legion is grateful the President's budget represents a 10-percent increase over the last budget. This demonstrates a mind set that places a priority on the debt owed to the men and women who have sacrificed so much and, yet, ask so little.

We understand these are hard times and hard choices must be made. What are the smart decisions in the current budget? Smart is funding $6 billion to enhance VA's ability to provide the best possible specialized care for post-traumatic stress, traumatic brain injury, and other mental health needs. Smart is funding $939 million towards programs to help eradicate veteran homelessness. Yet, we are left with the question, are these decisions based on the reality of today overlooking the probability of tomorrow?

Some of the $6 billion will help meet this research need, but is that enough? This money seems to be directed at the immediate medical needs of these veterans, but perhaps not the long-term needs of those very same veterans. Does it address the chasm between the advances in treatment of PTSD and TBI in DoD and is available once they leave the service and separate to return to their homes in upstate New York or rural Indiana?

We face many new and evolving medical concerns for which the VA is uniquely placed to a be a trailblazer in research. Perhaps one of the greatest investments to consider is to give VA funding to lead this research. Given the intellectual and technological might of this Nation, there is no reason the VA should not be the world expert and leading authority on TBI, PTSD, amputation and prosthetic medicine.

Fully fund VA research for prosthetics, vision, medical, and TBI and PTSD. Give this aspect the needed money and let it be what we all imagine it can be. VA must lead from the front, not play catch-up for the rest of the world.

Despite these positives, VA seems short-sighted in their allocation of resources for tomorrow. A reduction of construction funds of $800 million certainly points to this. Infrastructure is vital. Infra-

structure is one of those things you can pay for now or later and if you choose to pay for it later, you always pay more.

How can we complete the new projects in Las Vegas, Denver, New Orleans and the upgrades needed nationwide without adequate funding? This is one area the American Legion strongly disagrees with the proposed budget and asks Congress to consider the importance of funding nearly twice that amount. Cutting money from construction creates an illusionary savings. You can choose to pay now or pay later, but the price of failure to invest in infrastructure will eventually come due. Smart money invests in infrastructure now.

We realize there is only so much money. We realize the American Legion as well as every other veterans' organizations here comes with expanded visions of what we need, what our veterans need, and what the VA must deliver. We remain committed to help you find savings within the existing budget, identifying chances to shift resources to serve the needs of the veterans sitting in the clinic in Florida and the future veteran sitting in the forward observation base in Afghanistan.

We find ourselves in that very same situation my father was in all those years ago, pointing out considerations that quite honestly you do not take account for as a 21-year-old. You can learn a lot by making bad choices and you also learn the older you get, the wiser your dad seems to be. It is the little things. It is the details you do not think about that make the sense in the long run.

I thank you again for the opportunity to present this testimony and will gladly answer any questions you might have.

[The prepared statement of Mr. Tetz appears on p. 92.]

The CHAIRMAN. We thank each and every one of you for your testimony.

The President's Commission on Fiscal Responsibility and Reform released its report back in December. And, basically, it said that everything needed to be on the table to include finding waste, fraud, and abuse that may exist in Federal agencies.

I know each of your organizations works very closely with VA as do your members in utilizing their services. And I would like to just ask, do you have any particular areas that you can bring to our attention so that we can help find these extra dollars?

Mr. BLAKE. Right now I do not know that I can answer that question, Mr. Chairman, but it is probably something where we could mine the information from the bulk of our organization and provide you with a better answer after having had a chance to sort of spread that word and that question around.

Mr. KELLEY. My office has taken some time to go ahead and look into some of that. And I will be happy to work with the Committee to identify more than a handful of areas where there are some savings.

Mr. VIOLANTE. Mr. Chairman, I think when you opened up this hearing, you pointed to a number of issues that we think need to be looked at, including the growth in the administrative side versus the hands-on services. So we certainly would be willing to work with staff to look into that to see if all those increases are as necessary as VA seems to think.

Ms. ROOF. As AMVETS has been saying for the past year and a half, I would love the opportunity to sit down with each and every one of you and identify some areas where we definitely believe there is duplication of efforts and so on.

Mr. TETZ. Mr. Chairman, we obviously join our fellow veterans organizations in that. Like all of us, we go out there and hear it and we will be happy to share that.

I think earlier Mr. Michaud brought up some of the duplicative contracting, some of the oversight. And if we can start looking at those little pieces, tens of millions of dollars here suddenly start adding up to big savings that we get out to the right people in the right places.

The CHAIRMAN. That they do. And I appreciate your willingness to work with the Committee and staff. This is something again that we pledge to work with you and hope that you will work with us and VA as well as we try to navigate through these very perilous financial waters that we find ourselves in here in the United States.

Mr. Blake, you talked about concerns regarding VA's proposed contingency fund. I have concerns as well. The Ranking Member and I have been discussing it. I would like you to expand a little bit, if you would, on your concerns.

Mr. BLAKE. Well, first let me say that when we had the briefing from the VA, it was a little unclear as to what exactly the contingency fund is. So maybe this is my interpretation of the way they explained it.

But as I understood it, the cost associated with that contingency fund is based on some assumptions they made for their model that is impacted by changes in the economic conditions, unemployment and things like that, as best as I can understand, which sounds a little bit like they have manipulated their health care projection model to serve a singular purpose beyond the broader scope of the model itself.

I guess the concern I have is do you need $953 million or do you not. I believe they do because I think our projections go along that line of thinking for workload and things like that and, yet, by identifying it as sort of a contingency fund, you say, well, maybe we need it or maybe we do not and, yet, their budget is built on the assumption that they need that money because it is included in their overall recommendation.

So I would sit here and say you need the money from *The Independent Budget's* perspective. We believe that money can be used and is needed. I think the VA should do the same.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Just three quick points.

First, in the past, some administrations have, after the Secretary's presentation, not stayed around to hear your testimony. I want to thank all of you for staying and listening to these stakeholders who worked so hard on this budget. So thank you.

Again, all of you who worked so hard on this, you give us material that we have to absorb and chew over for a long period of time. But we have a lot of confidence in it because of the work you put into it. We are going to use this again and again and again and

there is a lot to absorb. I just want to thank you once more for each year that you put such hard work in it.

Lastly, I want to just point out the success that you all had. Most of your organizations had as your top priority last year the forward or advanced funding. You showed how important that was.

We are going around and around on the Continuing Resolution. Various agencies do not know what the budget will be. They cannot plan. They cannot move forward while the health care budget of the VA is solid and they are working from it. Veterans are being positively impacted by that.

So that was your work, all of you, and it shows how necessary it was because this year, the first year that it was in effect, it is absolutely necessary that we had it. So I want to just thank you for all the work you did on that and all this stuff on *The Independent Budget.* We will be using it for the coming year.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Bilirakis.

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

Mr. Blake, in your testimony, you make reference to medical and prosthetic research. Many breakthroughs have been made with medical technology and products.

Do you believe that the VA has the necessary tools to partner with companies that develop and produce such cutting-edge products to ensure that we are providing veterans with the highest quality of life possible? And anyone who wants to comment on that as well, I would appreciate it.

Thank you.

Mr. BLAKE. If by necessary tools you mean the funding, I think my statement speaks for itself. The concern I have is for years, we felt like medical and prosthetic research was under-funded. And in the last 2, 3 years, the Congress as a whole, has committed to funding medical and prosthetic research at a more appropriate level.

And I think it is absolutely necessary because of the demand for advanced prosthetics and the things across the spectrum that particularly this newest generation of veterans have placed on the VA for their needs and because, you know, this is a young generation that is going to rely on these things for a very long time. And so we need to make sure that the VA is prepared to address those needs for a long time.

So we are certainly disappointed to see that the Administration is coming with a significantly reduced recommendation for medical and prosthetic research. In fact, it is $72 million below what may or may not end up being the appropriated level when H.R. 1 or whatever the final version of the funding is. So that would suggest a pretty significant curbing in the availability of grants and such like that which are the way that the VA sort of farms out its research programs. So I would certainly have real concerns about that.

The CHAIRMAN. Anyone else on this particular subject matter?

Mr. TETZ. Mr. Bilirakis, our concern and what we are hearing out in the field is the discrepancy once they leave the service. They sit there and they go through the DoD and they get the quality of care and the tools and the prosthetics that they need and all of a

sudden, they come back out and they get into their local community and they cannot service that.

And there should be that seamless help to say, hey, we had you covered when you were wearing the uniform and now that you are wearing a suit, we still have you covered. And that is a bigger piece. So it goes beyond merely just keeping on top of that advances but making sure that it is hand in hand and seamless.

Mr. BILIRAKIS. Good point. Anyone else?

Ms. ROOF. Just a real quick point I would like to add in. I think a lot of times when people think prosthetics, they think a leg or an arm. I think it is really, really important for everyone to remember anything that goes on a veteran, in a veteran, or a veteran uses is a prosthetic device from a heart stent to a prosthetic leg to a service dog. So I agree with Carl, 100 percent on the funding aspect. So I would want everyone to keep that in mind when talking about cutting that kind of funding.

Mr. BILIRAKIS. Okay. Mr. Kelley and anyone who wants to comment on this, I would appreciate it. In general, is the VA adequately transforming to meet the different needs of the men and women who serve in Iraq and Afghanistan and what are the top concerns associated with ensuring that changes are meeting veterans' needs? We will start with Mr. Kelley if that is okay.

Mr. KELLEY. Mr. Bilirakis, I had a hard time hearing the question.

Mr. BILIRAKIS. I will repeat it if that is okay. Is the VA adequately transforming to meet the different needs of the men and women who have served in Iraq and Afghanistan? And, secondly, what are the top concerns associated with ensuring that the changes are meeting veterans' needs?

Mr. KELLEY. Sure. I think they are making strides. I do not know how you predicate adequate if we still have a suicide rate that is 18 veterans a day. And so they are making strides. They are going in the right direction, but there are areas that need to continue to be improved, mental health, suicide prevention, making sure that the needs of women veterans are being met.

There was a GAO report back in December that showed that women veterans who applied for a disability rating for PTSD related to combat service were denied at a very high rate and men were accepted at a very high rate.

But in reversing that, if they applied for some other type of mental health issue, whether it was military sexual trauma or some other sort of trauma that affected them psychologically, women were rated at a very high rate and men were rated at a very low rate.

So there is still some training that needs to be done within VA to make sure that they have a full understanding of the needs of gender—I guess gender specific needs.

Mr. BILIRAKIS. Thank you.

Anyone else wish to comment?

Mr. VIOLANTE. I would just like to add to that. I agree. I think there is a lot more work that needs to be done with regards to women veterans. There are more of them. There are now women serving in combat coming back with combat disabilities. And VA needs to be mindful of that and work towards improving access.

I think one area that they have greatly improved is what they are doing jointly with DoD at a lot of the separation centers with regards to getting claims done before men and women leave the military. And that seems to be working rather well. So we are happy to see that.

And I think better collaboration between DoD and VA with regards to electronic records would be very helpful.

Mr. BLAKE. I want to go back to something that I think Mr. Michaud or a number of the Members on the panel mentioned earlier. It is not just about health care. They talked about the evolution of the virtual lifetime record. That is not just their medical record, but it could be their DoD service record and all that. I do not think that is something that can happen fast enough. I think that is something that should have happened long ago.

I mean, we talk about the overwhelming problems with the claims backlog and a lot of times, you hear about just the sheer volume and weight of paper and things like that. So I know that the Administration and Secretary Shinseki has made one of their top priorities being this conversion into a virtual lifetime record. And we hope that that is something that will be expedited, not just we are still working on seeing how close we are and all that. That needs to happen. It needs to be done.

And now, in defense of the VA, it is not just a VA problem. I mean, DoD has some blame in not getting this going faster as well. And we have talked to some of the folks on the Armed Services side about our concern with their involvement in this as well. But that is something that needs to be done yesterday.

Mr. BILIRAKIS. Thank you.

The CHAIRMAN. Dr. Benishek.

Mr. BENISHEK. My concern about the electronic record, do you get a copy of all your records that you have had from DoD when you are in the service? You know, I have a little bit of concern about the fact that sometimes the electronic record can be lost easier than the paper record. I have concerns about that. Does anybody have any insight as to what that is about or is that going to be a problem?

The problem that I see for veterans is they are delayed in their benefits because they cannot find their records. I mean, that is what I hear all the time. We cannot prove that you are saying what you said. And I just do not see how that is really possible. I mean, the guy was in the service. I mean, how can you not, you know what I mean?

Mr. KELLEY. If a servicemember has the foresight to make copies of their medical record, they will leave the military with their medical record. But they have to have the foresight to say I am going to take my medical record down to the copy machine, make a copy of everything that is in there so I can have my own personal record. That is not something that they tell them to do. They have to do that on their own.

The idea of having a database that loses accessibility, whatever happens, that system goes down, and you cannot retrieve it, it is no better or no worse than having paper copies. St. Louis is an example. We lost hundreds of thousands, if not millions of documents from Vietnam era veterans who are without medical records be-

cause they did not make their own. The military kept them in St. Louis and the building burned.

So there will always be a fear of lost records. Is it a good idea to hand a veteran his or her medical records the day they leave? Absolutely. Is it a good idea to have them electronically so it is easily accessible by the VA? Absolutely.

Mr. BENISHEK. Thank you.

I yield the remainder of my time.

The CHAIRMAN. Mr. Flores.

Mr. FLORES. I want to thank you for joining us today and also for *The Independent Budget* that you have prepared for our use. I think that will be a helpful tool.

Have you looked at the section of the VA budget about greening the VA? In the grand scheme of things, it is minor dollars, but I just wondered if it might be better deployed. We are talking about $124 million.

Mr. BLAKE. We do not typically dig down that deep, but if there is something you have an issue of concern about, I will be glad to look at it.

Mr. FLORES. I am just thinking about the allocation in terms of we have talked about raising administrative costs, we have talked about not enough resources going to help the vets directly, but on the other hand, we have $124 million to green the VA. I was wondering what your——

Mr. BLAKE. I have a hard enough time understanding regular budgeting without understanding how you quantify greening to be perfectly honest with you. But, again, it is something we would certainly take a look at.

Mr. FLORES. Okay. If you have any feedback, you can provide it back to us. Thank you.

I yield back.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

And thank you all for coming and speaking with us today.

Just a real quick question. The claims backlog, everybody is talking about it. That is what we are focused on. You know, certainly it is addressed in the budget.

In your view, and no particular order to answer here, what is your top three things that you think we can do or should be done to reduce that backlog?

Mr. VIOLANTE. Mr. Johnson, it is interesting because right now we are not focused so much on legislative fixes. We are still looking at that to see what is working. VA has roughly about 48, 50 pilot programs out there that they are running and we would like to see what the results are of those pilot programs.

The big key to all of this is their VBMS and how that system is going to operate their IT system and whether or not it is a good searchable database, whether or not it is rules based. And that is why we have asked Congress to monitor that closely, maybe even bring in some third-party experts.

I mean, I do not know that any of us here are IT experts. But we know what we would like to see the end result be and that is a searchable electronic database rules based system. So that is a key element and if you can keep an eye on that.

I mean, the other part of this is training. We do not believe that VA personnel are adequately trained to do the job that they are supposed to do to get the case right the first time. So training is an important element.

And another element is accountability. No one is held accountable for the fact that the decisions are wrong. The only thing they are held accountable for is did they do a decision, right or wrong. So we would like to see some accountability in there.

And I think if we can get those elements and get VA focused on that, I think we can tackle this claims backlog and get things under control.

Mr. TETZ. I would really echo many of the things that my counterpart said. You know, too often we want to throw more things at them. Too often we want to say, hey, let's get another project in there, let's do another, what do you think.

And with these pilot programs that are out there and the opportunities out there, we really need to take a step back and look at those and say what works, what does not, what is realistic. And until you can sit there and work through that, you cannot say what those successes are.

Currently, the VBMS when it is implemented, when it is actually there could have a tremendous, tremendous help. It also could be a disaster and we could be upside down there. But I think that, you know, training all those folks who are brought on board and creating a way for us to know, the VA leadership and for the public to know that those folks are using every hour they can dedicate to those and the work they are doing is quality work and not just getting shoved around to level to level. Make certain that all that staff we brought on board and all that time is going to actually help the veteran at the end and decrease and break the backlog.

Mr. JOHNSON. Sorry. I want to take just a couple of seconds and give you some encouragement. I came to Congress from the role of Chief Information Officer for a global manufacturing company and spent 27 years in the Air Force as an IT geek.

So in our Subcommittee on Oversight and Investigations, we have already begun a very open dialogue with Mr. Baker and the team from the VA and we are going to be looking at these things. I certainly am concerned because this is not rocket science. These are technologies that are available, have been available, and, you know, why we are not putting them to good use for our veterans, we are going to be digging into that and where we can help push those along.

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

The CHAIRMAN. Thank you very much

Anything else for the good of the order?

[No response.]

The CHAIRMAN. I thank you very much again for your indulgence, also in waiting through the delays with the votes. We thank you for your testimony.

And also thank you to the VSOs and to VA for your timely submission of your statements. It is very important that we and the staff are able to get them in a timely fashion so that we can go through them to develop questions prior to this hearing.

So, again, without objection, each Member will have 5 legislative days to submit further testimony, revise and extend extraneous materials. Any objection?

[No response.]

The CHAIRMAN. Without objection, so ordered.

And with that, this hearing is adjourned.

[Whereupon, at 1:42 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman, Full Committee on Veterans' Affairs

Welcome, Secretary Shinseki, to you and your team. Thank you for being here today to present the President's fiscal year 2012 budget request for the Department of Veterans Affairs (VA). Welcome also to the veterans' organizations that are with us today.

Let me say at the outset that I look forward to a close working relationship with all of you as we work to improve the delivery of benefits and services to America's veterans.

As everyone knows, this is a tougher budget to measure because we do not have a full-year appropriation for every VA account for the current fiscal year. That said, if the numbers in the House CR bill are carried forward I see the President's fiscal year 2012 budget as, roughly, a 3.5 percent increase in VA discretionary spending. Relative to prior years, this is a much more measured request.

What is important, however, is not the percentage increase it is whether the resources requested meet our obligations to America's veterans and America's taxpayers. Toward that end, I have several initial observations.

First, I'm interested to learn how this budget will chart a path forward to address the broken disability claims system. Staffing for compensation claims has tripled since the late 1990's, numerous Information Technology tools have been utilized, and there have been different organizational models attempted. Nothing has worked. I want to know how this budget takes a new approach to this challenge.

Second, I'm interested in learning how this budget is prioritized to meet the needs of family caregivers of severely wounded Iraq and Afghanistan veterans.

The reaction to VA's initial plan to implement the new Family Caregiver law has been negative. I will explore ways we might be able to refocus resources for this important initiative.

Third, I'd like to know what energy went into eliminating wasteful, redundant spending. The President's bipartisan Deficit Reduction Commission suggested that every agency, VA included, step up to the plate.

I have to say, when I look at this budget and I see that it proposes a funding level for the Office of the Secretary that is 41 percent higher than 2009 levels; 50 percent higher for the Office of Congressional and Legislative Affairs; 96 percent higher for the Office of Policy and Planning; and 140 percent higher for the Office of Public and Intergovernmental Affairs . . . it raises all kinds of red flags.

Finally, there are some curious new accounting mechanisms proposed in this budget. VA proposes that a portion of its 2012 medical care budget be classified as a 'contingency fund.'

It also proposes that Congress appropriate money VA says it can save through management efficiencies so that it can then carry that money over into another fiscal year. These are new concepts that I'd like to get more detail on.

Mr. Secretary, we are all acutely aware of the fiscal and economic crisis our Nation is in . . . debt of $14 Trillion, a deficit this year of $1.55 Trillion, unemployment hovering at just under 10 percent.

We also are aware of the obligation we have to those who defend our freedoms every day. That is the privilege we all have in serving on this Committee. One measure of that obligation is how well we are addressing veterans' needs through the programs and services administered by VA.

So, there is a balance that must be struck a balance that recognizes both the moral duty we have to care for those who served in uniform and the reality that funding for that care doesn't exist in a vacuum.

Let me borrow a quote from recent history that touches on the challenge we face in finding that balance

> *'[T]he Committee's Members have kept in mind the fiscal limitations within which we must operate if we are to get Federal spending under control and*

thereby reduce the Federal deficit and debt. We believe that the Government can be fiscally responsible while still fulfilling its commitments to the most deserving among us—including our Nation's veterans. We also are mindful that uncontrolled Federal spending threatens the long-term health of the Nation's economy and, in turn, could adversely affect the provision of veterans' benefits. Thus, we recognize that those who have worn the uniform in defense of the Nation seek, as we do, to protect the health of Nation's economy.'

Now, I know some listening might think I'm quoting from a Tea Party Committee.

No, these were views expressed in a letter signed by every Member, Democrat and Republican, of the Senate Committee on Veterans' Affairs back in 1997, including the current Chairman of that Committee.

I recognize that times are different now than they were then. We are now fighting a war on terrorism that has placed demands on VA's medical and benefits system, so our priorities must obviously reflect that basic fact.

But here is another difference, the deficit then was only $128 billion, today it's over 10 times larger.

Moving forward, I sincerely hope every Member of this Committee can work together to find common ground on the difficult choices ahead. Together, I truly believe we can meet our commitments to veterans while also being mindful of our fiscal stewardship of taxpayer dollars.

Prepared Statement of Hon. Bob Filner, Ranking Democratic Member, Full Committee on Veterans' Affairs

Thank you, Mr. Chairman.

I want to thank Secretary Shinseki for appearing before us this morning to testify as to the resource requirements of the Department of Veterans Affairs for the upcoming fiscal year, and the VA's recommendation for an advance appropriation for medical care for fiscal year 2013.

I would also like to thank the representatives of the veterans service organizations who annually co-author *The Independent Budget,* and The American Legion, for presenting us with their views as to the needed funding levels for veterans' programs.

Although I have a number of concerns regarding the funding levels you propose, and questions regarding some of the assumptions and estimates that underlie your request, if you, Secretary Shinseki, tell me that this is what you need to get the job done in the coming fiscal year, then I will offer you my support and I will fight to get you the funding levels you say you need.

I do, however, have concerns about your request for a "contingency fund" and questions as to whether your "operational improvements" will actually generate the cost savings you estimate, but I will work with my colleagues to ensure that you have the bottom-line dollars that you need to care for our veterans in the coming fiscal year.

I look forward to hearing from our veterans' groups as to how they generated their recommendations, and to hear from them their experiences, and the experiences of their fellow veterans, who are on the receiving end of the programs we fund. What is the need out there and is the need being met?

Every year I refer to *The Independent Budget* as "my bible" when it comes to helping us decide what funding levels to recommend to the Budget Committee— this year is no different. Budgets speak louder than words as to what our priorities are as a country. Caring for our veterans is a national priority.

I am hopeful that all of us, working together, will be able to provide the VA with the funding it needs, and that the VA will be a faithful steward of the taxpayer dollars it receives. I firmly believe that you should request what you need, and that you need every dollar that you request.

Thank you, Mr. Chairman. I yield back the balance of my time.

Prepared Statement of Hon. Ann Marie Buerkle

Thank you, Mr. Chairman.

As a Freshman Member of this Committee and Chair of the Subcommittee on Health, I take very seriously my responsibility to ensure that the Department of Veterans Affairs is adequately funded to provide our veterans with the benefits their service afforded them.

We are all aware of our country's current economic crisis. We have a $14 trillion debt. We have an unemployment rate that is close to 10 percent. There is no doubt we have to take a critical look at how we spend our tax dollars and make tough choices.

However, laws providing for the care of our Nation's veterans were some of the very first laws enacted by Congress because our Founding Fathers had the foresight to know that America's veterans deserve the gratitude of a grateful Nation and providing care and benefits for those who had proved so worthy would make our country stronger.

I hope that our hearing this morning will point the way toward close cooperation among all of us as advocates of our Nation's veterans to respond to their evolving needs and those of their families. That does not mean that there aren't many areas where we can improve. We can, we should, and we will conduct rigorous oversight to ensure the VA is being a responsible steward of taxpayer dollars.

I want to thank the Secretary for his appearance before the Committee today and I thank you for your leadership.

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

I look forward to today's discussion and yield back my time.

Prepared Statement of Hon. Silvestre Reyes

Thank you Mr. Chairman,

Secretary Shinseki, I want to thank you for coming today to address our concerns with the care of our Nation's Veterans. I also want to thank you for your outstanding service to this Nation. As a Veteran, the issues we address in this Committee are very personal to me. They are also very personal to the more than 80,000 veterans that live in my district.

Many Veterans issues have come to the forefront in the recent weeks. They include violations of the Servicemember's Civil Relief Act, high rates of homeless veterans, failure of the administration to honor the Caregivers and Veterans Omnibus Health Services Act, and the recent lawsuit by victims of sexual assault, although against the U.S. Department of Defense (DoD), it is brought by veterans. These are just a few issues that are affecting the brave men and women who have fought for this country.

Even with all these high profile issues, the most important thing we can give our Veterans is comprehensive health care for the injuries they sustained in service of their Nation. As a Member of this Committee, and the Armed Services Committee, I feel very strongly that one of the most effective ways the Veterans Administration can provide these services to our Soldiers, Sailors, Airmen, and Marines is to ensure a seamless hand-off between the Department of Defense and the VA. Too often wounded servicemembers must wait for months while their records are transferred between the two agencies, and what's worse, is that the information that is transferred is not comprehensive in regards to what our soldiers were exposed to on the battlefield. The Vietnam War ended almost 40 years ago, and to this day there are Veterans that have still not received medical care for their exposure to Agent Orange.

It is my goal that we address all of the challenges facing our Veterans. Although we cannot erase the mistakes of the past, it is imperative that we move forward with the programs that will efficiently and effectively provide care to those who have given so much defending this country.

Thank you Mr. Chairman, and I yield back the balance of my time.

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

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

Thank you for the opportunity to present the President's 2012 Budget and 2013 Advance Appropriations Requests for the Department of Veterans Affairs (VA). Budget requests for this Department deliver the promises of Presidents and fulfill the obligations of the American People to those who have safeguarded us in times of war and peace.

Today, the Nation's military remains deployed overseas as it has during the last 9 years of major conflict. Our requirements have grown over the past 2 years as we addressed longstanding issues from past wars and watched the requirements for those fighting the current conflicts grow significantly. These needs will continue long after the last American combatant departs Iraq and Afghanistan. It is our intent to continue to uphold our obligations to our Veterans when these conflicts have subsided, something that we have not always done in the past. Not upholding these obligations in the past has left at least one generation of Veterans struggling in anonymity for decades. We, who sent them, owe them better.

VA has an obligation to track, communicate to stakeholders, and take decisive action to consistently meet the requirements of our Nation's Veterans for care and services. We pay great attention to detail but there are many factors in the health care market that we cannot control. We must mitigate the risk inherent when requirements for Veterans' care and services, and costs in the health care market, exceed our estimates. This request is the Department's plan for managing that risk and meeting our obligations to all Veterans effectively, accountably, and efficiently.

The President's budget for 2012 requests $132 billion—$62 billion in discretionary funds and $70 billion in mandatory funding. Our discretionary budget request represents an increase of $5.9 billion, or 10.6 percent, over the 2010 enacted level.

Our plans for 2012 and 2013 pursue strategic goals we established 2 years ago to transform VA into an innovative, 21st century organization that is people-centric, results-driven, and forward-looking. These strategic goals seek to reverse in-effective decision-making, systematic inefficiency, and poor business practices in order to improve quality and accessibility to VA health care, benefits, and services; increase Veteran satisfaction; raise readiness to serve and protect in a time of crisis; and improve VA internal management systems to successfully perform our mission. We seek to serve as a model of governance, and this budget is shaped to provide VA both the tools and the management structure to achieve that distinction.

For almost 146 years now, VA and its predecessor institutions have had the singular mission of caring for those who have "borne the battle" and their survivors. This is our only mission, and to do that well, we operate the largest integrated health care system in the country; the eighth largest life insurance entity covering both active duty members as well as enrolled Veterans; a sizable education assistance program; a home mortgage enterprise which guarantees over 1.4 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system, which continues to lead the country as a high performing institution.

For 2 years now, we have disciplined ourselves to understand that successful execution of any strategic plan, especially one for a Department as large as ours, requires good stewardship of resources entrusted to us by the Congress. Every dollar counts, both in the current constrained fiscal environment and during less stressful times. Accountability and efficiency are behaviors consistent with our philosophy of leadership and management. The responsibility of caring for America's Veterans on behalf of the American people demands unwavering commitment to effectiveness, accountability, and in the process, efficiency. In the past 2 years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste.

Stewardship of Resources

VA has made great progress instilling accountability and disciplined processes by establishing our Project Management Accountability System (PMAS). This approach has created an information technology (IT) organization that can rapidly deliver technology to transform VA. PMAS is a disciplined approach to IT project development whereby we hold ourselves and our private-sector partners accountable for cost, schedule and performance. In just 1 year, PMAS exceeded an 80 percent success rate of meeting customers' milestones.

In addition to PMAS, we adopted a new acquisition strategy to make more effective use of our IT resources. This new strategy, Transformation Twenty-One Total Technology (T4—for short), will consolidate our IT requirements into 15 prime contracts, leveraging economies of scale to save both time and money and enable greater oversight and accountability. T4 also includes significant goals for subcontractors and other protections to make sure Veteran-owned small businesses get a substantial share of the work. Seven of the 15 prime contracts are reserved for Veteran-owned small businesses, and four of the seven are reserved for service-disabled small businesses.

In developing the 2012 budget, VA used an innovative, Department-wide process to define and assess VA's capital portfolio. This process for Strategic Capital Invest-

ment Planning (SCIP) is a transformative tool enabling VA to deliver the highest quality of services by investing in the future and improving efficiency of operations. SCIP has captured the full extent of VA infrastructure and service gaps and developed both capital and non-capital solutions to address these gaps through 2021. SCIP also produced VA's first-ever Department-wide integrated and prioritized list of capital projects, which is being used to ensure that the most critical infrastructure needs are met, particularly in correcting safety, security, and seismic deficiencies, and creating consistent standards across the system.

The use of metrics to monitor and assess performance is another key strategy we employ to ensure the effective use of resources and accountability. For example, in November 2010, VA launched two online dashboards to offer transparency of the clinical performance of our health care system to the general public. First, VA's *Linking Information Knowledge and Systems* (LinKS) provides outcome measurement data in areas such as acute, intensive, and outpatient care. This allows management to assess a specific medical facility's performance against other facilities while, at the same time, serving as a motivational tool to improve performance. The dashboard, *Aspire,* compiles data from VA's individual hospitals and hospital systems to measure performance against national private-sector benchmarks. Financial and performance metrics also provide the foundation for monthly performance reviews that are chaired by the Deputy Secretary. These monthly meetings play a vital role in monitoring performance throughout the Department, and are designed to ensure both operational efficiency and the achievement of key performance targets.

We also demonstrated our ongoing commitment to effective stewardship of our financial resources by obtaining our 12th consecutive unqualified (clean) audit opinion on VA's consolidated financial statements. In 2010, we were successful in remediating 3 of 4 longstanding material weaknesses, a 75 percent reduction in just 1 year. We also began implementation of a number of key management initiatives that will allow us to better serve Veterans by getting the most out of our available resources:

- Reducing improper payments and improving operational efficiencies in our medical fee care program will result in estimated savings of $150 million in 2011. This includes continued expansion of the Consolidated Patient Account Centers to standardize VA's billing and collection activities.
- Implementing Medicare's standard payment rates will allow VA to better plan and redirect more funding into the provision of health care services. The estimated savings of this change in business practices in 2011 is $275 million.
- Consolidating contracting requirements, adopting strategic sourcing and other initiatives will reduce acquisition costs by an estimated $177 million in 2011.

The effective use of information technology is critical to achieving efficient health care and benefits delivery systems for Veterans. To accelerate the process for adjudicating disability claims for new service-connected presumptive conditions associated with exposure to Agent Orange, we implemented a new on-line claims application and processing system.

A recent independent study, which covered a 10-year period between 1997 and 2007, found that VA's health IT investment during the period was $4 billion, while savings were more than $7 billion.[1] More than 86 percent of the savings were due to the elimination of duplicated tests and reduced medical errors. The rest of the savings came from lower operating expenses and reduced workload. VA is continuing to modernize its electronic medical records to optimally support health care delivery and management in a variety of settings. This effort includes migrating the current computerized patient record system into a modern, Web-based electronic health record.

Advance appropriations for VA medical care require a multi-year approach to budget planning whereby 1 year builds off the previous year. This provides opportunities to more effectively use resources in a constrained fiscal environment as well as to update requirements.

Multi-Year Plan for Medical Care Budget

The 2012 budget request for VA medical care of $50.9 billion is a net increase of $240 million over the 2012 advance appropriations request of $50.6 billion in the 2011 budget. This is the result of an increase of $953 million associated with poten-

[1] **The Value From Investments In Health Information Technology At The U.S. Department Of Veterans Affairs,** Colene M. Byrne, Lauren M. Mercincavage, Eric C. Pan, Adam G. Vincent, Douglas S. Johnston, and Blackford Middleton, *Health Aff April 2010 29:4629–638.*

tial increased reliance on the VA health care system due to economic employment conditions, partially offset by a rescission of $713 million which reflects the cumulative impact of the statutory freeze on pay raises for Federal employees in 2011 and 2012. The 2013 request of advance appropriations is $52.5 billion, an increase of $1.7 billion over the 2012 budget request.

The establishment of a Contingency Fund of $953 million for medical care is requested in 2012. These contingency funds would become available for obligation if the Administration determines that additional costs, due to changes in economic conditions as estimated by VA's Enrollee Health Care Projection Model, materialize in 2012. This economic impact variable was incorporated into the Model for the first time this year. Based on experience from 2010, the need for this fund will be carefully monitored in 2011 and 2012. This cautious approach recognizes the potential impact of economic conditions as estimated by the Model to ensure funds are available to care for Veterans, while acknowledging the uncertainty associated with the new methodology incorporated into the Model estimates.

Another key building block in developing the 2012 and 2013 budget request for medical care is the use of unobligated balances, or carryover, from 2011 to meet projected patient demand. This carryover of more than $1 billion, which includes savings from operational improvements, supports anticipated costs for providing medical care to Veterans in 2012 and 2013 and is factored into VA's request for appropriations. This is a vital component of our multi-year budget and any reductions in the amount of 2011 projected carryover funding would require increased appropriations in 2012 and 2013.

Transforming VA

The Department faces an increasingly challenging operating environment as a result of the changing population of Veterans and their families and the new and more complex needs and expectations for their care and services. Transforming VA into a 21st-century organization involves a commitment to many broad challenges: to stay on the cutting edge of health care delivery; to lay the foundation for safe, secure, and authentic health record interoperability; to deliver excellent service for Veterans who apply for disability and education benefits; and to create a modern, efficient, and customer-friendly interface that better serves Veterans. In this journey, we are focusing on opportunities to improve our efficiency and effectiveness and the individual performance of our employees.

Our health informatics initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. The delivery of health care will be better tailored to the individual Veteran, yet utilize treatment regimens validated through population studies. Veterans will receive fewer unnecessary tests and procedures and more standardized care based on best practices and empirical data.

The purpose of the VA Innovation Initiative (VAi2) is to identify, fund, and test new ideas from VA employees, academia, and the private sector. The focus is on improving access, quality, performance, and cost. VA remains committed to the best system of delivering quality care and benefits to Veterans. VAi2 plays an important role by enabling the use of promising technologies in the design of cost-effective solutions. For example, TBI Toolbox pilot, located at McGuire VA Medical Center in Richmond, Virginia, will test a software tool to standardize data gathered from brain injury treatments. The strategy will allow sharing of rapidly evolving treatment guidelines at VA polytrauma centers and Department of Defense medical facilities, as well as patient progress and outcomes.

The 2012 budget continues our focus on three key transformational priorities I established when I became Secretary: Expanding access to benefits and services; reducing the claims backlog; and eliminating Veteran homelessness by 2015. These priorities address the most visible and urgent issues in VA.

Expanding Access to Benefits and Services

Expanding access to health care and benefits for underserved Veterans is vital to VA's success in best serving Veterans of all eras.

The Veterans Relationship Management (VRM) initiative will provide Veterans, their families, and survivors with direct, easy, and secure access to the full range of VA programs through an efficient and responsive multi-channel program, including phone and Web services. VRM will provide VA employees with up-to-date tools to better serve VA clients, and empower clients through enhanced self-service capabilities. Expanding the self-service capabilities of the *eBenefits* on-line portal is one of the early successes of the VRM program in 2010, and expansion of eBenefits

functionality continues through quarterly releases and programs to engage new users.

VA also saw significant progress in expanding access to Veterans. In July 2010, the *Center for Women Veterans* sponsored a forum to highlight enhancements in VA services and benefits for women Veterans which resulted in an information toolkit for advocates such as Veteran Service Organizations to share with their constituencies.

Outreach was extended directly to women when, for the first time in 25 years, VA surveyed women Veterans across the country to (1) identify in a national sample the current status, demographics, health care needs, and VA experiences of women Veterans; (2) determine how health care needs and barriers to VA health care differ among women Veterans of different generations; and (3) assess women Veterans' health care preferences in order to address VA barriers and health care needs. The interim report, released in summer 2010, informs policy and planning and provides a new baseline for program evaluation with regard to Veterans' perceptions of VA health services. The final report will be released in spring 2011.

The *Enhancing the Veteran Experience and Access to Health care* (EVEAH) initiative will expand health care for Veterans, including women and rural populations. Care alternatives will be created to meet these special population access needs, including the use of new technology. Where technology solutions safely permit, VA has already transitioned from inpatient to outpatient settings through the use of telemedicine, in-home care, and other delivery innovations.

One area of success is our expansion of telehome health-based clinical services in rural areas, which increases access, and reduces avoidable travel for patients and clinicians. In 2010, the total average daily census in telehome health was 31,155. This program will continue to expand to an estimated average daily census of 50,147 in 2012, an increase of 60 percent over 2010.

Through the *Improve Veteran Mental Health* (IVMH) initiative more Veterans will have access to the appropriate mental health services for which they are eligible, regardless of their geographic location. VA is leveraging the virtual environment with services such as the *Veterans' Suicide Prevention Chat Line* and real-time clinical video conferences.

Reducing the Claims Backlog

One of VA's highest priority goals is to eliminate the disability claims backlog by 2015 and ensure all Veterans receive a quality decision (98 percent accuracy rate) in no more than 125 days. VBA is attacking the claims backlog through a focused and multi-pronged approach. At its core, our transformational approach relies on three pillars: a culture change inside VA to one that is centered on advocacy for Veterans; collaborating with stakeholders to constantly improve our claims process using best practices and ideas; and deploying powerful 21st century IT solutions to simplify and improve claims processing for timely and accurate decisions the first time.

The Veterans Benefits Management System (VBMS) initiative is the cornerstone of VA's claims transformation strategy. It integrates a business transformation strategy to address process and people with a paperless claims processing system. Combining a paperless claims processing system with improved business processes is the key to eliminating the backlog and providing Veterans with timely and quality decisions. The Virtual Regional Office, completed in May 2010, engaged employees and subject-matter experts to determine system specifications and business requirements for VBMS. The first VBMS pilot began in Providence in November 2010. Nationwide deployment of VBMS is expected to begin in 2012.

VA is encouraging Veterans to file their Agent Orange-related claims through a new on-line claims application and processing system. Vietnam Veterans are the first users of this convenient automated claims processing system, which guides them through Web-based menus to capture information and medical evidence for faster claims decisions. While the new system is currently limited to claims related to the new Agent Orange presumptive conditions of Parkinson's Disease, Ischemic Heart Disease, and Hairy Cell Leukemias, we will expand it to include claims for other conditions.

VA also published the first set of streamlined forms capturing medical information essential to prompt evaluation of disability compensation and pension claims, and dozens more of these forms are in development for various disabilities. The content of these disability benefit questionnaires is being built into VA's own medical information system to guide in-house examinations. Veterans can provide them to private doctors as an evidence guide that will speed their claims decisions.

Another initiative to reduce the time needed to obtain private medical records utilizes a private contractor to retrieve the records from the provider, scan them into a digital format, and send them to VA through a secure transmission. This contract frees VA staff to focus on processing claims more quickly.

Additional claims transformation efforts deployed nationwide in 2010 include the Fully Developed Claims initiative to promptly rate claims submitted with all required evidence and an initiative to proactively reach out to Veterans via telephone to quickly resolve claims issues.

VA needs these innovative systems and initiatives to expedite claims processing as the number of claims continue to climb. The disability claims workload from returning war Veterans, as well as from Veterans of earlier periods, is increasing each year. Annual claims receipts increased 51percent when comparing receipts from 2005 to 2010 (788,298 to 1,192,346). We anticipate claims receipts of nearly 1.5 million in 2011 (including new Agent Orange presumptive) and more than 1.3 million claims in 2012. The funding request in the President's budget for VBA is essential to meet the increasing workload and put VA on a path to achieve our ultimate goal of no claims over 125 days by 2015.

Eliminating Veteran Homelessness

VA has an exceptionally strong track record in decreasing the number of homeless Veterans. Six years ago, there were approximately 195,000 homeless Veterans on any given night; today, there are about 75,600. VA uses a multi-faceted approach by providing safe housing; outreach; educational opportunities; mental health care and treatment; support services; homeless prevention services, and opportunities to return to employment. The National Call Center for Homeless has received 13,000 calls since March 2010, and 18,000 Veterans and families of Veterans have been provided permanent housing through VA and Housing and Urban Development Department programs. These Veterans were also provided with dedicated case managers and access to high-quality VA health care.

The *Building Utilization Review and Repurpose (BURR)* study is using VA's inventory of vacant/underutilized buildings to house homeless and at-risk Veterans and their families, where practical. Congress allocated $50 million to renovate unused VA buildings and VA has identified 94 sites with the potential to add approximately 6,300 units of housing through public/private ventures using VA's enhanced-use lease authority. This legislative authority is scheduled to lapse at the end of calendar year 2011. The Administration remains committed to this important program, and a proposal to address the expiration will accompany the Department's legislative package submitted through the President's Program. In addition to helping reduce homelessness, vacant building reuse is being considered for housing for Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans, polytrauma patients, assisted living, and seniors.

Homelessness is both a housing and health care issue, heavily burdened by depression and substance abuse. Our 2012 budget plan also supports a comprehensive approach to eliminating Veteran homelessness by making key investments in mental health programs.

The 2012 budget includes $939 million for specific programs to prevent and reduce homelessness among Veterans. This is an increase of 17.5 percent, or $140 million over the 2011 level of $799 million. This increase includes an additional $50.4 million to enhance case management for permanent housing solutions offered through the *Housing Urban Development-VA Supported Housing* (HUD–VASH) program. These funds are required to maintain the services that keep Veterans rescued from homelessness sheltered; get the remaining men and women off the streets whom we have not reached in the past; and, prevent additional Veterans from becoming homeless during a time of war and difficult economic conditions.

Mental Health

The mental health of Veterans is a more important issue now than ever before, as increasing numbers of Veterans are diagnosed with mental health conditions, often coexisting with other medical problems. More than 1.2 million of the 5.2 million Veterans seen in 2009 in VA had a mental health diagnosis. This represents about a 40 percent increase since 2004.

Veterans of Iraq and Afghanistan rely on mental health care from VA to a greater degree than earlier groups of Veterans. Diagnosis of PTSD is on the rise as the contemporary nature of warfare increases both the chance for injuries that affect mental health and the difficulties facing Veterans upon their return home. In addition, mental health issues are often contributing factors to Veterans' homelessness.

In order to address this challenge, VA has significantly invested in our mental health care workforce, hiring more than 6,000 new mental health care workers since 2005. In 2010, VA hired more than 1,500 clinicians to conduct screenings and provide treatment as well as trained over 1,000 clinicians in evidenced-based practices. The Department has also established high standards for the provision of mental health care services through the recent publication of our Handbook on Uniform Mental Health Services in VA medical centers and clinics, and we have developed an integrated mental health plan with DoD to ensure better continuity of care—especially for Veterans of Iraq and Afghanistan. The 2012 budget includes $6.2 billion for mental health care programs, an increase of $450 million, or 8 percent over the 2011 level of $5.7 billion.

Medical Care Program

We expect to provide medical care to over 6.2 million unique patients in 2012, a 1.4 percent increase over 2011. Among this community are nearly 536,000 Veterans of Iraq and Afghanistan, an increase of over 59,000 (or 12.6 percent) above 2011.

The 2012 budget will support several new initiatives in addition to our efforts to eliminate Veteran homelessness. For example, $344 million is provided for the activation of newly constructed medical facilities. In addition, we provide $208 million to implement provisions of the Caregivers and Veterans Omnibus Health Services Act and improve the quality of life for Veterans and their families.

The 2012 budget also includes operational improvements that will make VA more effective and efficient in this challenging fiscal and economic environment. VA is proposing $1.2 billion of operational improvements which include aligning fees that VA pays with Medicare rates, reducing and improving the administration of our fee-based care program, clinical staff realignments, reducing indirect medical and administrative support costs, and achieving significant acquisition improvements to increase our purchasing power.

Beginning in 2010, VHA embarked on a multi-year journey to enhance significantly the experience of Veterans and their families in their interactions with VA while continuing to focus on quality and safety. This journey required the VHA to develop new models of health care that educated and empowered patients and their families, focused not only on the technical aspects of health care but also designed for a more holistic, Veteran-centered system, with improved access and coordination of care. New Models of Health Care is a portfolio of initiatives created to achieve these objectives. We are re-designing our systems around the needs of our patients and improving care coordination and virtual access through enhanced secure messaging, social networking, telehealth, and telephone access.

An essential component of this approach is transforming our primary care programs to increase our focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams. The new model of care will improve health outcomes and the care experience for our Veterans and their families. The model will standardize health care policies, practices and infrastructure to consistently prioritize Veterans' health care over any other factor without increasing cost or adversely affecting the quality of care. This important initiative will enable VA to become a national leader in transforming primary care services to a medical home model of health care delivery that improves patient satisfaction, clinical quality, safety and efficiencies. VA Telehealth and the Home Care Model will develop a new generation of communication tools (i.e. social networking, micro-blogging, text messaging, and self management groups) that VA will use to disseminate and collect critical information related to health, benefits and other VA services.

VA is taking this historic step in redefining medical care for Veterans with the adoption of a modern health care approach called PACT, which stands for *Patient Aligned Care Team.* PACT is VA's adaptation of the popular contemporary team-based model of health care known as *Patient Centered Medical Home* designed to provide continuous and coordinated care throughout a patient's lifetime.

Medical Research

VA's many trailblazing research accomplishments are a source of great pride to our department and the Nation. Today's committed VA researchers are focusing on traumatic brain injury, post-traumatic stress disorder, post-deployment health, women's health and a host of other issues key to the well-being of our Veterans. As one of the world's largest integrated health care systems, VA is uniquely positioned to not only conduct and fund research, but to develop solutions and implement them more quickly than other health care systems—turning hope into reality for Veterans and all Americans.

VA's budget request for 2012 includes $509 million for research, a decrease of $72 million below the 2010 level. In addition, VA's research program will receive approximately $1.2 billion from medical care funding and Federal and non-Federal grants. These research funds will continue support for genomic medicine, point of care research, and medical informatics and information technology. Genomic medicine, also referred to as personalized medicine, uses information on a patient's genetic make-up to tailor prevention and treatment for that individual. The Million Veteran Program invites users of the VA health care system nationwide to participate in a longitudinal study with the aim of better understanding the relationship between genetic characteristics, behaviors and environmental factors, and Veteran health.

To leverage data in the electronic health record, *VA Informatics and Computing Infrastructure* (VINCI) is creating a powerful and secure environment within the Austin Information Technology Center. This environment will allow VA researchers to access more easily a wide array of VHA databases using custom and off-the-shelf analytical tools. The *Consortium for Health care Informatics Research* (CHIR) will provide research access to patient information in VA's *Computerized Patient Record System* (CPRS) narrative text and laboratory reports. Together, VINCI and CHIR will allow data mining to accelerate findings and identify emerging trends. Ultimately, this critical work will lead to greater effectiveness of our medical system—improving value by assisting in the prevention and cure of disease.

Veteran Benefits

The 2012 budget request for the Veterans Benefits Administration is $2.0 billion, an increase of $330 million, or 19.5 percent, over the 2010 enacted level of $1.7 billion. This budget supports ongoing and new initiatives to reduce disability claims processing time, including development and implementation of further redesigned business processes. It funds an increase in FTE of 716 over 2010 to 20,321 to assist in reducing the benefits claims backlog. It also supports the administration of expanded education benefits eligibility under the Post-9/11 GI Bill, which now includes benefits for non-college degree programs, such as on-the-job training, flight training, and correspondence courses. In addition, the 2012 budget request supports the following initiatives:

Integrated Disability Evaluation System (IDES) Program

IDES simplifies the process for disabled servicemembers transitioning to Veteran status, improves the consistency of disability ratings, and improves customer satisfaction. An IDES claim is completed in an average of 309 days; 43 percent faster than in the legacy system. VA and DoD worked together to increase the number of sites for the IDES program from 21 to 27 in 2010. The six new sites are Fort Riley, Fort Benning, Fort Lewis, Fort Hood, Fort Bragg and Portsmouth Naval Hospital, and VA and DoD will continue to expand the IDES program.

IDES is being expanded to provide Vocational Rehabilitation and Employment (VR&E) services to active duty Servicemembers transitioning through the IDES. These services range from a comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment purposes as well as support services to identify and maintain employment. The budget request includes $16.2 million for 110 FTE for the VR&E program to support IDES.

Veterans Benefits Management System (VBMS)

In 2011, we will conduct two of three planned pilot programs to test VBMS, the new paperless claims processing system. Each pilot will expand on the success of the first pilot by adding additional software components. In the 2012 budget request for information technology, we will invest $148 million to complete pilot testing and initiate a national rollout.

VetSuccess on Campus

In July 2009, VA established a pilot program at the University of South Florida called *VetSuccess on Campus* to improve graduation rates by providing outreach and supportive services to Veterans entering colleges and universities and ensuring that their health, education and benefit needs are met. The program has since expanded to include an additional seven campuses, serving approximately 8,000 Veterans. The campus Vocational Rehabilitation Counselor (VRC) and the Vet Center Outreach Coordinator liaise with school certifying officials, perform outreach, and communicate with Veteran-students to ensure their health, education, and benefit needs are met. This will enable Veterans to stay in college to complete their degrees and enter career employment. In addition, it provides Veterans the skills necessary to gain employment after graduation, which can help prevent Veteran homelessness.

The 2012 budget includes $1.1 million to expand the program to serve an additional 9,000 Veteran students on nine campuses, more than doubling the size of the current program.

National Cemetery Administration

The budget plan includes $250.9 million in operations and maintenance funding for the National Cemetery Administration (NCA). The funding will allow us to provide more than 89.8 percent of the Veteran population a burial option within 75 miles of their residences by keeping existing national cemeteries open and establishing new State Veterans cemeteries, as well as increasing outreach efforts.

VA expects to perform 115,500 interments in 2012, a 1.0 percent increase over 2011. In 2012, NCA will provide maintenance of 8,759 developed acres, 3.0 percent over the 2011 estimate, while 3,228,000 or 2.6 percent more gravesites will be given perpetual care.

The budget request will allow NCA to maintain unprecedented levels of customer satisfaction. NCA achieved the top rating in the Nation four consecutive times on the prestigious American Customer Satisfaction Index (ACSI) established by the University of Michigan. ACSI is the only national, cross-industry measure of satisfaction in the United States. On the most recent 2010 survey and over the past decade, NCA's scores bested over 100 Federal agencies and the Nation's top corporations including Ford, FedEx and Coca Cola, to name a few. Our own internal surveys confirm this exceptional level of performance. For 2010, 98 percent of the survey respondents rated the appearance of national cemeteries as excellent; 95 percent rated the quality of service as excellent.

NCA has implemented innovative approaches to cemetery operations: the use of pre-placed crypts, that preserve land and reduce operating costs; application of "water-wise" landscaping that conserves water and other resources; and installation of alternative energy products such as windmills and solar panels that supply power for facilities. NCA has also utilized biobased fuels that are homegrown and less damaging to the environment. NCA is developing an independent study of emerging burial practices throughout the world to inform its planning for the future.

Support for the Veterans Cemetery Grants Program continues in 2012 with $46 million to fund the highest priority Veterans cemetery grant requests ready for award. In addition to State cemetery grants, NCA is engaged in discussions with tribal governments regarding the construction of Veterans' cemeteries on their land and is awarding six such grants in 2011. The inclusion of tribal governments as grant recipients recognizes and empowers the authority of these groups to represent a unique group of Veterans and respond to their needs.

Capital Infrastructure

Congressional support of VA has resulted in 63 major construction projects funded in whole, or in part, since 2004. When combined with investments in our minor construction and major lease programs, this has contributed to a plant inventory which includes 5,541 owned facilities, 1,629 leased facilities, 155 million square feet of occupied space (owned and leased) and 33,718 acres of owned real property.

To best utilize resources, VA has reduced its inventory of owned vacant space by 34 percent, from 8.6 million square feet in 2001 to 5.7 million square feet in 2010. As discussed previously, we are using the *Building Utilization Review and Repurpose* (BURR) effort to reuse vacant space for homeless Veterans and their families. BURR also identifies other potential reuses of vacant and underutilized space and land within VA's inventory such as assisted living, senior housing, and housing for Veterans of Iraq and Afghanistan and their families. VA also houses homeless Veterans in public/private ventures through enhanced-use leasing.

Major Construction

The major construction request in 2012 is $589.6 million in new budget authority. In addition, VA has been the beneficiary of a favorable construction market and, as a result, is able to reallocate $135.6 million from previously authorized and appropriated projects to accomplish additional project work—resulting in a total of $725.2 million for the major construction program. This reflects the Department's continued commitment to provide quality health care and benefits through improving its infrastructure to provide for modern, safe, and secure facilities for Veterans. It includes seven ongoing medical facility projects (New Orleans, Denver, San Juan, St. Louis, Palo Alto, Bay Pines, and Seattle) and design for three new projects (Reno, West Los Angeles and San Francisco) primarily focused on safety and security corrections. One cemetery expansion will be completed to maintain and improve burial service in Honolulu, HI.

Minor Construction

In 2012, the minor construction request is $550.1 million. In support of the medical care and medical research programs, minor construction funds permit VA to realign critical services, make seismic corrections, improve patient safety, enhance access to health care and patient privacy, increase capacity for dental care, improve treatment of special emphasis programs, and, expand our research capability. We also use minor construction funds to improve the appearance of our national cemeteries. Further, minor construction resources will be used to comply with energy efficiency and sustainability design requirements.

Greening VA

The "greening VA" effort continues to be strong. There are 21 facilities Green Globe-certified and four LEED-certified. We have completed energy efficiency benchmarking for 99 percent of VA-owned facilities and obtained the Energy Star label for 30 VA sites since 2003. Electric meter installations were completed for 60 percent of targeted buildings and we are installing solar energy systems at 35 sites for a total capacity of 30 megawatts. VA has installed wind turbines at two sites, awarded two ground source heat pump projects, awarded five renewably fueled cogeneration projects, and completed one fuel cell project.

In 2012, we plan to invest $27 million for solar photovoltaic projects, $51 million in energy infrastructure improvements, $21 million in renewably fueled cogeneration using biomass (wood waste) or biogas (waste methane), $1 million in sustainable building, $14 million for wind projects, and $10 million for alternative fueling projects and expansion of environmental management systems.

Information Technology

Information Technology (IT) is integral to the delivery of efficient and effective service to Veterans. IT is not a supplementary function—it is key to the delivery of efficient, modern health care. The 2012 budget includes $3.161 billion to support Information Technology (IT) development, operations and maintenance expenses. The 2012 budget will fund the Department's highest IT priorities as well as information security programs, which protect privacy and provide secure IT operations across VA. Under our disciplined development program, PMAS, the delivery of customer software milestones exceeds 80 percent which is up from just 20 percent before the implementation of PMAS. The budget request will also fund systems that VA will develop and implement under the Caregivers and Veterans Omnibus Health Services Act of 2010.

In 2010, VA made the sound business decision to discontinue the Integrated Financial Accounting System (IFAS) and the data warehouse component of the Financial and Logistics Integrated Technology Enterprise (FLITE), but will continue to provide funding for the Strategic Asset Management (SAM) system in 2011 and 2012. OI&T will fund other continuing projects such as Compensation and Pension Records Interchange (CAPRI) which offers VBA Rating Veteran Service Representatives and Decision Review Officers help in building the rating decision. CAPRI does this by creating a more efficient means of requesting compensation and pension examinations and navigating existing patient records.

Veterans Relationship Management (VRM)

The 2012 IT budget for VRM is $108 million, and will support continued development of the on-line portal as well as the development of Customer Relationship Management capabilities.

Virtual Lifetime Electronic Record (VLER)

The Virtual Lifetime Electronic Record (VLER) is a Federal, inter-agency initiative to provide portability, accessibility and complete health, benefits, and administrative data for every servicemember, Veteran, and their beneficiaries. The goal of this major initiative is to establish the interoperability and communication environment necessary to facilitate the rapid exchange of patient and beneficiary information that will yield consolidated, coherent and consistent access to electronic records between DoD, VA, and the private sector.

VLER will not create a new data record, but it will ensure availability of reliable data from the best possible source. The VLER health component of this initiative is in operation at two pilot sites with a plan to add nine more pilots this fiscal year. VLER will work closely with other major initiatives including the Veterans Benefits Management System (VBMS) and the Veterans Relationship Management (VRM). A total of $70 million in IT funds in 2012 is required to complete the effort and move to national production and deployment of initial VLER capabilities. The VLER partnership between VA and the Department of Defense will serve as a positive

model for electronic health record interoperability in the country, which has been an Administration priority.

Summary

VA is the second largest Federal department and has over 300,000 employees. Among the many professions represented in the vast VA workforce are physicians, nurses, counselors, claims processers, cemetery groundskeepers, statisticians, engineers, architects, computer specialists, budget analysts, police, and educators—all working with the greatest determination to best serve all generations of Veterans. In addition, VA has approximately 140,000 volunteers serving Veterans at our hospitals, Vet Centers and cemeteries. There are things that they do that cannot be converted into dollar values—patience, dignity and respect for Veterans, some of whom are heavily challenged by the memories of their wars.

As advocates for Veterans and their families, VA is committed to providing the very best services. I will do everything possible to ensure that we wisely use the funds Congress appropriates for VA to improve the quality of life for Veterans and the efficiency of our operations—innovatively and transparently—as we deliver on the enduring promises of Presidents and the obligations of the American people to our Veterans.

I am honored to present the President's 2012 budget request for VA, and to represent all VA employees and the interests of those outside of VA, who share our commitment to Veterans.

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

Chairman Miller, Ranking Member Filner, 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 2012.

With the newly elected 112th Congress just beginning to conduct business, it is important to once again review and assess the efforts of the 111th Congress to provide sufficient, timely, and predictable funding for the Department of Veterans Affairs (VA), particularly the VA health-care system. The first session of the 111th Congress laid the groundwork for a historic year in 2010. In 2009 the President signed Public Law 111–81, the "Veterans Health Care Budget Reform and Transparency Act," which required the President's budget submission to include estimates of appropriations for the Medical Care accounts for fiscal year (FY) 2012 and thereafter (advance appropriations) and the VA Secretary to provide detailed estimates of the funds necessary for these accounts in budget documents submitted to Congress. Consistent with advocacy by *The Independent Budget,* the law also required a thorough analysis and public report by the Government Accountability Office (GAO) of the Administration's advance appropriations projections to determine whether that information is sound and accurately reflects expected demand and costs to be incurred in FY 2012 and subsequent years.

The Independent Budget veterans service organizations (IBVSOs) were pleased to see that in February 2010 the Administration released a detailed estimation of its FY 2011 funding needs as well as a blueprint for the advance funding needed for the Medical Care accounts of VA for FY 2012. It is important to note that last year was the first year that the budget documents included advance appropriations estimates. Unfortunately, due to differences in interpretation of the language of Public Law 111–81, the GAO did not provide an examination of the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model. *The Independent Budget* was informed that the GAO was not obligated to report on the advance appropriations projections of VA until at least 2011. The IBVSOs look forward to working with Congress to ensure that the GAO fulfills its responsibility this year.

For FY 2011, Congress provided historic funding levels for VA in the House and Senate versions of the Military Construction and Veterans Affairs appropriations bill that matched, and in some cases exceeded, the recommendations of *The Independent Budget.* Unfortunately, as has become the disappointing and recurring process, the Military Construction and Veterans Affairs appropriations bill was not completed even as the new fiscal year began October 1, 2010. Although the House passed the bill in the summer, the Senate failed to enact the bill in a timely manner. This fact serves as a continuing reminder that, despite excellent funding levels

provided over the past few years, the larger appropriations process continues to break down over matters unrelated to VA's budget due to partisan political gridlock.

Fortunately, this year, the enactment of advance appropriations has temporarily shielded the VA health-care system from this political wrangling and legislative deadlock. However, the larger VA system is still negatively affected by the incomplete appropriations work. VA still faces the daunting task of meeting ever-increasing health-care demand as well as demand for benefits and other services.

In February 2010, the President released a preliminary budget submission for VA for FY 2011. The Administration recommended an overall funding authority of $60.3 billion for VA, approximately $4.3 billion above the FY 2010 appropriated level but approximately $1.2 billion less than *The Independent Budget* recommended. The Administration's recommendation included approximately $51.5 billion in total medical care funding for FY 2011. This amount included $48.1 billion in appropriated funding and nearly $3.4 billion in medical care collections. The budget also included $590 million in funding for Medical and Prosthetic Research, an increase of $9 million over the FY 2010 appropriated level.

For FY 2011, *The Independent Budget* recommended that the Administration and Congress provide $61.5 billion to VA, an increase of $5.5 billion above the FY 2010 operating budget level, to adequately meet veterans' health-care and benefits needs. Our recommendations included $52 billion for health care and $700 million for medical and prosthetic research.

The Administration also included an initial estimate for the VA health-care accounts for FY 2012. Specifically, the budget request calls for $54.3 billion in total budget authority, with $50.6 billion in discretionary funding and approximately $3.7 billion for medical care collections. Unfortunately, because work on the FY 2011 appropriations bill was not completed, advance appropriations funding for FY 2012 remains in limbo.

Moreover, recent actions by VA suggest that the FY 2011 advance appropriations funding levels (which were affirmed in the President's budget request) may not be sufficient to support the health-care programs managed by VA. In a letter sent to Congress on July 30, 2010, VA Secretary Eric Shinseki explained that he believes the advance appropriations levels provided for FY 2011—that virtually match the Administration's request for FY 2011—will be insufficient to meet the health-care demand that VA will face this year. He also emphasized that the passage of Public Law 111–163, the "Caregivers and Veterans Omnibus Health Services Act," and Public Law 111–148, the "Patient Protection and Affordable Care Act," will increase workloads for VA. Unfortunately, the House version of the FY 2011 Military Construction and Veterans Affairs appropriations bill did not fully address this projected current year demand. Likewise, the Senate version of the appropriations bill is apparently insufficient to meet the new demand the Secretary projects.

While we appreciate the funding levels that are provided by the appropriations bills, we believe that the Secretary's letter sends a clear message that, absent some unclear "management action" by VA, more funding will be needed for FY 2011 for VA Medical Care accounts. We hope that as the House and Senate finally complete work on the FY 2011 Military Construction and Veterans' Affairs appropriations bill, proper consideration must be given to this concern.

Funding for FY 2012

Last year the Administration recommended an advance appropriation for FY 2012 of approximately $50.6 billion in discretionary funding for VA medical care. The House Committee on Appropriations supported this recommendation in H.R. 1 as well. When combined with the $3.7 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2012 is approximately $54.3 billion. However, included in the President's Budget Request for FY 2012, the Administration revised the estimates for Medical Care down by $713 million due to the proposed Federal pay freeze (a factor not included in H.R. 1).

Of particular concern to *The Independent Budget* is an ill-defined contingency fund that would provide $953 million more for Medical Services for FY 2012. Moreover, we are especially concerned that the VA presumes "management improvements" of approximately $1.1 billion to be directed towards FY 2012 and FY 2013; and yet, the VA does not define the relationship between the contingency fund and the "management improvements" that it proposes. Additionally, we are concerned about the revised estimate in Medical Care Collections from the originally projected $3.7 billion to now only $3.1 billion. Ultimately, the VA seems to recommend a revised decrease to approximately $53.9 billion for Medical Care for FY 2012.

For FY 2012, *The Independent Budget* recommends approximately $55.0 billion for total medical care, an increase of $3.4 billion over the FY 2011 operating budget

level currently proposed in H.R. 1, the "Continuing Resolution for FY 2011." 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 2012, *The Independent Budget* recommends approximately $43.8 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$41,274,505,000
Increase in Patient Workload	$1,495,631,000
Additional Medical Care Program Costs	$1,010,000,000
Total FY 2012 Medical Services	$43,780,136,000

Our growth in patient workload is based on a projected increase of approximately 126,000 new unique patients—Priority Group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.0 billion. The increase in patient workload also includes a projected increase of 87,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans at a cost of approximately $306 million.

Finally, our increase in workload includes the projected enrollment of new Priority Group 8 veterans who will use the VA health care system as a result of the Administration's continued efforts to incrementally increase the enrollment of Priority Group 8 veterans by 500,000 enrollments by FY 2013. We estimate that as a result of this policy decision, the number of new Priority Group 8 veterans who will enroll in the VA should increase by 125,000 between FY 2010 and FY 2013. Based on the Priority Group 8 empirical utilization rate of 25 percent, we estimate that approximately 31,250 of these new enrollees will become users of the system. This translates to a cost of approximately $148 million.

Lastly, *The Independent Budget* believes that there are additional projected funding needs for the VA. Specifically, we believe there is real funding needed to restore the VA's long-term care capacity (for which a reasonable cost estimate can be determined based on the actual capacity shortfall of the VA), to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service), and to meet the new projected demand associated with the provisions of P.L. 111–163, the "Caregivers and Veterans Omnibus Health Services Act." In order to restore the VA's long-term care average daily census (ADC) to the level mandated by P.L. 106–117, the "Veterans Millennium Health Care Act," we recommend $375 million. In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $250 million. This increase in prosthetics funding reflects the significant increase in expenditures from FY 2010 to FY 2011 (explained in the section on Centralized Prosthetics Funding) and the expected continued growth in expenditures for FY 2012.

Finally, we believe that there will be a significant funding need in order for the VA to address the provisions of P.L. 111–163, specifically as it relates to the caregiver provisions of the law. During consideration of the legislation, the costs were estimated to be approximately $1.6 billion between FY 2010 and FY 2015. This included approximately $60 million identified for FY 2010 and approximately $1.54 billion between FY 2011 and FY 2015. However, no funding was provided in FY 2011 to address this need. As a result, the VA will have an even greater need for funding to support P.L. 111–163 between FY 2012 and FY 2015 in order to fully implement these provisions. While the Administration claims to have provided an additional $208 million for implementation of P.L. 111–163, we remain concerned about the lack of action by the VA thus far to actually implement the law. Moreover, it is not clear where that additional funding is included in the FY 2012 Medical Care budget request. With this in mind, *The Independent Budget* recommends approximately $385 million to fund the provisions of P.L. 111–163 in FY 2012.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $5.4 billion, approximately $50 million above the FY 2011 appropriated level. Finally, for Medical Facilities, *The Independent Budget* recommends approximately $5.9 billion, approximately $160 million above the FY 2011 appropriated level. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2012 baseline of approximately $1.1 billion. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended 2 to 4 percent of plant replacement value. In fact, the VA should actually be receiving at least $1.7 billion annually for NRM (Refer to Construction section article "Increase Spending on Nonrecurring Maintenance").

For Medical and Prosthetic Research, *The Independent Budget* recommends $620 million. This represents a $39 million increase over the FY 2011 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.

Advance Appropriations for FY 2013

As explained previously, P.L. 111–81 required the President's budget submission to include estimates of appropriations for the medical care accounts for FY 2012 and subsequent fiscal years. With this in mind, the VA Secretary is required to update the advance appropriations projections for the upcoming fiscal year (FY 2012) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2013. Moreover, the law also requires a thorough analysis and public report of the Administration's advance appropriations projections by the GAO to determine if that information is sound and accurately reflects expected demand and costs.

The Independent Budget is pleased to see that the Administration has proposed an increase in the Medical Care accounts for FY 2013. We simply urge Congress to remain vigilant to ensure that the proposed funding levels for FY 2013 are in fact sufficient to meet the continued growth in demand on the health care system. Moreover, it is important to note that this is the first year that the GAO will examine the budget submission to analyze its consistency with VA's Enrollee Health Care Projection Model. *The Independent Budget* looks forward to examining all of this new information and incorporating it into future budget estimates.

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

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

Prepared Statement of Raymond C. Kelley, Director,
National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

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

The Department of Veterans Affairs (VA) manages a wide portfolio of capital assets throughout the nationwide system of health-care facilities. According to the latest VA Capital Asset Plan, VA owns 5,405 buildings and almost 33,000 acres of land. It is a vast network of facilities that requires much time and attention from VA's capital asset managers. Unfortunately, VA's infrastructure is aging rapidly. Although Congress has funded a significant number of new facilities in recent years, the vast majority of existing VA medical centers and other associated buildings are on average more than 60 years old.

Aging facilities create an increased burden on VA's overall maintenance requirements. They must be maintained aggressively so that their building systems—electrical, plumbing, capital equipment, etc.—are up to date and that these facilities are able to continue to deliver health care in a clean and safe environment. Older, out-of-date facilities do not just present patient safety issues: from VA's perspective, older buildings often have inefficient layouts and inefficient use of space and energy. This means that even with modification or renovation, VA's operational costs can be higher than they would be in a more modern structure.

VA has begun a patient-centered reformation and transformation of the way it delivers care and new ways of managing its infrastructure plan based on the needs of sick and disabled veterans in the 21st century. Regardless of what the VA healthcare system of the future may look like, our focus must remain on ensuring a lasting, accessible, modernized system that is dedicated to the unique needs of veterans

while also providing unparalleled and timely care when and where veterans need it.

The Capital Asset Realignment for Enhanced Services (CARES) process, VA's data-driven assessment of current and future construction needs, gave VA a long-term roadmap and has helped guide its capital planning process over the past 10 years. The CARES process developed a large number of significant construction objectives that would be necessary for VA to fulfill its obligation to sick and disabled veterans. Over the past several years, the Administration and Congress have made significant inroads in funding these priorities. Since fiscal year (FY) 2004, $5.9 billion has been allocated for these projects.

The Independent Budget veterans service organizations believe that CARES was a necessary undertaking and that VA has made slow but steady progress on many of these critical projects. In the post-CARES era, many essential construction projects are still awaiting authorization and funding, and the IBVSOs firmly believe that Congress cannot allow the construction needs that led to the CARES blueprint to be disregarded. Both strong oversight and sufficient funding are critical in this ongoing task of maintaining the best care for veterans.

Given the challenges presented by the CARES blueprint, including a backlog of partially funded construction projects, high costs of individual projects, and our concern about the timeliness of these 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' care—VA has proposed a new program, named "Strategic Capital Investment Planning" (SCIP). This initiative will address some of the infrastructure issues that have been noted in *The Independent Budget.*

SCIP is VA's newest approach to reevaluating its aging and underutilized infrastructure, as well as examining the lack of infrastructure in various locations around the country. The intent of SCIP, according to VA, is to scrutinize all property so that VA can best address gaps in delivery of care and services to veterans. Unlike CARES, SCIP will cover all of VA, not only Veterans Health Administration facilities; however, similar to CARES, SCIP is designed to evaluate the condition of VA infrastructure, in order to build a 10-year integrated capital plan. The goal is to improve quality of and access to VA services by modernizing facilities based on current and future needs. If SCIP is approved as VA's capital planning method, the Department plans to begin this process with the FY 2012 budget cycle.

VA has also advised the IBVSOs that SCIP is intended to address the funding shortfall of $24.3 billion to deal with major construction and facility condition assessment backlogs, inefficient use of resources, and high maintenance costs, as well as an existing commitment of about $4.4 billion to complete ongoing major construction projects. If approved, the goal of this new initiative must be a comprehensive plan that will improve quality by providing equitable access to services for all veterans across the VA system of care and services. As the age of VA structures increase, costs go up, often dramatically so. Accordingly, more funding is spent on older projects, leaving less for other maintenance and construction needs and increasing the overall budget for both major and minor construction. VA must adopt a plan for the future that will review and assess all current and future needs while providing priorities and transparency at the forefront.

A draft of the SCIP proposal was most recently provided to the IBVSOs in October 2010. The overview included a future-oriented view of VA capital needs beginning with the 2012 budget. According to VA, SCIP would adapt to changes in environment, provide a comprehensive planning process for all projects, and result in one prioritized listing of capital projects VA wide. The list intends to ensure equitable access to services for veterans across the country and includes major and minor construction, nonrecurring maintenance, and leasing.

Because SCIP is a new initiative, *The Independent Budget* veterans service organizations encourage VA to be transparent during the process and would advise that challenges must be met when reviewing all current and future needs of its aging infrastructure. The goal must be a comprehensive plan that will improve quality by maintaining equitable access to services across the VA system. The changing healthcare delivery needs of veterans, including reduced demand for inpatient beds and increasing demand for outpatient care and medical specialty services, along with limited funding available for construction of new facilities, has created a growing backlog of projects that are becoming more expensive to complete. VA has advised that SCIP is intended to address the funding shortfalls of its current capital backlog needs.

Major and Minor Construction Accounts

The Department of Veterans Affairs continues to be faced with challenges with respect to the maintenance backlog. VA regularly surveys each facility as part of

the Facilities Condition Assessment (FCA) process. VA estimates the cost of repair and uses this cost estimate as a component of its Federal Real Property Report requirements. According to its latest 5–Year Capital Plan, VA has estimated the total cost of repairing all *"D*-rated" and *"F*-rated" FCA deficiencies at a cost of $8 billion, even as it and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management. Although Congress has increased recent funding for nonrecurring maintenance (NRM), these funding levels only touch the surface of the backlog.

For years, NRM and other maintenance needs were significantly underfunded, and massive backlogs ensued (see "Increased Spending on Nonrecurring Maintenance" in this *Independent Budget*). Maintenance is only a small fraction of the major infrastructure issues confronting the system. *The Independent Budget* veterans service organizations (IBVSOs) are also concerned about the huge backlog of major medical construction projects and the political and economic reality that fully funding each of these projects and constructing them in a timely manner may not be feasible.

One of the reasons for such a large backlog of construction projects is because Congress allocated so little funding during the Capital Asset Realignment for Enhanced Services (CARES) process. The Appropriations Committees provided few resources during the initial review phase, and against our advice, preferred to wait for the result of CARES. Because of our convictions that a number of these projects needed to go forward and that they would be fully justified through any plans developed by CARES, the IBVSOs argued that a *de facto* moratorium on construction was unnecessary and would be harmful. The House agreed with our views as evidenced by its passage of the Veterans Hospital Emergency Repair Act, March 27, 2001; however, Congress never appropriated funding to carry out the purposes of that act, and the construction and maintenance backlogs continued to grow.

Upon completion of the CARES decision document in 2004, former VA Secretary Anthony Principi testified before the Health Subcommittee of the House Committee on Veterans' Affairs. He noted that CARES "reflects a need for additional investment of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care." In a November 17, 2008, letter to the Senate Committee on Veterans' Affairs, then-Secretary James Peake reported that VA would need at least $6.5 billion over the following 5 years to meet its funding requirements for major medical facility construction projects.

As noted previously, VA has proposed a new program, Strategic Capital Investment Planning (SCIP), to address some of the construction and infrastructure issues presented in *The Independent Budget.* Given the President's pledge to create a VA for the 21st century, the IBVSOs expect the Department to proceed with its SCIP plan in a transparent way, coordinate the plan through our community and other interested parties, and provide its plan to Congress for review and approval if required. However, until SCIP is fully implemented, we fear that VA's capital programs and the significant effects on the system as a whole and veterans individually will go unchanged; ultimately risking a diminution of care and services provided by VA to sick and disabled veterans in substandard facilities.

Until the SCIP plan is approved and in place across the VA network of care, the IBVSOs will continue to argue for sufficient funding needs to maintain VA's capital infrastructure and to ensure a safe and useful system for all veterans who need VA health care. With this in mind, the IBVSOs would like to outline the components of our Major and Minor Construction account requests of this *Independent Budget.*

MAJOR CONSTRUCTION

Category	Recommendation ($ in Thousands)
Major Medical Facility Construction	$1,850,000
NCA Construction	$61,000
Advance Planning	$45,000
Master Planning	$15,000
Historic Preservation	$20,000
Medical Research Infrastructure	$150,000
Miscellaneous Accounts	$60,000
TOTAL	**$2,201,000**

MINOR CONSTRUCTION

Category	Funding ($ in Thousands)
Veterans Health Administration	$450,000
National Cemetery Adminsitration	$100,000
Veterans Benefits Administration	$20,000
Staff Offices	$15,000
TOTAL	**$585,000**

Major Medical Facility Construction—This amount would allow VA to continue to address the backlog of partially funded construction projects which includes any ongoing major construction projects already approved. Depending on the stage in the process and VA's ability to complete portions of the projects within the fiscal year, remaining funds could be used for projects identified by VA as part of SCIP.

National Cemetery Administration—This amount would fund a number of national cemeteries from VA's priority list as well as potential projects identified by SCIP.

Advanced Planning—This amount helps develop the scope of the Major Medical Facility construction project as well as to identify proper requirements for their construction. It allows VA to conduct necessary studies and research similar to the planning process in the private sector.

Master Planning—A description of *The Independent Budget* request follows later in the text.

Historic Preservation—A description of *The Independent Budget* request follows later in the text.

Miscellaneous Accounts—These included the individual line items for such accounts as asbestos abatement, the judgment fund, and hazardous waste disposal.

Minor Construction Account—SCIP has already identified minor construction projects that update and modernize VA's aging physical plant, ensuring the health and safety of veterans and VA employees.

Medical Research Infrastructure—Funding needs to be allocated by Congress to allow for needed renovations to VA research facilities.

Medical Research Infrastructure—A description of *The Independent Budget* request follows later in the text.

National Cemetery Administration—This includes minor construction projects identified by SCIP to include the construction of several columbaria, installation of crypts, and landscaping and maintenance improvements.

Veterans Benefits Administration—This includes several minor construction projects identified by SCIP in addition to the leasing requirements the Veterans Benefits Administration needs. It also includes $2 million transferred yearly for the security requirements of its Manila office.

Staff Offices—This includes minor construction projects related to staff offices, including increased space and numerous renovations for the VA Office of Inspector General.

We view these issues as the critical areas that must be addressed when developing our funding recommendations. We would also like to note that within many of these categories lies ongoing and unfunded projects as well as backlogged facility repairs and maintenance.

INADEQUATE FUNDING AND DECLINING CAPITAL ASSET VALUE:

The Department of Veterans Affairs must protect against deterioration of its infrastructure and a declining capital asset value.

Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission on Accreditation of Health care Organization (JCAHO) standards, replacing aging physical plant equipment, and projects that were identified by the Capital Asset Realignment for Enhanced Services (CARES) initiative, the VA construction budget continues to be inadequate. During the past decade of underfunded construction budgets, 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 facilities have an average age of more than 60 years, and it is essential that funding be increased to renovate, repair, and replace these aging structures and physical systems. In the past, *The Independent Budget* veterans service organizations (IBVSOs) have cited the recommendations of the final Report of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF). To underscore the importance of this issue, we again cite the recommendations of the PTF. It was noted that VA health-care facility major and minor construction over the 1996 to 2001 period averaged only $246 million annually, a recapitalization rate of 0.64 percent of the $38.3 billion total plant replacement value. At this rate of investment, VA would be recapitalizing its infrastructure every 155 years.

If maintenance and restoration were considered along with major construction, VA invests less than 2 percent of plant replacement value for its entire facility infrastructure nationwide. A minimum of 5 percent to 8 percent investment of plant replacement value is necessary to maintain health-care infrastructure. If this rate is not improved, veterans could be receiving care in potentially more unsafe and dysfunctional settings as time goes along. Improvements in the delivery of health care to veterans require that VA adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities. The FY 2008 VA Asset Management Plan provided the most recent estimate of plant replacement value (PRV).Using the guidance of the Federal Government's Federal Real Property Council, VA's PRV is more than $85 billion. The IBVSOs appreciate the Administration's efforts to increase the total capital budget, and we hope future requests will be more in line with the system's needs.

Recommendations:

Congress and the Administration must ensure that adequate funds are appropriated for VA's capital needs so that it can properly invest in its physical assets to protect their value and to ensure that it can continue to provide health care in safe and functional facilities long into the future.

INCREASED SPENDING ON NONRECURRING MAINTENANCE:

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

For years *The Independent Budget* veterans service organizations (IBVSOs) have stressed the importance of providing necessary funding for nonrecurring maintenance (NRM) accounts to ensure that longstanding and continual upkeep requirements at VA facilities are met. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are onetime repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Nonrecurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

When NRM projects are ignored, the results can be detrimental to the value of a VA property and the quality of care they facilitate for veterans. Nonrecurring maintenance projects that are left undone inevitably require more costly and time-consuming repairs when they are eventually addressed. Furthermore, this lack of attention to basic structural maintenance issues jeopardizes the safety of staff and patients. Because delayed maintenance projects always require a more invasive response as opposed to situations in which NRM is responsibly managed, the IBVSOs believe neglecting such projects is tantamount to denying veterans timely and professional care and even placing them in danger.

Accordingly, to fully maintain its facilities, VA needs an NRM annual budget of at least $1.7 billion. Teams of professional engineers and cost estimators survey each medical facility at least once every 3 years as part of VA's Facilities Condition Assessment (FCA) process. These surveys assess all components of a given facility to include internal issues, such as plumbing, and external issues, such as parking and mobility barriers. Each component of a facility is given a letter grade, *A* through *F*. Areas given a grade of *F* no longer function or are in danger of imminent structural or system failure. VA estimates the cost of repair for each item that is rated *D* or *F* and then uses this cost estimate as a component of its Federal Real Property Report requirements. VA's latest 5-Year Capital Plan estimated the total cost of repairing all *D*-rated and *F*-rated FCA deficiencies at a staggering $8 billion, even as VA and Congress have greatly increased the amount of funding and resources devoted to this critical aspect of capital asset management. Since that time, NRM received a one-time allocation of $1 billion through Public Law 111–5, the "American Recovery and Reinvestment Act."

VA uses the FCA reports as part of its Federal Real Property Council metrics. The department calculates a Facility Condition Index (FCI), which is the ratio of the cost of FCA repairs compared to the cost of replacement. According to the FY 2008 Asset Management Plan, this metric has declined from 82 percent in 2006 to 68 percent in 2008. VA's strategic goal is 87 percent, and for the Department to meet that goal, it would require a sizeable investment in NRM and minor construction. Given the low level of funding NRM accounts have historically received, the IBVSOs are not surprised that basic facility maintenance remains a challenge for VA.

In addition, the IBVSOs have long-standing concerns with how this funding is apportioned once received by VA. Because NRM accounts are organized under the Medical Facilities appropriation, it has traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health-care dollars to those areas with the greatest demand for health care, and is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as intense. We are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.

Another issue related to apportionment of funding and the budget cycle has been well documented. Prior to the passage of advance appropriations, the GAO had found that the bulk of NRM funding was not apportioned until September, the final month of the fiscal year. For example, the GAO reported that 60 percent of total NRM funding for FY 2006 was allocated in September of that year.

In other words, during the first 11 month of FY 2006, only 40 percent of NRM funding had been allocated even as VA knew any unobligated funds would be remitted to the Department of the Treasury by statute. This is a shortsighted policy that impairs VA's ability to properly address its maintenance needs, and with NRM funding year to year, those conditions, which lead to a functional mishandling of essential funds, have been changed by advance appropriations. Medical accounts are now appropriated by Congress a year in advance to allow VA the ability to plan farther in advance and reduce the impact of delayed appropriations.

Not receiving timely appropriations from Congress has curtailed the positive impacts of medical spending over the years, and Congress must now provide oversight of this process to ensure that these upfront dollars for NRM and all medical spending realize their potential benefits. Congress and VA should provide oversight to ensure this change will not result in medical center managers continuing to sit on unspent funds for longer periods of time, but that it will produce more efficient spending and better planning, thereby eliminating the previous situation in which these managers sometimes spent a large portion of their maintenance funding very late in the fiscal year.

Recommendations:

VA must dramatically increase funding for nonrecurring maintenance (NRM) in line with the industry standard of 2 percent to 4 percent of plant replacement value in order to maintain modern, safe, and efficient facilities. Congress should provide VA with additional maintenance funding in the Medical Facilities appropriation to enable the Department to begin addressing the substantial maintenance backlog of Facilities Condition Assessment—identified projects.

Congress should provide NRM funding to support maintenance and upgrades to VA's research infrastructure. Portions of the NRM account should continue to be funded outside of the Veterans Equitable Resource Allocation formula so that funding is allocated to the facilities that have the greatest maintenance needs, rather than based on other criteria unrelated to the condition of facilities. Congress must provide oversight of the NRM funding allocated through the advance appropriations process to ensure NRM funds are being spent in such a way to meet their full potential.

MAINTAIN CRITICAL VA HEALTH INFRASTRUCTURE:

The Department of Veterans Affairs must execute a comprehensive, strategic health infrastructure plan that is focused on the unique needs of its veteran population. In order to reduce the growing backlog and maintenance needs of its medical facilities, Congress and the Administration must work together to secure the Department's future by designing the "VA of the 21st century."

Today we find ourselves at a critical juncture with respect to how VA health care will be delivered and what the VA of the future will be like in terms of its health care facility infrastructure. One fact is certain—our Nation's sick and disabled veterans deserve and have earned a stable, accessible VA health-care system that is dedicated to their unique needs and can provide high-quality, timely care where and when they need it. Given these significant challenges and the shift in care in many areas, in 2008 VA developed a new approach to dealing with infrastructure, the Health Care Center Facility (HCCF) leasing program. Under the HCCF leasing program, in lieu of the traditional approach to major medical facility construction, VA would obtain by long term lease a number of large outpatient clinics built privately to VA specifications. These large clinics could provide a broad range of outpatient services, including primary and specialty care as well as outpatient mental health services and ambulatory surgery.

According to VA, inpatient needs at such sites would be managed through contracts with affiliates or local private medical centers. *The Independent Budget* veterans service organizations (IBVSOs) believe that the adoption of Strategic Capital Investment Planning (SCIP) and more HCCF leasing proposals illustrate a shift toward reliance on health care leasing or a build-to-suit strategy with reliance on community providers or academic affiliates for inpatient services, rather than VA constructing its own comprehensive medical centers. We remain watchful as to how such arrangements will be managed and what unintended consequences may await sick and disabled veterans and those who represent them.

Further, SCIP must be clearly explained and integrated with all stakeholders involved in the process—specifically, how will it be developed and prioritized, and will the implementation of the HCCF model impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs? VA noted that, in addition to any new HCCF facilities, it would maintain its VA medical centers, larger independent outpatient clinics, community-based outpatient clinics (CBOCs), and rural outreach clinics.

VA has argued that adopting the HCCF model would allow it to quickly establish new facilities that would provide 95 percent of the care and services veterans need in their catchment areas, specifically primary care, a variety of specialty care services, mental health, diagnostic testing, and same-day ambulatory surgery. Initially, the IBVSOs have been supportive of the goals of this program. The HCCF model seems to offer a number of benefits in addressing VA capital infrastructure problems, including more modern facilities that meet current life-safety codes, better geographic placements, increased patient safety, reductions in veterans' travel costs, and increased personal convenience.

This process could also offer the advantage of quick completion as compared to the existing major construction design-authorization-appropriation process, thus allowing more flexibility to respond to changes in patient loads and technologies and making possible net savings in operating costs and in facility maintenance.

While it offers these obvious advantages, the HCCF model raises concerns about VA's plan for providing inpatient services. VA suggests it will contract for these essential services with affiliates or community hospitals. The IBVSOs believe this program would privatize many services that we believe VA should continue to provide directly to veterans. We are also deeply concerned about the overall impact of this new model on the future of VA's system of care, including the potential unintended consequences on continuity of high quality care; maintenance of VA's specialized medical programs for spinal cord injury, blindness, amputation care, and other health challenges of seriously disabled veterans; delivery of comprehensive services; its recognized biomedical research and development programs; and, in particular, the impact on its renowned graduate medical education and health profession training programs, in conjunction with long-standing affiliations with nearly every health professions university in the Nation.

Moreover, we believe the HCCF model could well challenge VA's ability to provide alternatives to maintaining directly its existing 130 nursing home care units now called "community living centers"), homelessness programs, domiciliary facilities, compensated work therapy programs, hospice and respite, adult day health-care units, the Health Services Research and Development Program, and a number of other highly specialized services, including 24 spinal cord injury/dysfunction centers, 10 blind rehabilitation centers, a variety of unique "centers of excellence" (in geriatrics, gerontology, mental illness, Parkinson's, and multiple sclerosis), and various critical care programs for veterans with serious and chronic mental illnesses.

In general, the IBVSOs believe the HCCF proposal could be a positive development, with good potential. But the process must be transparent to all those in-

volved—veterans, stakeholders, community leaders, VA employees—and there must be a well-thought-out and well-communicated plan to carry out the HCCF policy. It has been proven that leasing can help to diminish long and costly in-house construction delays and can be adaptable, especially when compared to costs for renovating existing VA major medical facilities. Leasing options have been particularly valuable for VA as evidenced by the success of the leased-space arrangements for many VA community-based outpatient clinics, Vet Centers, and leased VA regional office staff expansions. However, the IBVSOs remain concerned with VA's plan for obtaining inpatient services under the HCCF model, and have many unanswered questions. There are major concerns with the pervasive contracting that would be mandated by this type of proposal.

Acknowledging all the changes taking place in health care, VA needs to look very closely at all its infrastructure plans, and needs to do a better job explaining to veterans, their representatives, and Congress what its plans are for every location, with a full exposition based on facts.

Responding to a Congressional request, VA addressed a number of specific questions related to its plan for the HCCF leasing initiative, including whether studies had been carried out to determine the effectiveness of the current approach; the full extent of the current construction backlog of projects; its projected cost over the next 5 years to complete; the extent to which national veterans organizations were involved in the development of the HCCF proposal; the engagement of community health-care providers related to capacity and willingness to meet veterans' needs; the ramifications on the delivery of long-term care and specialized services; and whether it would be able to ensure that needed inpatient capacity would remain available indefinitely.

Based on its response, the IBVSOs believe VA has a reasonable foundation for assessing capital needs and has been forthright with the estimated total costs for ongoing major medical facility projects, and that the HCCF model can be a basis for meeting some of these needs at lower cost. We agree with VA's assertion that it needs a balanced capital assets program, of both owned and leased buildings, to ensure that demands are met under current projections. Likewise, we agree with VA that the HCCF concept could provide modern health-care facilities relatively quickly that might not otherwise be available because of the predictable constraints of VA's major construction program.

However, what is not clear to us is the extent to which VA plans to deploy the HCCF model. In areas where existing CBOCs need to be replaced or expanded with additional services due to the need to increase capacity, the HCCF model would seem appropriate and beneficial.

On the other hand, if VA plans to replace the majority or even a large fraction of all VA medical centers with Health Care Center Facilities, such a radical shift would pose a number of concerns for us. Nevertheless, the IBVSOs see this challenge as only a small part of the overall picture related to VA health infrastructure needs. The emerging HCCF plan does not address the fate of VA's 153 medical centers located throughout the Nation that are on average 60 years of age or older. It does not address long-term-care needs of the aging veteran population, inpatient treatment of the chronically and seriously mentally ill, the unresolved rural health access issues, the lingering questions on improving VA's research infrastructure, or the fate of VA's academic training programs. Fully addressing these and related questions is extremely important and will have an impact on generations of sick and disabled veterans far into the future.

We would like to reiterate: Creating a VA of the 21st century must include all stakeholders' interests. The IBVSOs expect VA to establish any new infrastructure plan in a transparent way; vet that plan through our community and other interested parties; and provide its plan to Congress for review, oversight, and approval if required by law. Congress and the Administration must work together to secure VA's future to design a VA of the 21st century. It will take the joint cooperation of Congress, veterans' advocates, and the Administration to support this reform, while setting aside resistance to change, even dramatic change, when change is demanded and supported by valid data.

Finally, one of our community's frustrations with respect to VA's infrastructure plans is lack of consistent and periodic updates, specific information about project plans, and even elementary communications. The IBVSOs ask that VA improve the quality and quantity of communications with us, our larger community, enrolled veterans, concerned labor organizations, and VA's own employees, affiliates, and other stakeholders as the VA capital planning process moves forward. We believe that all of these groups must be made to understand VA's strategic plan and how it may affect them, positively and negatively. Talking openly and discussing potential changes will help resolve the understandable angst about these complex and impor-

tant questions of VA health-care infrastructure. While we agree that VA is not the sum of its buildings, and that a veteran patient's welfare must remain at the center of the Department's concern, VA must be able to maintain an adequate infrastructure around which to build and sustain "the best care anywhere."

If VA keeps faith with these principles, the IBVSOs are prepared to aid and support VA in accomplishing this important goal.

Recommendations:

VA must develop a well-thought-out health-care infrastructure and strategic plan that becomes the means for it to establish a veterans health-care system for the 21st century. Congress, the Administration, and internal and external stakeholders must work together to secure VA's future, while maintaining the integrity of the VA health-care system and all the benefits VA brings to its unique patient population.

VA's new proposal, the Strategic Capital Investment Planning (SCIP) and VA's health Care Center facility leasing proposal must be clearly explained and integrated with all stakeholders involved in the process, including how will it be developed, prioritized, and implemented, and how it will impact VA's specialized medical care programs, continuity of high-quality care, delivery of comprehensive services, protection of VA biomedical research and development programs, and particularly the sustainment of VA's renowned graduate medical education and health profession training programs.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the authors of this *Independent Budget,* concerning its plans for future infrastructure improvements through the HCCF leasing and other approaches.

VA must improve the quality and quantity of communications with internal and external communities of interests, including the authors of this *Independent Budget,* concerning its plans for future infrastructure improvements through the HCCF leasing and other approaches.

EMPTY OR UNDERUTILIZED SPACE AT MEDICAL CENTERS:

The Department of Veterans Affairs must use empty and underutilized space appropriately.

The Department of Veterans Affairs maintains approximately 1,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. It costs VA from $1 to $3 per square foot per year to maintain a vacant building. Studies have shown that the VA medical system has extensive amounts of empty space that can be reused for medical services. It has also been shown 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, as well as the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable, and if it is, it is usually at a prohibitive cost. Unoccupied rooms on the eighth floor used as a medical surgical unit, for example, cannot be used to offset a deficiency of space in the second floor surgery ward. Medical space has a very critical need for inter- and 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 on everything around it. These secondary impacts greatly increase construction expense and can disrupt patient care. Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot necessarily be altered. Different aspects of medical care have various requirements based upon these permanent characteristics. Laboratory or clinical spacing cannot be interchanged with ward space because of the different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Laboratories should have long structural bays and function best without windows. When renovating empty space, if an area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient if simply renovated. Renovating old space, rather than constructing new space, often provides only marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would cost. Factoring in domino or secondary costs, the renovation can end up costing more while producing a less satisfactory result.

Renovations are sometimes appropriate to achieve those critical functional adjacencies, but are rarely economical. As stated earlier in this analysis, the average age of VA facilities is 60 years. Many older VA medical centers that were rapidly

built in the 1940s and 1950s to treat a growing war veteran population are simply unable to be renovated for modern needs. Most of these so called "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. Many of them also have long, narrow wings radiating from small central cores, 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 existing unused space is its location. Much of it is not in a prime location; otherwise, it would have been previously renovated or demolished for new construction. This space is typically located in outlying buildings or on upper floor levels and is unsuitable for modern use.

Public Law 108–422 incentivized VA's efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a Capital Asset Fund (CAF). Further, that law required VA to develop short- and long-term plans for the disposal of these facilities in an annual report to Congress. VA must continue to develop these plans, working in concert with architectural master plans and the long-range vision for all such sites.

Recommendations:

VA must develop a plan for addressing its excess space in non historic properties that is not suitable for medical or support functions because of its permanent characteristics or locations

PROGRAM FOR ARCHITECTURAL MASTER PLANS:

Each VA medical facility must develop a detailed master plan and delivery models for quality health care that are in a constant state of change as a result of factors that include advances in research, changing patient demographics, and new technology.

The Department of Veterans Affairs must design facilities with a high level of flexibility in order to accommodate new methods of patient care and new standards of care. VA 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 existing programs based on projected needs through capital planning strategy.

A facility master plan is a comprehensive tool to examine and project potential new patient care programs And how they might affect the existing health-care facility design. It also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future projects and facility needs. This often results in shortsighted construction that restricts rather than expands options for the future. *The Independent Budget* veterans service organizations 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; $15 million should be budgeted for this purpose.

We 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. VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

Recommendations:

Congress must appropriate $15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan is to be reviewed every 5 years and modified accordingly based on changing needs, technologies, new programs, and new patient care delivery models.

ARCHITECT–LED DESIGN–BUILD PROJECT DELIVERY:

The Department of Veterans Affairs must evaluate use of architect-led design-build project delivery.

VA currently employs two project delivery methods: design-bid-build and design-build. Design-bid build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

Design-bid-build is the most common method of project design and construction. In this method, an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents, contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to insure that the design intent and quality of the project is reflected in the delivered facility. In this project delivery model, the architect is an advocate for the owner.

The design-build project delivery method 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 VA and reduce the project delivery schedule. Design build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project.

This places the contractor as the design builder. One particular method of project delivery under the design-build model is called contractor-led design build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In this method, as used by VA, a second architect and design professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor rather than an advocate for VA, the contractor may sacrifice the quality of material and systems in order to add to his own profits at the expense of VA. In addition, much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led 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 often do 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, compromising VA's design standards.

Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment.

This may force VA to go to some form of formal dispute resolution, such as litigation or arbitration. An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This has many benefits to VA. These include ensuring the quality of the project, since the architect reports directly to VA.

A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result, the architect is able to access pricing options during the design process and develop the design accordingly. Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project commences, the request-for-proposal process is streamlined. As a result, the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led design-build model reduces the number of project claims and disputes. It prevents the contractor from "low-balling," a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating VA change orders along the way.

In addition to selecting the proper method of project delivery, there is much to learn from the design and construction process for each individual project. It is important for VA to apply these "lessons learned" to future projects.

Recommendations:

VA must establish a category system Ranking design/construction project types by complexity. This system should be used to determine if the project is a candidate

for the design-build method of project management. The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects,

VA must evaluate the use of architect-led design build as the preferred method of project delivery in place of contractor-led design-build project delivery. 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. This information should be compiled and used as a guide to future projects. This document should be updated regularly to include projects as they are completed.

INCREASE NEED FOR VA RESEARCH SPACE AND INFRASTRUCTURE MPROVEMENTS:

The Department of Veterans Affairs needs research space renovations and improved infrastructure.

A state-of-the-art physical environment for VA research promotes excellence in science as well as teaching and patient care. Research opportunities help VA recruit and retain the best and brightest clinician scientists to care for veterans. However, many VA facilities effectively have run out of usable research space. Also, research "wet" laboratory ventilation, electrical supply, plumbing, and other projects appear frequently on internal VA lists of needed upgrades along with research space renovations and new construction, but these projects languish due to the weight VA places on direct medical care projects as opposed to research space and facility needs.

Five years ago, the House Appropriations Committee expressed concern (House Report 109–95) 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." The 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.

To comply, VA initiated a comprehensive assessment of VA research infrastructure. To prompt VA to complete its long overdue assessment, House Report 111–564 accompanying the FY 2011 VA appropriations bill directed the Department to provide its final report to Congress by September 1, 2010, with details of any recent renovations or new construction.

As of publication of this *Independent Budget,* VA had not released the results of its review. According to an October 26, 2009, VA report to the VA National Research Advisory Committee, however, preliminary results of the review indicated, "there is a clear need for research infrastructure improvements throughout the system, including many that impact on life safety."

The Independent Budget veterans service organizations (IBVSOs) are concerned that a significant cause of VA's research infrastructure neglect is that neither VA nor Congress provides direct funding for research facilities. The VA Medical and Prosthetic Research appropriation excludes funding for construction, renovation, or maintenance of VA research facilities. VA researchers must rely on their local facility management 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 facility direct patient care needs (such as medical services infrastructure, capital equipment upgrades and replacements, and other medical maintenance needs) for funds provided under either the Major Medical Facility, Minor Construction, or Medical Facilities appropriations accounts.

The IBVSOs believe that correction of VA's known infrastructure deficiencies should become a higher VA and Congressional priority. Therefore, we recommend VA promptly submit to Congress the report it requested in 2006, provide construction funding sufficient to address VA's five highest priority research facility construction needs as identified in its facilities assessment report, and approve a pool of funding targeted at renovating existing research facilities to address the current and well-documented shortcomings in research infrastructure. For these funding needs we recommend $150 million and $50 million, respectively. Additionally, an emerging problem is that VA research facilities often are not an integral component of planning for new VA medical centers (including new medical centers in Las Vegas, Denver, and Orlando).

Modern-day biomedical research needs customized power, safety, privacy, and configuration requirements that should be fundamental to the new construction planning processes, not an expensive afterthought. The IBVSOs urge the Administration to require that research space be made an integral component of planning for every new medical center and that such space be designed by architects and engineers experienced in contemporary research facility requirements.

Recommendations:

Congress should require VA to report its findings from its research infrastructure review, now pending more than 5 years. Congress should authorize construction of, and appropriate $150 million in FY 2012 to advance, the five highest priority research construction projects identified by VA in its research infrastructure review, and provide VA an additional $50 million in maintenance funding (in the Non Recurring Maintenance account) in FY 2012 to address current shortfalls in VA's research laboratories and other research space.

PRESERVATION OF VA'S HISTORIC STRUCTURES:

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The Department of Veterans Affairs 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, of those who cared for their wounds, and of those who helped to build this great Nation. Of the approximately 2,000 historic structures in the VA historic building inventory, many are neglected and deteriorate year after year because of a lack of any funding for their upkeep. 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 but may be used for other purposes. For the past 7 years, *The Independent Budget* veterans service organizations (IBVSOs) have recommended that VA conduct an inventory of these properties to classify their physical condition and study their potential for adaptive reuse. VA has moved in that direction; historic properties have been identified. Many of these buildings have been placed in an "Oldest and Most Historic" list and require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone, they cannot be recaptured. For example, the Greek Revival Mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can be restored and used as a facility or network training space for about $1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility at a cost of $6 million. These expenditures would be much less than the cost of new facilities and would preserve history simultaneously. The preservation of VA's historic buildings also fits into the VA's commitment to "green" architecture. Materials would be reused, reducing the amount of resources needed to manufacture and transport new materials to building sites.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds. The IBVSOs encourage VA to use the tenants of Public Law 108–422, the "Veterans Health Programs Improvement Act," in improving the plight of VA's historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital assets fund resulting from the sale or leases of other unneeded VA properties.

Recommendations:

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties. VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or the Members of the Committee may have.

Prepared Statement of Joseph A. Violante, National Legislative Director, Disabled American Veterans

Chairman Miller, Ranking Member Filner and Members of the Committee:

On behalf of the Disabled American Veterans and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to present the recommendations of *The Independent Budget* for the fiscal year 2012 budget in the area of veterans' benefits. As you know, *The Independent Budget* is a collaboration amongst the DAV, AMVETS, Paralyzed Veterans of America and Veterans of Foreign Wars.

First, however, I want to congratulate you, Chairman Miller, on your selection to lead this great Committee. I also want to welcome back the Committee's Ranking Minority Member and past Chairman, Bob Filner. The DAV looks forward to working together with both of you, as well as all of the returning and new Members of the Committee, to improve the lives of our Nation's veterans, particularly disabled veterans, their families and survivors.

For the past 25 years, *The Independent Budget* has provided Congress and the Administration with budget and policy recommendations to strengthen programs serving America's veterans. I note with appreciation that Public Law 111–275, the Veterans Benefits Act of 2010, which was enacted in the last Congress, contained a number of provisions addressing recommendations made to this Committee by *The Independent Budget*. In particular, the new law includes an increase in the automobile grant from $11,000 to $18,900; an expansion of eligibility for Aid and Attendance benefits for veterans suffering from traumatic brain injury; an increase in Supplemental Service-Disabled Veterans' Insurance (SDVI or "RH") from $20,000 to $30,000; and an increase in Veterans Mortgage Life Insurance (VMLI) for disabled veterans from $90,000 to $150,000 effective October 1, 2011, with a 2012 increase to $200,000. Each of these and many other provisions in this new law will make a real difference in the lives of thousands of disabled veterans and their families and we thank this Committee for helping to enact this legislation.

SUFFICIENT STAFFING FOR THE VETERANS BENEFITS ADMINISTRATION

Mr. Chairman, for fiscal year 2012, *The Independent Budget* recommends only modest increases in personnel levels for the Veterans Benefits Administration (VBA), and those increases are targeted at Vocational Rehabilitation and Employment (VR&E) and the Board of Veterans' Appeals (BVA). Over the past couple of years, with strong support from Congress, VBA's Compensation and Pension Service has seen a significant increase in personnel to address the rapidly rising workload they face. It is important to note that this large increase in claims processors could actually result in a short-term net decrease in productivity, due to experienced personnel being taken out of production to conduct training, and the length of time it takes for new employees to become fully productive. While we do not recommend additional staffing increases at this time, we do recommend that VBA conduct a study on how to determine the proper number of full-time employees necessary to manage its growing claims inventory so that claims are decided accurately and in a timely manner.

The Independent Budget does, however, recommend that Congress authorize at least 160 additional full-time employees for the VR&E Service for fiscal year (FY) 2012, primarily to reduce current case manager workload. A 2009 study by the GAO found that 54 percent of Department of Veterans Affairs Regional Offices (VAROs) reported they had fewer counselors than they needed and 40 percent said they had too few employment coordinators. VR&E officials indicated that the current caseload target is 1 counselor for every 125 veterans, but that ratio is reported to be as high as 1 to 160 in the field. An increase of 100 new counselors would address that gap. Given its increased reliance on contract services, VR&E also needs an additional 50 full-time employee equivalents (FTEE) dedicated to management and oversight of contract counselors and rehabilitation and employment service providers. In addition, VR&E has requested at least 10 FTEE in FY 2012 to expand its college program—'Veteran Success on Campus," and we support that request.

With the number of claims for benefits increasing over the past several years, so too is the number of appeals to the BVA. On average, BVA receives appeals on 5 percent of all claims, a rate that has been consistent over the past decade. With the number of claims projected to rise significantly in the coming years, so too will the workload at BVA, and thus the need for additional personnel. Funding for the BVA must rise at a rate commensurate with its increasing workload so it is properly staffed to decide veterans' appeals in an accurate and timely manner.

CLAIMS PROCESSING REFORM: GET IT RIGHT THE FIRST TIME

The VBA is at a critical juncture in its efforts to reform an outdated, inefficient, and overwhelmed claims-processing system. After struggling for decades to provide timely and accurate decisions on claims for veterans' benefits, the VBA over the past year has started down a path that may finally lead to essential transformation and modernization, but only if it has the leadership necessary to undergo a cultural shift in how it approaches the work of adjudicating claims for veterans benefits.

The number of new claims for disability compensation has risen to more than 1 million per year and the complexity of claims have also increased as complicated new medical conditions, such as traumatic brain injury, have become more preva-

lent. To meet rising workload demands, *The Independent Budget* has recommended, and Congress has provided, significant new resources to the VBA over the past several years in order to increase their personnel levels. Yet despite the hiring of thousands of new employees, the number of pending claims for benefits, often referred to as the backlog, continues to grow.

As of January 31, 2011, there were 775,552 pending claims for disability compensation and pensions awaiting rating decisions by the VBA, an increase of 289,081 from 1 year ago. About 41 percent of that increase is the result of the Secretary's decision to add three new presumptive conditions for Agent Orange (AO) exposure: ischemic heart disease, B-cell leukemia, and Parkinson's disease. Even discounting those new AO-related claims, the number of claims pending rose by 171,522, a 37 percent increase of pending claims over just the past year. Overall, there are 331,299 claims that have been pending greater than VA's target of 125 days, which is an increase of 147,930, up more than 80 percent in the past year. Not counting the new AO-related, over 50 percent of all pending claims for compensation or pension are now past the 125-day target set by the VBA.

Worse, by the VBA's own measurement, the accuracy of disability compensation rating decisions continues to trend downward, with their quality assurance program, known as the Systematic Technical Accuracy Review (STAR) reporting only an 83 percent accuracy rate for the 12-month period ending May 31, 2010. Moreover, VA's Office of Inspector General found additional undetected or unreported errors that increased the error rate to 22 percent. Complicating the Department's problems is its reliance on an outdated, paper-centric processing system, which now includes more than 4.2 million claims folders.

Faced with all of these problems, VA Secretary Shinseki last year set an extremely ambitious long-term goal of zero claims pending more than 125 days and all claims completed to a 98 percent accuracy standard. Throughout the year he repeatedly made clear his intention to "break the back of the backlog" as his top priority. While we welcome his intention and applaud his ambition, we would caution that eliminating the backlog is not necessarily the same goal as reforming the claims-processing system, nor does it guarantee that veterans are better served.

The backlog is not the problem, nor even the cause of the problem; rather, it is only one symptom, albeit a very severe one, of a much larger problem: too many veterans waiting too long to get decisions on claims for benefits that are too often wrong. If the VBA focuses simply on getting the backlog number down, it can certainly achieve numeric success in the near term, but it will not necessarily have addressed the underlying problems nor taken steps to prevent the backlog from eventually returning. To achieve real success, the VBA must focus on creating a veterans' benefits claims-processing system designed to "get each claim done right the first time." Such a system would be based upon a modern, paperless information technology and workflow system focused on quality, accuracy, efficiency, and accountability.

Recognizing all of the problems and challenges discussed above, we have seen some positive and hopeful signs of change. VBA leadership has been refreshingly open and candid in recent statements on the problems and need for reform. Over the past year, dozens of new pilots and initiatives have been launched, including a major new IT system that is now being field-tested. The VBA has shared information with the veterans service organizations (VSOs) about its ongoing initiatives and sought feedback on these initiatives. These are all positive developments.

Yet despite the new openness and outreach to the VSO community, we remain concerned about VBA's failure to fully integrate service organizations in reforming the claims process. VSOs not only bring vast experience and expertise about claims processing, but our local and national service officers hold power of attorney for hundreds of thousands of veterans and their families. In this capacity, VSOs are an integral component of the claims process. We make the VBA's job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources to develop and adjudicate them. VBA leadership must commit to a true partnership with service organizations, and infuse this new attitude throughout the VBA from central office down to each of the 57 regional offices.

Mr. Chairman, the VBA must also change how it measures success and rewards performance in a manner designed to achieve the goal of "getting it right the first time." Unfortunately, most of the measures that the VBA employs today, whether for the organization as a whole, or for regional offices or employees, are based primarily on measures of production, which reinforces the goal of ending the backlog. VBA must change how it measures and reports progress and success so that there are more and better indicators of quality and accuracy. VBA must also continue to review employee performance standards to ensure that it creates incentives and accountability to achieve quality and accuracy, not just increased speed or production.

PILOT PROGRAMS

As the VBA moves forward with dozens of pilots and initiatives designed to modernize and streamline the claims-processing system, it is imperative that the VBA have a systematic method for analyzing and integrating "best practices" that improve quality and accuracy, rather than just those that may increase production. One of the most important new initiatives is the use of templates for medical evidence, which VBA calls Disability Benefits Questionnaires (DBQs). There are currently three DBQs that have been approved for use in claims for the three new presumptive conditions associated with Agent Orange exposure: ischemic heart disease, Parkinson's disease, and B-cell leukemia. An additional 76 DBQs are in various stages of the development and approval process. We support the use of DBQs as a method to streamline and improve the quality and timeliness of decisions; however, it is crucial that DBQs are properly completed, either by VA or private medical examiners. VBA employees must be properly trained so they understand that DBQs are but one piece of evidence that must be considered in the development and decision-making process. VBA's rating specialists must properly consider the evidentiary weight and value of all evidence related to the claim and address it adequately in the reason and bases of the subsequent decision.

One of the major new claims process reform initiatives is the Fully Developed Claims (FDC) program, which began as a pilot program mandated by Public Law 110–389, and was rolled out to all VAROs last year. We were pleased that VBA modified the FDC application process at our request so that a veteran could make an informal notification to the VBA of his or her intention to file a FDC claim, thereby protecting the earliest effective date for receipt of benefits. However, we have been hearing numerous reports from the field that local ROs are not allowing such informal claims to be made. We have also been told that that the participation level of veterans in the FDC program remains low. We continue to believe in the FDC program and urge this Committee to work with us and VBA to address the obstacles to its success.

In order to synthesize the "best practices" from all of the ongoing pilots, VBA recently started a new Integration Laboratory at their Indianapolis Regional Office. Given all of the pressure to "break the backlog" by increasing production, we have concerns about whether the VBA will successfully extract and then integrate the best practices from so many ongoing initiatives. Given the enormous pressure to reduce the backlog, we are concerned that there could be a tendency to focus on process improvements that result in greater production rather than those that lead to greater quality and accuracy.

Congress must continue to provide aggressive oversight of the VBA's myriad ongoing pilots and initiatives to ensure that practices adopted and integrated into a cohesive new claims process are judged first and foremost on their ability to help VA get claims "done right the first time."

TRAINING AND QUALITY CONTROL

Mr. Chairman, two longstanding weaknesses of VBA's claims adjudication process are training and quality control, which should be linked to create a single continuous improvement program, both for employees and for the claims process itself. Quality control programs can identify areas and subjects that require new or additional training for VBA employees and better training programs for employees and managers should improve the overall quality of the VBA's work.

VBA's primary quality assurance program is the STAR program. The STAR program was last evaluated by the VA Office of Inspector General (OIG) in March 2009, with the OIG finding that STAR does not provide a complete assessment of rating accuracy. Although the STAR reviewers found that the national accuracy rate was about 87 percent, the OIG found additional errors and projected an overall accuracy rate of only 78 percent. In addition to rectifying errors found by the OIG, we recommend that the VBA establish a true quality control program that looks at claims "in-process" in order to determine not just whether a proper decision was made, but how it was arrived at in order to identify ways to improve the system. The data from all such reviews should be incorporated into the VBA's new information technology systems being developed so that analysis can provide management and employees important insights into processes and decisions. This in turn would lead to quicker and more accurate decisions on benefits claims, and most important, the delivery of all earned benefits to veterans, particularly disabled veterans, in a timely manner.

Training is essential to the professional development of an individual and tied directly to the quality of work they produce, as well as the quantity they can accurately produce. Veterans service organization officers have been told by many VBA employees that meeting production goals is the primary focus of management,

whereas fulfilling training requirements and increasing quality is perceived as being secondary. An overemphasis on productivity must not interfere with the training of new employees who are still learning their job.

The GAO recently conducted a study to determine the appropriateness of training for experienced claims processors and the adequacy of VBA's monitoring and assessment of such training. Of particular interest are GAO findings that experienced claims processors' had concerns with the training received—specifically the hours, amount, helpfulness, methods, and timing of training. Likewise, as the GAO report pointed out, there is very little done by the VBA to ensure the required training is completed or to assess the adequacy and consistency of the training, nor to properly ascertain the total number of employees who have met the annual training requirement. In fact, only one VARO met the annual training requirement and nine VAROs had less than half their employees meet the annual training requirement. It is simply unacceptable to have only one VARO meeting the most basic requirement of ensuring that all its employees complete 80 hours of training. VBA must place greater emphasis on training by implementing stricter monitoring mechanisms for all VAROs and ensuring that they are held accountable for failure to meet this minimal standard.

Mr. Chairman, Public Law 110–389, the "Veterans' Benefits Improvement Act of 2008," required the VBA to develop and implement a certification examination for claims processors and managers; however, today there are still gaps in the implementation of these provisions. While tests have been developed and piloted for Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs), additional tests need to be developed and deployed for Decision Review Officers and supervisory personnel. None of these certification tests are mandatory for all employees, nor are they done on a continuing basis.

The VBA cannot accurately assess its training or measure an individual's knowledge, understanding, or retention of the training material without regular testing. It is important, however, that all testing and certification be applied equally to employees and to the people who supervise and manage them. All VBA employees, coaches, and managers should undergo regular testing to measure job skills and knowledge, as well as the effectiveness of the training.

Equally important, testing must properly assess the skills and knowledge required to perform the work of processing claims. Many employees report that the testing does not accurately measure how well they perform their jobs, and there have been reports that significant numbers of otherwise qualified employees are not able to pass the tests. VBA must ensure that certification tests are developed that accurately measure the skills and knowledge needed to perform the work of VSRs, RVSRs, decision review officers, coaches and other managers.

Successful completion of training by all employees and managers must be an absolute requirement for every VARO and must be a shared responsibility of both employees and management. Managers must be held responsible for ensuring that training is offered and completed by all of their employees. However it is also the responsibility, as well as part of the performance standard, for employees to complete their training requirements. Managers must provide employees with the time to take training and employees must fully and faithfully complete their training as offered. Neither should be able or pressured to just "check the box" when it comes to training.

NEW VBA INFORMATION TECHNOLOGY SYSTEMS

Mr. Chairman, undoubtedly the most important new initiative underway at the VBA is the Veterans Benefits Management System (VBMS), which is designed to provide the VBA with a comprehensive, paperless, and ultimately rules-based method of processing and awarding claims for VA benefits, particularly disability compensation and pension. Following initial design work, the VBMS had its first phase of development in Baltimore last year where a prototype system was tested in a virtual regional office environment. The first actual pilot of the VBMS system was begun in November 2010 at the Providence, Rhode Island Regional Office. The 6-month pilot program began with simulated claims and was scheduled to begin working on actual "live" claims early this year. A second 6-month pilot is expected to begin in May 2011 at the Salt Lake City Regional Office, which will build on the work begun at Providence. A third pilot is scheduled to begin in November 2011 at an undesignated location, and the final national rollout of the VBMS is schedule to take place in 2012.

Although the development and deployment of a modern information technology (IT) system to process claims in a paperless environment is long overdue, we have concerns about whether the VBMS is being rushed to meet self-imposed deadlines in order to show progress toward "breaking the back of the backlog." While we have

long believed that the VBA's IT infrastructure was insufficient, outdated, and constantly falling further behind modern software, Web, and cloud-based technology standards, we would be equally concerned about a rushed solution that ultimately produces an insufficiently robust IT system.

Given the highly technical nature of modern IT development, we would urge Congress to fully explore these issues with the VBA and suggest that it could be helpful to have an independent, outside, expert review of the VBMS system while it is still early enough in the development phase to make course corrections, should they be necessary.

To be successful, the VBMS must include the maximum level of rules-based decision support feasible at the earliest stages of development in order to build a system capable of providing accurate and timely decisions, as well as include real-time, quality control as a core component of the system. VBA must also commit to incorporating all veterans' legacy paper files into the paperless environment of the VBMS within the minimum amount of time technically and practically feasible.

DISABILITY COMPENSATION AND QUALITY OF LIFE

The Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation published a report in 2007, "A 21st Century System for Evaluating Veterans for Disability Benefits," recommending that the current VA disability compensation system be expanded to include compensation for nonwork disability (also referred to as "noneconomic loss) and loss of quality of life. Nonwork disability refers to limitations on the ability to engage in usual life activities other than work. This includes ability to engage in activities of daily living, such as bending, kneeling, or stooping, resulting from the impairment, and to participate in usual life activities, such as reading, learning, socializing, engaging in recreation, and maintaining family relationships. Loss of quality of life refers to the loss of physical, psychological, social, and economic well-being in one's life.

The IOM report stated that, "... Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating Schedule and other ways. Modern concepts of disability include work disability, nonwork disability, and quality of life (QOL) . . . " The congressionally-mandated Veterans Disability Benefits Commission (VDBC), established by the National Defense Authorization Act of 2004 (Public Law 108–136), spent more than 2 years examining how the rating schedule might be modernized and updated. Reflecting the recommendations of the IOM study, the VDBC in its final report issued in 2007 recommended that the "... veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life."

The IOM Report, the VDBC (and an associated Center for Naval Analysis study) and the Dole-Shalala Commission (President's Commission on Care for America's Returning Wounded Warriors) all agreed that the current benefits system should be reformed to include noneconomic loss and quality of life as a factor in compensation.

The Independent Budget recommends that Congress finally address this deficiency by amending title 38, United States Code, to clarify that disability compensation, in addition to providing compensation to service-connected disabled veterans for their average loss of earnings capacity, must also include compensation for their noneconomic loss and for loss of their quality of life. Congress and VA should then determine the most practical and equitable manner in which to provide compensation for noneconomic loss and loss of quality of life and then move expeditiously to implement this updated disability compensation program.

ELIMINATION OF CONCURRENT RECEIPT FOR ALL DISABLED VETERANS

Mr. Chairman, many veterans retired from the armed forces based on longevity of service must forfeit a portion of their retired pay, earned through faithful performance of military service, before they receive VA compensation for service-connected disabilities. This is inequitable—military retired pay is earned by virtue of a veteran's career of service on behalf of the Nation, careers of usually more than 20 years. Entitlement to compensation, on the other hand, is paid solely because of disability resulting from military service, regardless of the length of service.

A disabled veteran who does not retire from military service but elects instead to pursue a civilian career after completing a service obligation can receive full VA compensation and full civilian retired pay—including retirement from any Federal civil service. A veteran who honorably served and retired for 20 or more years and suffers from service-connected disabilities due to disability should have that same right.

Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to their rightfully earned VA disability compensation if rated less than 50 percent.

REPEAL OF OFFSET AGAINST SURVIVOR BENEFIT PLAN

When a disabled veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive Dependency and Indemnity Compensation (DIC) from VA. This benefit indemnifies survivors, in part, for the losses associated with the veteran's death from service-connected causes or after a period of time when the veteran was unable, because of total disability, to accumulate an estate for inheritance by survivors.

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

We strongly believe this offset is inequitable because no duplication of benefits is involved. Payments under the SBP and DIC programs are made for different purposes. Under the SBP, a dependent purchases coverage that would be paid in the event of the death of the servicemember. On the other hand, DIC is a special indemnity compensation paid to the survivor of a servicemember who dies while serving or a veteran who dies from service-connected disabilities. In such cases, VA indemnity compensation should be added to the SBP, not substituted for it.

We note that surviving spouses of Federal civilian retirees who are veterans are eligible for dependency and indemnity compensation without losing any of their purchased Federal civilian survivor benefits. The offset penalizes survivors of military retired veterans whose deaths are under circumstances warranting indemnification from the government separate from the annuity funded by premiums paid by the veteran from his or her retired pay. Congress should repeal the offset between DIC and the SBP.

In addition, Congress should lower the age required for survivors of veterans who died from service-connected disabilities who remarry to be eligible for restoration of dependency and indemnity compensation to conform with the requirements of other Federal programs. Current law permits the VA to reinstate DIC benefits to remarried survivors of veterans if the remarriage occurs at age 57 or older or if survivors who have already remarried apply for reinstatement of DIC at age 57. Although we appreciate the action Congress took to allow this restoration of rightful benefits, the current age threshold of 57 years is arbitrary. Remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. We believe the survivors of veterans who died from service-connected disabilities should not be further penalized for remarriage and that equity with beneficiaries of other Federal programs should govern Congressional action for this deserving group.

VA SCHEDULE FOR RATING DISABILITIES

The amount of disability compensation paid to a service-connected disabled veteran is determined according to the VA Schedule for Rating Disabilities (VASRD), which is divided into 15 body systems with more than 700 diagnostic codes. In 2007, both the VDBC, as well as the IOM Committee on Medical Evaluation of Veterans for Disability Compensation in its report "A 21st Century System for Evaluating Veterans for Disability Benefits," recommended that VA regularly update the VASRD to reflect the most up-to-date understanding of disabilities and how disabilities affect veterans' earnings capacity.

In line with these recommendations, the VBA is currently engaged in the process of updating the 15 body systems, beginning with mental disorders and the musculoskeletal system. Additionally, it has committed to regularly updating the entire VA Schedule for Rating Disabilities every 5 years.

In January 2010, the VBA held a Mental Health Forum jointly with the Veterans Health Administration (VHA), which included a VSO panel. In August 2010, the

VBA and VHA held a Musculoskeletal Forum, which also included a VSO panel. Just a few weeks ago, a series of four public forums were held in Scottsdale, Arizona over the course of 2 weeks on four additional body systems. The Arizona sessions in particular, were far removed from the public and offered little opportunity for most VSOs to observe, much less offer any input.

While we are appreciative of such efforts, we are concerned that except for these initial public forums, VBA is not making any substantial efforts to include VSO input during the actual development of draft regulations for the updated rating schedule. Since the initial public meetings, the VBA has not indicated it has any plans to involve VSOs at any other stage of the rating schedule update process other than what is required once a draft rule is published, at which time they are required by law to open the proposed rule to all public comment. We strongly believe that the VBA would benefit from the collective and individual experience and expertise of VSOs and our service officers throughout the process of revising the rating schedule. In addition, since the VBA is committed to a continuing review and revision of the rating schedule, we believe it would be beneficial to conduct reviews of the revision process so that future body system rating schedule updates can benefit from "lessons learned" during prior body system updates.

Mr. Chairman and Members of the Committee, this concludes my statement and I would be happy to answer any questions you may have.

Prepared Statement of Christina M. Roof, National Acting Legislative Director, American Veterans (AMVETS)

Chairman Miller, Ranking Member Filner and distinguished Members of the Committee, on behalf of AMVETS I would like to thank you for allowing myself and representatives of the other member organization authors of *The Independent Budget* to share with you our recommendations on the Department of Veterans Affairs Fiscal Year 2012 budget, in what we believe to be the most fiscally responsible way of ensuring the quality and integrity of the care and benefits our veterans community receive.

AMVETS is honored to join our fellow Veterans' Service Organizations in presenting *The Independent Budget's* recommendations on the Fiscal Year 2012 Department of Veterans Affairs Budget Request. AMVETS testifies before you as a co-author of The FY 2012 *Independent Budget.* This is the 25th year AMVETS, the Disabled American Veterans, the Paralyzed Veterans of America and the Veterans of Foreign Wars have combined our expertise, experiences and resources to produce this unique and in-depth document; one that has stood the test of time.

In developing *The Independent Budget* we are always guided by the same set of principles. These principles include, first, our belief that veterans should not have to wait for the benefits to which they are entitled through their service to our country. Second, every veteran must be ensured access to the highest quality medical care available. Third, specialized care must remain a top priority and focus of the Department of Veterans Affairs (VA). Furthermore, we believe veterans must be guaranteed timely access to the full continuum of health care services, including, but not limited to, long-term care. Finally, veterans must be assured accessible burial in a State or national cemetery regardless of their location.

As a partner of *The Independent Budget,* AMVETS devotes a majority of our time to the concerns and matters of the Department of Veterans Affairs National Cemetery Administration (NCA) and to all of the aspects of veteran entrepreneurship and Federal procurement. Today I will be speaking directly to these two issues.

By way of background, the stated mission of The National Cemetery Administration (NCA) is to honor veterans with final resting places in national shrines and with lasting tributes that commemorate their service to our Nation. Their vision is to serve all veterans and their families with the utmost dignity, respect, and compassion and ensure that every national cemetery will be a place that inspires visitors to understand and appreciate the service and sacrifice of our Nation's veterans. Furthermore, many States have established State veterans cemeteries. Eligibility is similar to that of the Department of Veterans Affairs (VA) national cemeteries, but may include residency requirements. Even though they may have been established or improved with government funds through VA's State Cemetery Grants Program, State veterans cemeteries are run solely by the States.

As of late 2010 the Department of Veterans Affairs National Cemetery Administration (NCA) maintained more than 3 million graves at 131 national cemeteries in 39 States and Puerto Rico. Of these cemeteries, 71 are open to all interment; 19 will accept only cremated remains and family members of those already interred;

and 41 will only perform interments of family members in the same gravesite as a previously deceased family member.[i]

VA estimates nearly 23 million veterans are living today. They include veterans from World Wars I and II, the Korean War, the Vietnam War, the Gulf War, the conflicts in Afghanistan and Iraq, the Global War on Terrorism, as well as peacetime veterans. With the anticipated opening of the newly planned national cemeteries, annual interments are projected to increase to approximately 116,000 in 2013, and are projected to maintain that level through 2015. Historically, only 12 percent of veterans opt for burial in a State or national cemetery, although these numbers are rising.

The most important obligation of the NCA is to honor the memory of America's brave men and women who served in the armed forces. Therefore, the purpose of these cemeteries as national shrines is one of 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 must be protected, respected 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 2010, $250 million was appropriated for the operations and maintenance of NCA, with approximately $2 million in carryover. NCA awarded 47 of its 50 minor construction projects that were in the operating plan. Additionally, the State Cemetery Grants Service (SCGS) awarded $48.5 million in grants for 12 projects.

NCA has done an exceptional job of providing burial options for the nearly 91 percent, about 170,000, of veterans who fall within a 75-mile radius threshold model. However, the NCA realized that, without adjusting this model, only one area, St. Louis, would qualify for a cemetery within the next 5 years and that the five highest veteran population concentrated areas of the country would never qualify if the threshold remained unchanged.

In 2010, the IBVSOs recommended several new threshold models for NCA to consider in an effort to best serve a veterans population declining in number. The IBVSOs are pleased to see that NCA has adjusted its model and will begin factoring in 80,000 veterans within a 75-mile radius for future cemetery placement. This modification will allow NCA to continue to provide burial options for veterans who would otherwise be limited geographically for this benefit.

National Cemetery Administration (NCA) Accounts

The Independent Budget recommends an operations budget of $275 million for NCA for fiscal year 2012 so it can meet the increasing demands of interments, gravesite maintenance and related essential elements of cemetery operations.

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.

However, the national cemetery system continues to face serious challenges. Though there has been significant progress made over recent years, NCA is still struggling to remove decades of blemishes and scars from military burial grounds across the country. Visitors to national cemeteries are still 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 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.

NCA has worked tirelessly to improve the appearance of our national cemeteries, investing $45 million in the National Shrine Initiative in FY 2010 and approximately $25 million per year for the three previous years. NCA has done an out-

[i] http://www.cem.va.gov/cem/cems/listcem.asp

standing job thus far in improving the appearance of our national cemeteries, but we have a long way to go to get us where we need to be. In 2006 only 67 percent of headstones and markers in national cemeteries were at the proper height and alignment. By 2009 proper height and alignment increased to 76 percent. NCA is on target to reach 82 percent this fiscal year. To ensure that NCA has the resources to reach its strategic goal of 90 percent, the IBVSOs recommend that NCA's operations and maintenance budget be increased by $20 million per year until the operational standards and measures goals are reached.

In addition to the management of national cemeteries, 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, 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 State Cemetery Grants Program

The State Cemeteries Grant Program (SCGP) 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 48 State and tribal government matching grants for cemetery projects.

The Independent Budget recommends Congress appropriate $51 million for SCGP for FY 2012. This funding level would allow SCGP to establish new State cemeteries at their current rate that will provide burial options for veterans who live in regions that currently have no reasonably accessible State or national cemeteries.

Burial Benefits

Burial allowance was first introduced in 1917 to prevent veterans from being buried in potter's fields. In 1923 the allowance was modified. The benefit was determined by a means test, and then in 1936 the means test was removed. In its early history the burial allowance was paid to all veterans, regardless of their service-connectivity of death. In 1973 the allowance was modified to reflect the status of service-connection. 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.

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 restore the original value of the benefit.

The IBVSOs are pleased that the last Congress acted to improve the benefits, raising the plot allowance to $700 as of October 1, 2011. However, there is still a serious deficit in original value of the benefit when compared to the current value.

While the cost of a funeral has increased by nearly 700 percent, the burial benefit has only increased by 250 percent. To restore both the burial allowance and plot allowance back to their 1973 values, the SC benefit payment should be $6,160, the NSC benefit value payment should be $1,918, and the plot allowance should increase to $1,150.

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 vet-

eran 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 an SC burial should be $2,793, the amount provided for an NSC burial should be $854, and the plot allowance should 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.

In addition to the recommendations we have mentioned, the IBVSOs also believe that Congress should enact legislation to adjust these burial benefits for inflation annually.

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.

NCA honors veterans with a final resting place that commemorates their service to this Nation. More than 3 million servicemembers who died in every war and conflict are honored through interment 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.

AMVETS' second focus in the FY 2012 IB is on veteran entrepreneurship and Federal procurement as it relates to Service Disabled Veteran Owned Small Businesses (SDVOSB) and Veterans Owned Small Businesses (VOSB). We believe that both of these issues play a vital role in the success of transitioning servicemembers and the quality of life for veterans. And while I do note that a majority of the proceeding information is focused on policy rather than hard fiscal numbers, we believe that broken policy, duplication of efforts and lack of oversight are key factors in determining fiscally responsible budgets.

Veteran Preference in Federal Hiring and Procurement

Supporting Service-disabled Veteran-owned Small Businesses (SDVOSBs) and Veteran-owned Small Businesses (VOSB) contributes significantly in sustaining a veteran's quality of life, while also contributing to the success and ease of transitioning from active duty to civilian life. Often in these tough economic times, self employment and entrepreneurship are the only ways many veterans are able to earn a living wage. Given the circumstances, now more than ever, Federal agencies must be held accountable to meet the Federal procurement goals outlined by Executive Order 13360, Sections 15 (g) and 36 of the Small Business Act and the numerous other published Federal regulations outlining veterans' preference and SDVOSB set-aside laws.

The GAO's most recent review of interagency agreements found that VA is still lacking an effective process to ensure that interagency agreements include the required language instructing all Federal agencies comply with VA's contracting goals and preferences for SDVOSBs and VOSBs. While it is noted that VA issued guidance to all contracting officers on managing interagency acquisitions in March 2009, the numerous interagency agreements still did not even include the required language addressing VA's contracting goals and preferences until it was amended on March 19, 2010. This serves as an example of how VA is clearly lacking an established hierarchy or clear delegation of duties in oversight activities. This lack of oversight is continuing to contribute to VA having no assurance or metrics in place to conduct proper oversight that agencies have made maximum feasible efforts to contract with SDVOSBs or VOSBs. This lack of oversight only stands to hurt those in which the laws were established to protect, the veterans.

We recommend stronger oversight, outreach and enforcement by all Federal agencies tasked with ensuring the success of our veteran entrepreneur community. This includes, but is not limited to, the U.S. Department of Labor (DOL), Office of Small Business Programs (OSBP), Small Business Administration (SBA), Office of Federal Contract Compliance and Procurement (OFCCP) and all other Federal agencies committing to reaching their 3 percent goal. All Federal agencies must make a high priority of assisting in the development and implementation of stronger strategies and accountability in reaching the 3-percent goal of veteran employment and contracting.

Congress must ensure adequate resources are available to effectively monitor and recognize those agencies that are not meeting the 3-percent goal and hold them accountable for failure. The annual reports filed by all Federal agencies, reporting the prior fiscal years' actual percentage of goal achieved, should serve as guidance as to which agencies need the most assistance in the development and implementation of stronger contracting plans and oversight.

Center for Veteran Enterprise

Another critical aspect in ensuring the success of our veteran entrepreneur community is promoting and assisting veterans in their entrepreneurial endeavors through programs such as the Center for Veteran Enterprise (CVE). CVE was established to assist all veterans with the numerous aspects of establishing and maintaining a small business. CVE is a subdivision of the Office of Small and Disadvantaged Business Utilization that extends entrepreneur services to veterans who own or who want to start a small business. CVE is also tasked with aiding other Federal contracting offices in identifying VOSBs in response to Executive Order 133600. In the past, VA has faced many obstacles, from lack of leadership to best practices with their entrepreneurship programs, which have directly resulted in and prevented the success of veteran owned businesses. For this reason, VA established the program entitled the Center for Veterans Enterprise (CVE) with the passage of the Veterans Entrepreneurship and Small Business Development Act of 1999. Furthermore, on Dec. 22, 2006, President Bush signed Public Law 109–461, the Veterans Benefits, Health Care, and Information Technology Act of 2006 in an effort to successfully identify and grant status to SDVOSBs. Effective June 20, 2007, this legislation authorized a unique "Veterans First" approach, specific to VA contracting.

As we move through the 21st century, during a time of war on multiple fronts, the VOSB and SDVOSB population continues to rise at a rate not seen since the end of World War II. As America's war-fighters transition back into civilian life, many are choosing to pursue lives as entrepreneurs. Given the almost 35 percent influx of VOSB and SDVOSB, it is vital that the Center for Veterans Enterprise be ready and able to meet the growing demand for their services. However, the IBVSOs do not believe that CVE is serving the needs of those veterans it was originally designed to help. Due to a lack of leadership over the past year, we have seen CVE slowly move from the role of assisting VOSB and SDVOSBs to that of an information and referral agency for other Federal and State agencies. We believe the Center for Veteran Enterprise must be brought back up to par with what it was originally tasked to do: assisting our veteran population in all aspects for their entrepreneurship endeavors. In order to effectively accomplish this Congress must provide dedicated funding and strong oversight in ensuring CVE is properly staffed, trained and funded.

Vendor Verification Systems

Another key part of protecting our veterans in a successful Federal procurement system is through a centralized vendor verification system. We believe it to be vital for all Federal agencies to utilize a continually updated, single centralized source database in the verification of all businesses claiming preferred status as a VOSB or SDVOSB.

At present, vendors desiring to do business with the Federal Government must register in the Central Contractor Registration (CCR) database, and those who indicate they are veterans or service-disabled veterans, self-certify their status without verification. P.L. 109–461 required VA to establish a Vendor Information Page (VIP) database to accurately identify businesses that are 51 percent or more owned by veterans or service-disabled veterans. This database was originally designed to act as a reliable, centralized database enabling all Federal agencies a single source in the identification of possible SDVOSB and VOSB for consideration during their procurement processes. Furthermore, both contractors and subcontractors involved in the procurement process of any government award is then required to provide the Secretary of Labor a specific breakdown of all information required by the VETS 100 and VETS 100–A filed on an annual basis, demonstrating their continued compliance with the contracts terms regarding veterans preference and status. As of April 15, 2009, approximately 18,000 SDVOSBs were registered in the Central Contractor Registration, however, due to lack of oversight and an inconsistent, self-reported status verification processes, many non-veteran-owned businesses are not receiving the protections they are entitled to under the law.

On February 8, 2010, the final CFR rules regarding "VA Veteran-Owned Small Business Verification Guidelines" were published. The document affirms as final, with changes, an interim final rule that implements portions of the Veterans Benefits, Health Care, and Information Technology Act of 2006. This law requires the Department of Veterans Affairs (VA) to verify ownership and control of veteran-owned small businesses, including service-disabled veteran-owned small businesses. This final rule declares to define the eligibility requirements for businesses to obtain verified status, explains examination procedures and establishes records retention and review processes. However, the newly published rule fails to outline any solid changes or improvements to the SDVOSB verification process. We further believe the newly published rules on the verification process focused on control and owner-

ship definitions, yet provided no clarification on the specifics of the verification process. The IBVSOs believe these updates to 38 CFR, Part 74 regarding P.L. 109–461 still leave the integrity of the SDVOSB and VOSB verification system open to fraud. This continued lack of clarity and non-uniformed inconsistent status verification processes will cause the same unwanted results of many veteran owned businesses not receiving the protections they are entitled to under the law.

VA has thus far been awarded $1.4 billion in recovery act funds to aide in the employment and contracting opportunities available to SDVOSB and VOSB. To date $538 million has been used on awards to SDVOSB and VOSB, according to VA. However, we have very serious concerns on how much of these appropriated funds were actually awarded to legitimate SDVOSB and VOSBs, due to the lack of verification processes in place at VA.

In an effort to resolve this issue we recommend that all Federal agencies should be required to certify veteran status and ownership through the VA's VIP program before awarding contracts to companies claiming veteran status. We also recommend the database be maintained and updated on a regular basis to avoid backlogs of vendors waiting to be certified or re-certified.

Furthermore, Congress must take the necessary actions in requiring all Federal agencies to use a single source database in all verifications of veteran ownership statuses before unknowingly awarding contracts to companies on the basis of claiming SDVOSB or VOSB preference. Finally, internal promotion and education on proper usage of the database should coincide with implementation of databases use.

Veteran Set-Asides

Protecting veteran set-asides within the Federal procurement system is a matter that must be addressed more rigorously within VA's training and personnel programs. Public Law 109–461, the "Veterans Benefits, Health Care and Information Technology Act of 2006," was signed Dec. 22, 2006, and went into effect on June 20, 2007. The law allows VA special authority to provide set-aside and sole-source contracts to small businesses owned and operated by veterans and service-disabled veterans. This legislation is codified in Title 38, United States Code, sections 8127 and 8128. After more than 3 years since its enactment, no significant change has been implemented with regard to how Federal contracting officers are trained. VA personnel involved in the acquisition process need to be trained and familiarized with all current and new authorizations and responsibilities under P.L. 109–461, as well as all other procurement directives regarding VOSBs and SDVOSBs. Our service disabled veterans who own small businesses cannot afford to wait any longer for VA to enforce compliance with the law.

Under current policy, no proof of compliance is required, nor do random labor audits occur. OIG has issued more than 10 reports illustrating these deficiencies in recent years. Most recently, in October of 2009 the GAO issued their report on "Service-Disabled Veteran-Owned Small Business Program: Case Studies Show Fraud and Abuse Allowed Ineligible Firms to Obtain Millions of Dollars in Contracts" to the Committee on Small Business. This report outlines how millions of dollars in set-aside contracts were awarded to non-SDVOSB businesses due to the gross lack of program controls in place to detect and prevent fraud. The report identified 10 case-study examples of firms that did not meet the basic SDVOSB program eligibility requirements, but yet received over $100 million in SDVOSB set-aside contracts. VA, DOL, SBA and the OFCCP must exercise better oversight and stronger enforcement with consequences for any government agency or nongovernment business claiming to be awarding set-asides to veteran-owned businesses when, indeed, they are not. There needs to be an immediate focus on proactive measures to eliminate untruths, such as "rent a vet," and cease only exercising "reactive" strategies. VA, the DOL, SBA, and OFCCP should pool all their resources and successful strategies to ensure swift action and to avoid duplication of efforts.

Furthermore, we believe VA must develop and implement uniformed training processes for all staff involved with the Federal procurement process, especially contracting officers. VA must also provide systems and metrics to identify the strengths and weaknesses in its procurement processes, as well as continued training and evaluations of contracting staff in efforts of successfully identifying weaknesses and strengths within the program as a whole.

Lastly, VA, DOL, SBA, OFCCP and the Employment and Training Administration must collaborate in developing and implementing a single-source database for employer outreach programs for the promotion of veterans' entrepreneurship at local and national levels. This system must allow all employers to locate veterans for employment as well as provide an updated listing of employment opportunities.

Again, Chairman Miller and Members of the Committee, we thank you for inviting us to share with you our recommendations and stand ready to answer any questions you may have.

Prepared Statement of Timothy M. Tetz, Director, National Legislative Commission, American Legion

Mr. Chairman and Members of the Committee:

The American Legion welcomes this opportunity to comment on the President's budget request.

President Obama has issued the challenge to invest in the future of America. The American Legion believes strongly in this ideal. Investment in the future means taking care of the needs of veterans today. Investing in the future means solving problems at their onset rather than reaping heavy debts down the road as the problems grow to unmanageable levels. Investing in the future means having the foresight to see tomorrow's problems today, and avoiding the errors of the past. Imagine how the lives of veterans today would be changed had this Nation had the foresight to invest in preparation to deal with the full consequences of Agent Orange, the ever-growing claims backlog, and substandard medical facilities as in days past.

Challenging tasks require aggressive solutions. The American Legion supports the value of fiscal responsibility and recognizes the economic stability of this Nation is vital to its overall security. Even in difficult times, however, there is always the duty to ensure that vital needs are not neglected. The budget, at a proposed 10.6 percent increase over fiscal year (FY) 2010 levels, recognizes meeting the needs of veterans continues to be an area where we must ensure proper funding.

Furthermore, with advance appropriations for the Department of Veterans Affairs (VA) now the law of the land, The American Legion is encouraged to see the proposed advance appropriations as the fruition of many years of hard work by our organization and others to ensure the stability and ability for long term health care planning in this sector.

The veterans' community is paradoxically vulnerable in many ways. Our Nation's defenders are visualized justly as brave and true sentinels, yet as they transition from warrior to citizen they face challenges not commensurate with the rest of the population. The twin scourges of joblessness and homelessness are growing and remain challenges. Veterans make up less than 10 percent of the population, yet face unemployment at rates two thirds higher than the overall average of America and while the numbers are being reduced, still the staggering figure of over 75,000 of our Nation's homeless are believed to be veterans. Clearly these are areas where we are not meeting the duty to care for our Nation's heroes.

These numbers of veterans in need are only going to grow. Already Defense Secretary Gates speaks of force reduction for those on Active Duty, and this will contribute more to the growing rolls of veterans as those servicemembers step down from active service. While it may not make the glamorous front page news, The American Legion has not forgotten that every single day the brave men and women of our armed forces overseas "leave the wire" to face roadside bombs, ambushes, combat and other hazards which continue to send service-disabled servicemembers back home to cope with the aftereffects of war. This is the true and on-going cost of war, and even in tough times this country cannot shirk the duty of paying that cost.

Therefore, it is absolutely critical the entire military and veterans' community (active duty, Reserve Component, and veterans) continue to remain supportive of honorable military service. No servicemember should ever doubt:

- 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.

When National Commander Jimmie Foster testified on September 22, 2010 before a Joint Session of the Committees on Veterans' Affairs, he clearly outlined the funding recommendations of The American Legion for FY 2012. Our testimony today reemphasizes those recommendations for certain specific areas.

MEDICAL SERVICES

The American Legion strongly supports the overall funding level for total medical services proposed by the administration.

The American Legion fully supports funding *"the best health care anywhere"*. VA reports that 6.1 million veterans will need to receive timely access to quality health care in this upcoming year alone. This represents an anticipated increase of 168,904 new patients who will "vote with their feet" in making VA their health care provider of choice. VA medical care is still America's best investment in quality health care delivery—the right care, at the right time, in the right facility. The Legion would further urge Congress to act now and ensure the passage of the full budget for FY 2011 so that a continuity of funding, to include all advanced appropriations, is available for full use and planning purposes.

Medical and Prosthetic Research

The American Legion recommends $600 million for Medical and Prosthetics Research in FY 2011.

The American Legion believes VA's focus in research must remain an understanding and improving treatment for medical conditions that are unique to veterans and their military service. Servicemembers are surviving catastrophically disabling blast injuries due to the superior armor they are wearing in the combat theater and 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. Clearly, adequate funding is needed to ensure that VA does not continue to lag behind DoD in this capacity, and both agencies should be pushing forward in the field of innovations in prosthetic technology.

There is a need for adequate funding of other VA research activities, including basic biomedical research and bench-to-bedside projects. Congress 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 (PTSD), rehabilitation; in addition, VA must have direction and funding to support supplementary research conducted jointly with DoD, the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

As challenging health concerns such as the long term effects of Traumatic Brain Injury (TBI), exposures to environmental hazards in domestic and overseas deployment, and the mental health impact of exposure to combat conditions as well as military sexual trauma and assault develop, it is essential that VA lead the way in research and development to combat and treat these conditions. Servicemembers afflicted by these conditions will have a deep and lasting effect on the economy through their reduced ability to contribute if these conditions are not treated and mitigated. Quite simply, the more that can be learned about diagnosing and treating these conditions, the more likely this Nation can avert catastrophic impact in the future.

Truly, investing in research at the onset is investing in the future. While The American Legion applauds the budget's stated research priorities of Mental Health, Gulf War Illness and Environmental Exposures, Prosthetics, and TBI and Spinal Cord Injuries, the allocated $509 million should be made more robust. As the lesson learned from Agent Orange exposure in Vietnam should have taught us, research delayed can have devastating economic impact down the road. Money invested now in this research has the potential to not only save this Nation money in the long run, but also ameliorate and alleviate the suffering of veterans at a time when the long term impact can be minimized.

DEPARTMENTAL ADMINISTRATION

Construction—Major and Minor

The American Legion recommends that the President's budget request for $590 million for Major Construction and $550 million for Minor Construction in FY 2012 be increased to $1.2 billion for Major Construction projects and $800 million for Minor Construction projects to provide for additional facilities particularly the aforementioned improvements to infrastructure, as well as Community-Based Outpatient Clinics in rural and highly rural areas and additional Vet Centers.

The American Legion has seen firsthand the structural deficiencies and challenges facing the infrastructure of the VA Health Care system as a part of the preparation for the annual System Worth Saving reports. During those site visits, many VA Medical Center staff have informed Legion personnel they are unable to dedicate needed funds towards construction projects due to the funding needs of actual medical care. Furthermore, many VA construction projects were only made possible through the use of funding from the America Reinvestment and Recovery Act. Such money is no longer available to meet the construction needs to shore up VA infrastructure in areas such as seismic criteria, aging electrical systems, insufficient parking and space utilization, and other needed areas. Therefore, the need to fully fund this area of the budget is even more apparent.

Recent reports of the VA Regional Office in Roanoke, VA noted the floors of the building were in danger of collapsing due to the aggregate weight of the claims files. While this highlights yet another major implication of the claims backlog, it also underlines this is not an area where VA can afford to scrimp and save. Substandard facilities do not serve the veterans of this country, and are a hazard to VA employees as well.

If we are to truly invest in the future of this country, there are few more sound decisions to be made than investing in infrastructure. Just as the roads and bridges of America must be upgraded to support the crumbling infrastructure and prevent even greater costs down the road, so too must the infrastructure of VA solidify to meet the needs of the growing veterans' community.

Whether it is much needed medical facilities in the rural regions of the country, repairs to aging urban hospitals, proper laboratory facilities, adequate parking or other needs, it is short-sighted to see opportunities to cut and save on immediate construction, for cuts to this area now will only bring far greater construction costs down the road. The wise fiscal decision is to invest carefully now to head off ballooning costs in the future.

Information Technology Systems

The American Legion urges Congress to ensure this key component receives full funding as VA transitions towards paperless processing, but also that this budget continues to fund the efforts towards a truly seamless electronic health records from induction in service through the rest of a veteran's life.

Since the data theft occurrence in May 2006, VA has implemented a complete overhaul of its Information Technology (IT) division nationwide. The American Legion is hopeful VA continues to take 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. 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.

As acknowledged by the GAO Report 11–265 "Electronic Health Records—DoD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs" there are still major hurdles to be overcome to achieve the goals set forth of a Virtual Lifetime Electronic Record for servicemembers from induction through the rest of their lives as active duty and veteran. The President's budget sets aside monies for this purpose, but it is vitally important to ensure that this component is not left behind, nor allowed to falter. Achieving this goal should remain a major priority of both DoD and VA in cooperation with one another.

Obviously, with VA's transformation of the VBA to a "paperless" processing system through the Veterans Benefits Management System (VBMS) this can be an area of great savings overall for VA as VBA moves out of the research and piloting

stage of this system and into regular operations. Start up costs can now be eliminated and hopefully VA will be vigilant in ensuring that this new system offers the speed and accuracy promised.

Homelessness

The American Legion supports sustaining funding levels addressing homelessness in the veterans' community and urges complete support through other Departments such as Housing and Urban Development to help eliminate homelessness among veterans.

The American Legion notes that by the VA Secretary's own recent estimates there are approximately 75,600 homeless veterans on the street each night as of 2009. This number represents a significant improvement over previous years. As far back as 2007 the estimates were over 150,000 and each year of concerted effort has brought further improvement and reduction of these numbers. Clearly the good work in this area must retain the funding to continue so that the levels will never again reach those seen in the past.

With 300,000 servicemembers entering the civilian sector each year since 2001 with at least a third of them potentially suffering from mental illness, such as the effects of Combat Stress, PTSD and TBI, nothing could more clearly indicate programs to prevent and assist homeless veterans are vitally needed. The American Legion applauds VA's continued emphasis as one of its priority items the elimination of homelessness among America's veterans.

FISCAL RESPONSIBILITY

Fiscal responsibility is of course a vital concern in the difficult times we are facing as a Nation. The American Legion strongly believes money spent must be spent wisely. To this end, all aspects of operation must be scrutinized, and where waste and mismanagement contribute to an inflated budget, these must be eliminated. Rather than wholesale cutting of necessary infrastructure, areas of redundancy must be sought, and targeted cuts to those areas serve a far better purpose in managing the budget of VA.

Better coordination with outside evaluations can help reduce internal costs of evaluation. For example, State Veterans' Homes are evaluated not only by VA internal evaluation, but also by outside Centers for Medicare and Medicaid Services (CMS) evaluation. Better coordination and standardization of evaluation could result in reduced costs of VA evaluations by millions of dollars by reducing this level of redundancy. The American Legion has also called for some time for VA to accept outside, third party evaluation of accuracy and quality rates in the benefits management and claims system. Such outside evaluation could further reduce costs where areas of redundancy with VA's own evaluative process can be found. Surely, though savings of this type may only rank individually in the tens of millions, these are funds that could be directed towards better use addressing shortfalls elsewhere.

Better Central Office oversight is further needed at the local level to ensure that money directed to the VISNs and Regional Offices are being spent in accordance with the direction of the administration. All too often in The American Legion visits to local areas as a part of the System Worth Saving (SWS) Reports and Regional Office Action Reviews (ROAR), discover wide variances in execution of basic policies and directives from region to region. To truly manage the budget of VA most effectively, developing uniform consistency is vital across the country.

CONCLUSION

In conclusion, The American Legion believes a true investment in the future means investing in key areas of infrastructure now and not making short-sighted cuts to vital areas that will only bring greater costs in the future.

Full funding of essential projects such as research in emerging health risks and disabilities, as well as the physical infrastructure of VA facilities, will be the prudent choice now to stave off even greater financial burdens down the road. VA must meet these challenges with an adequate budget to fund these necessary aims.

The American Legion welcomes the opportunity to work with this Committee on the enactment of a timely, predictable and sufficient budget for the Department of Veterans Affairs.

VA MEDICAL DISCRETIONARY PROGRAMS

	P.L. 111-117 FY 2010 VA Final Funding	P.L. 111-322 FY 2011 VA Funding	President's FY 2012 VA Budget Proposal	FY 2013 Proposed Advance Appropriations	American Legion's FY 2013 Request
Medical Supplies	$34.7 billion	$37.1 billion	$39.5 billion	$41.3 billion	$38.1 billion
Medical Support & Compliance	$4.9 billion	$5.3 billion	$5.4 billion	$5.7 nillion	$5.3 billion
Medical Facilities	$4.8 billion	$5.7 billion	$5.4 billion	$5.4 billion	$6.2 billion
Medical/Prosthetic Research	$581 billion	$581 million	$509 million	------	$600 million
Medical Care Collections Fund	[$2.9 billion]	[$2.9 billion]	[$3.1 billion]	------	------
Total Medical Care	**$47.9 billion**	**$51.6 billion**	**$53.9 billion**	**$52.4 billion**	**$50.2 billion**

VA NON-MEDICAL DISCRETIONARY PROGRAMS

	P.L. 111-117 FY 2010 VA Final Funding	P.L. 111-322 FY 2011 VA Funding	President's FY 2012 VA Budget Proposal	American Legion's FY 2012 Request
Major Construction	$1.2 billion	$1.2 billion	$590 million	$1.2 billion
Minor Construction	$703 million	$703 million	$550 million	$800 million
State Veterans' Homes Construction Grants	$100 million	$100 million	$85 million	$100 million
State Veterans' Cemeteries Construction Grants	$46 million	$46 million	$46 million	$60 million
General Operating Expenses	$2.1 billion	$2.5 billion	$2.5 billion	$2.6 billion
Information Technology	$3.3 billion	$3.3 billion	$3.2 billion	$3.5 billion
National Cemetery System	$250 million	$250 million	$251 million	$260 million

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS
FISCAL YEAR 2012
BUDGET ESTIMATE

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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

INTRODUCTION

The United States Court of Appeals for Veterans Claims (Court) is a national court of record established by the Veterans Judicial Review Act, Pub. L. No. 100–687, Division A (1988) (The Act). The Act, as amended, is codified in part at 38 U.S.C. §§ 7251–7299. The Court is part of the Federal judicial system and has a permanent authorization for seven judges, one of whom serves as chief judge. The judges are appointed by the President, by and with the advice and consent of the Senate, for 15-year terms, except that two have been appointed for 13-year terms pursuant to Pub. L. No. 106–117, Nov. 30, 1999. Two additional positions have been authorized but not yet filled, and one judge recently entered senior status, such that the Court currently has three vacancies. Our senior judges, now numbering 6, are available for service, and have been recalled the past several years. One judge is retired due to permanent disability. Certain decisions by the Court are reviewable by the United States Court of Appeals for the Federal Circuit and, if *certiorari* is granted, by the United States Supreme Court. Further, for management, administration, and expenditure of funds, the Court exercises the authorities provided for such purposes applicable to other courts under Title 28, U.S. Code.

The Court has exclusive jurisdiction to review decisions made by the Department of Veterans Affairs' Board of Veterans' Appeals (Board) that adversely affect a person's entitlement to VA benefits. This judicial review, although specialized in scope, is the same as that performed by all other United States Courts of Appeal. In cases before it, the Court has the authority to decide all relevant questions of law; to interpret constitutional, statutory, and regulatory provisions; and to determine the meaning or applicability of actions/decisions by the Secretary of Veterans Affairs. The Court may affirm, set aside, reverse, or remand those decisions as appropriate. Additionally, the Court has authority under 28 U.S.C. § 1651, to issue all writs necessary or appropriate in aid of its jurisdiction, and to act on applications under 28 U.S.C. § 2412(d), the Equal Access to Justice Act (EAJA).

The Court is empowered to compel actions of the Secretary that are unlawfully withheld or unreasonably delayed, and can set aside decisions, findings, conclusions, rules, and regulations issued or adopted by the Secretary, the Board, or the Board Chairman that are arbitrary or capricious, an abuse of discretion or otherwise not in accordance with law, contrary to constitutional right, in excess of statutory jurisdiction or authority; or without observance of the procedures required by law. The Court also may hold unlawful and set aside or reverse findings of material fact that are adverse to the appellant if the findings are clearly erroneous.

The Court is located in Washington, D.C., *see* 38 U.S.C. § 7255 (requiring the principal offices of the Court to be located in the D.C. metropolitan area), but as a national court, the Court may conduct hearings anywhere in the United States.

APPROPRIATION LANGUAGE
GENERAL AND SPECIAL FUND

SALARIES AND EXPENSES

For necessary expenses for the operation of the United States Court of Appeals for Veterans Claims as authorized by 38 U.S.C. §§ 7251–7299, [$90,146,729] **$55,796,690**: Provided that, of the foregoing amount, **$25,000,000** shall be transferred to the General Services Administration (GSA) for the design engineering and site acquisition of a courthouse to house the United States Court of Appeals for Veterans Claims: Provided further, that [$2,515,229] **$2,726,363** shall be available for the purpose of providing financial assistance as described, and in accordance with the process and reporting procedures set forth, under this heading in Public Law No. 102–229.

PROGRAM JUSTIFICATION

Court Caseload Trends and Variations:

The United States Court of Appeals for Veterans Claims is one of the busiest Federal appellate courts, when considering numbers of appeals per judge. Approxi-

mately 200 cases were filed monthly from FY 1999 through FY 2004. Thereafter the caseload began a steady increase, with the Court averaging 350 cases filed per month for the past several years. The chart below shows the figures by fiscal year since FY 1999. In addition, in FY 2010 the Court acted on over 2,600 applications for fees and expenses authorized by the Equal Access to Justice Act (EAJA). 28 U.S.C. § 2412(d).

Appeals to the Court come from the pool of cases in which the Board has denied some or all benefits sought by claimants. Also, under its All Writs Act authority, the Court has jurisdiction to consider petitions for extraordinary relief or writs of mandamus filed by claimants who believe that unlawful action is being taken by the Secretary of Veterans Affairs on their claims. As the number of claims processed by the Board has increased over the years, and as the number of issues raised in each claim has grown, the number of appeals filed with the Court has increased, although not on a linear path. Every indication is that the number of cases handled by the Board will continue to increase, and we anticipate that this will result in continued growth in the number of appeals to the Court over time.

	FY 99	**FY 00**	**FY 01**	**FY 02**	**FY 03**	**FY 04**	**FY 05**	**FY 06**	**FY 07**	**FY 08**	**FY 09**	**FY 10**
BVA TOTAL DENIALS	14881	14080	8514	8606	10228	9299	13033	18107	16531	17005	17601	13788
CASE FILINGS TO USDAVC	2397	2442	2296	2150	2532	2234	3466	3729	4644	4128	4725	4341
CASE FILINGS AS % OF DENIALS	16.1%	17.3%	27.0%	25.0%	24.0%	24.2%	26.6%	20.6%	28.1%	24.3%	26.8%	31.5%

Unrepresented Appellants:

The Pro Bono Representation Program (the Pro Bono Program or Program) began in FY 1992 when Congress authorized the Court to fund a pilot Pro Bono Representation Program in the amount of $950,000 from that fiscal year's appropriation. Under this program, the Legal Services Corporation (LSC) administers pro bono representation and legal assistance to veterans and their survivors who have appeals at the Court and who are unable to afford legal representation. The Court and the parties benefit from this Program because when an attorney is retained, the issues and arguments presented in the brief are generally more detailed and thorough than would be if the claimant had remained unrepresented.

The now well-established Pro Bono Program continues to receive funding through the Court's annual appropriation. Before FY 1997, Congress gave the Court limited discretion over the Pro Bono Program's funding level. Since FY 1997, the Appropriations Subcommittees have considered the Program's budget request separately from the Court's budget request, although both are submitted together. The Program budgeted $2,515,229 in FY 2011. Distribution of the grant and oversight for the Program continues to be performed by the LSC, which provides monitoring, evaluation, and technical support, as it does for all of its grantees. The Pro Bono Program's FY 2012 request for $2,726,363 is attached at Appendix A.

Staffing Requirements:

The Court requests funding for 127 full-time equivalent (FTE) positions. This request represents no increase from the FY 2011 level. It includes, as did the 2011 budget, staffing for two additional chambers, as authorized by 38 U.S.C. § 7253(i). It also includes one Secretary for support to our senior judges in service, one additional staff attorney, and a senior attorney position (for possible service as an Appellate Commissioner), originally requested for FY 2011; these positions have not been filled as of this writing because we are operating on a continuing resolution for FY 2011.

Veterans Courthouse:

The United State Court of Appeals for Veterans Claims is the newest Federal court and the only Article I court without a dedicated courthouse. Since at least 2003, several of our Nation's largest Veterans Service Organizations (VSOs) have supported a dedicated courthouse for veterans seeking judicial review. In 2004, the House of Representatives expressed its sense that the Court "should be housed in a dedicated courthouse" that would be "symbolically significant of the high esteem the Nation holds for its veterans" and would "express the gratitude and respect of the Nation for the sacrifices of those serving and those who have served in the Armed Forces, and their families" (H.R. 3936). That sentiment was echoed in 2007 with the sense of Congress that the Court be provided appropriate office space "to provide the image, security, and stature befitting a court that provides justice to the

veterans of the United States" (S. 1315). The Board of Judges fully supports the convictions expressed by Congress and the VSOs.

In 2004, pursuant to Congressional support and funding, an initial and a follow-on study were undertaken by GSA to determine the feasibility of acquiring a dedicated courthouse. In 2009, eight National VSOs collaboratively sent a letter to Congress expressing their strong support of legislation that would authorize the funding and construction of a veterans courthouse. In FY 2009, Congress responded by appropriating $7 million (M) for advance planning and architectural design, and those funds were transferred to GSA for completion of a pre-development planning study (planning study). The Court made no specific funding request for the courthouse project in its FY 2010 budget request because the planning study had not yet been concluded and plans were too uncertain at that time to make such a request prudent.

Following receipt of a GSA estimate that $62M was needed for construction funding, this amount was requested in the Court's FY 2011 budget. In response, the House proposed full funding at $62M, and the Senate proposed $25M—sufficient funding, per GSA, to perform more detailed design and planning, and to purchase necessary land adjacent to GSA property being considered for the courthouse, the next steps in the process. The FY 2011 budget request has not yet been acted on because we are operating on a continuing resolution, and therefore no funding has been appropriated for construction of the courthouse in FY 2011. Subsequent to submitting the Court's FY 2011 request, GSA presented a more specific courthouse cost estimate based on the particular location and general design developed in the planning study. This estimate reflects a substantial cost increase for project completion over the FY 2011 budget request. We understand that GSA has either briefed or offered to brief the appropriate congressional Committees as to the basis for the cost increase.

Given the increased cost estimate from GSA and need for close study thereof, and mindful of the Court's responsibility to ensure fiscal prudence, our FY 2012 request includes $25M, necessary for funding the next steps toward construction, i.e., more detailed planning, design and land acquisition. (This $25M is not needed in FY 2012 if the $25M for the veterans courthouse is appropriated in FY 2011.) We are sensitive to budget constraints and understand that priorities must be set by Congress; however, if any Federal courthouses are to be funded for construction, we support the veterans who contend that their courthouse should be one of them.

FISCAL YEAR 2010 PROGRAM

The Court's FY 2010 program accomplished the following:

Opened 4,341 new cases, including appeals from decisions of the Board of Veterans' Appeals and petitions for extraordinary relief directed to the Court. During the same period, the Court disposed of 5,141 cases through a combination of court orders, single judge decisions, and panel opinions. In addition, the Court ruled on thousands of motions and took action on 2,653 applications for attorney fees filed under the Equal Access to Justice Act.

Paid all obligations and staffed all positions necessary for the continued, proper functioning of the Court.

Received a clean audit with no exceptions for FY 2010.

Continued to develop and execute plans for construction of a veterans courthouse for the United States Court of Appeals for Veterans Claims, including coordinating with GSA.

Continued to work with GSA to locate additional leased space for existing staff and two new judicial chambers.

Continued the agreements with the U.S. Marshals Service (U.S.MS) for Court security, with the Department of Agriculture's National Finance Center (NFC) for payroll/personnel services, and with the Bureau of the Public Debt (BPD) for administrative payments, credit-card, travel, and financial accounting and reporting services. Also, continued existing agreement with the Administrative Office of U.S. Courts (AO) for electronic-case filing (e-filing) system support.

Transferred appropriations made available for the Pro Bono Representation Program.

FISCAL YEAR 2011 PROGRAM

To maintain and enhance the FY 2010 initiatives, the Court's FY 2011 budget request reflected the following:

Funding to pay for projected expenses to staff and support the operations of the Court to ensure its continued, proper functioning throughout the fiscal year, including two new chambers and three FTE positions not previously required—a secretary

for the senior judges, a staff attorney, and a senior attorney (for possible service as an appellate commissioner).

Funding to have the Court's financial statements audited.

Funding to build a veterans courthouse at GSA cost estimate.

Funding to acquire additional leased space to meet space needs for existing staff and two new judicial chambers.

Funding to continue agreements with the USMS for Court security, with the Department of Agriculture's NFC for payroll/personnel services, and with BPD for administrative payments, credit-card, travel, and financial accounting and reporting services. Also, to continue existing agreement with the AO for e-filing system support.

Funding to be made available for the Pro Bono Representation Program.

FISCAL YEAR 2012 PROGRAM

To maintain and enhance the FY 2011 initiatives, the Court's FY 2012 budget request reflects the following:

Funding to pay for projected expenses to staff and support the operations of the Court to ensure its continued, proper functioning throughout the fiscal year, including two new chambers to accommodate the two judges authorized by Congress (judges authorized but not yet appointed), and three FTE positions first requested for funding in FY 2011 (budget not yet approved)—a secretary for the senior judges, a staff attorney, and a senior attorney (for possible service as an appellate commissioner).

Funding to have the Court's financial statements audited.

Funding for design and site acquisition toward ultimate construction of a veterans courthouse. The FY 2012 request includes funding for the next major step in the construction, planning, and design process, as opposed to full construction cost funding, and is subject to continued congressional and veteran support for a veterans courthouse at this time.

Funding to acquire additional leased space to meet space needs for existing staff and two new judicial chambers.

Funding to continue agreements with the USMS for Court security, with the Department of Agriculture's NFC for payroll/personnel services, and with BPD for administrative payments, credit-card, travel, and financial accounting and reporting services. Also, to continue existing agreement with the AO for e-filing system support.

Funding to be made available for the Pro Bono Representation Program.

SUMMARY OF FISCAL YEAR 2012 BUDGET REQUEST
(in thousands of dollars—$000)

A summary of the FY 2012 funding requirements for conducting the Court's activities follows:

	FY 2011 Appropriation	FY 2012 Estimate	Change
FTE Positions	127	127	0
Personnel Compensation and Benefits	$17,458	$17,863	+$405
Other Objects (Operating Expenses)	$8,174	$10,208	+$2,034
Courthouse	$62,000	$25,000	–$37,000
Grants	$2,515	$2,726	+$211
Budget Authority/ Appropriation	$90,147	$55,797	–$34,350

The FY 2012 budget request of $55,796,690 reflects a decrease of $34,350,039 from the Court's budget request for FY 2011. This significant decrease results primarily from the fact that $62,000,000 was requested in FY 2011 for construction of a veterans courthouse. That request has not been approved, and indications from congressional staff are that the project will be funded, if at all, in a piecemeal fashion tied to major steps in the construction process. GSA advises that $25,000,000

will fund the next major step, which is design engineering and site acquisition, and this is the amount reflected in our FY 2012 budget request.

The Court's operating expenses reflect an overall increase of $2,033,827, primarily due to the fact that two new chambers for which funding was requested and appropriated in 2010 were not built out and equipped because the judges were not appointed, and funding for this purpose was not requested in our FY 2011 budget request. The FY 2012 request for personnel compensation and benefits reflects an increase of $405,000 over our FY 2011 budget request to accommodate scheduled step increases and time-in-grade promotions for current FTE positions. There is also a $211,000 increase requested by the Pro Bono Representation Program.

FISCAL YEAR 2012 PROGRAM FUNDING CHANGES
(in thousands of dollars—$000)

Personnel Compensation and Benefits: +$405

The overall increase in personnel compensation and benefits includes maintaining FTE positions at the FY 2011 level, as well as accommodating scheduled step increases and time-in-grade promotions.

All Other Objects (Operating Expenses): +$2,034

The increase in operating expenses is due largely to anticipated one-time expenses to build out and equip two new chambers for two additional judges authorized and anticipated to be appointed.

Courthouse: (–$37,000)

This significant decrease results primarily from the fact that $62,000,000 was requested in FY 2011 for construction of a veterans courthouse that has not been approved, with indications from congressional staff that the project will be funded, if at all, in a piecemeal fashion tied to major steps in the construction process. GSA advises that $25,000,000 will fund the next major step, which is design engineering and site acquisition.

Grants: +$211

The grantee, Pro Bono Representation Program, explains its request in Appendix A.

Total Changes: –$34,350

DETAILS OF FISCAL YEAR 2012 FUNDING CHANGES
(in dollars—$0)

The following information provides details for the funding changes from the FY 2011 budget request:

PERSONNEL COMPENSATION & BENEFITS: +$405,000

The overall increase in personnel compensation and benefits includes maintaining existing FTE positions as well as accommodating possible promotional allowances.

OTHER OBJECTS (OPERATING EXPENSES): +$2,033,827

TRAVEL: +$55,000

Budget requests in FY 2010 and FY 2009 have proven to be inadequate, but this trend was identified after submission of the FY 2011 budget. This increase will accommodate ongoing Court travel for oral arguments outside of the Washington, D.C. Metropolitan Area.

TRANSPORTATION OF EQUIPMENT: +$1,000

Budget requests in FY 2010 and FY 2009 have proven to be inadequate, but this trend was identified after submission of the FY 2011 budget. This increase will accommodate ongoing Court activities, to include transportation of things associated with Court travel as well as continue to fund for anticipated additional staff.

RENTAL PAYMENTS TO GSA: +$105,000

This increase is attributed to the estimated rental costs for the current space (42,541 sq ft) plus future space (13,000 sq ft). The amount is calculated based on information provided by GSA.

RENTAL PAYMENTS TO OTHERS: **+$3,600**

This increase is attributed to the estimated rental cost for garage and storage space.

COMMUNICATIONS, UTILITIES, AND MISCELLANEOUS CHARGES: **+$25,000**

This increase is based on increased communications and utilities costs experienced over the past 2 years and projected additional costs to provide communications and utilities associated with the appointment of two additional judges, additional staff, and an increase in future leased space of approximately 13,000 sq ft.

PRINTING & REPRODUCTION: **+$7,000**

Increased to accommodate additional printing costs for a Bench and Bar Conference.

ALL OTHER SERVICES: **+$100,000**

This increase is due to increased cost associated with the USMS contract for Court security officers, finance and accounting services, guards in the building and garage pursuant to the FPS contract, security-system maintenance, and projected cost associated with the appointment of two additional judges, additional staff, and an increase in future leased space of approximately 13,000 sq ft.

SUPPLIES & MATERIALS: **+$60,000**

This increase is for the initial set up and supply for two new chambers to accommodate two additional judges and the required supporting staff.

EQUIPMENT: **+$625,000**

This increase reflects our scheduled industry standard (3-year) replacement program for IT equipment and continued enhancement of electronic filing and case management.

CONTRIBUTION TO JUDGES RETIREMENT TRUST FUND: **+$1,052,227**

This increase reflects the amount required to maintain the statutorily required estimate for full funding as of September 30, 2011, for the retirement fund, as estimated by Actuary's report.

COURTHOUSE: **(–$37,000,000)**

This significant decrease results primarily from the fact that $62,000,000 was requested in FY 2011 for construction of a veterans courthouse that has not been approved, with indications from congressional staff that the project will be funded, if at all, in a piecemeal fashion tied to major steps in the construction process. GSA advises that $25,000,000 will fund the next major step, which is design engineering and site acquisition.

GRANTS: **+$211,134**

The grantee, Pro Bono Representation Program, explains its request in Appendix A.

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

PROGRAM AND FINANCING

(in thousands of dollars)

	2010 Actual	2011 Budget Request	2012 Estimate
OBLIGATIONS BY PROGRAM ACTIVITY			
10.00 Total obligations	$25,436.0	$90,147.0	$55,797.0
BUDGETARY RESOURCES AVAILABLE FOR OBLIGATION			
21.40 Unobligated balance available, start of year		$ --	
22.0 New budget authority (gross)	$27,115.0	$90,147.0	$55,797.0

PROGRAM AND FINANCING—Continued

(in thousands of dollars)

	2010 Actual	2011 Budget Request	2012 Estimate
22.30 Unobligated balance expiring	$1,679.0	$ --	$ --
23.95 New Obligations	$25,436.0	$90,147.0	$55,797.0
24.40 Unobligated balance available, end of year	$ --	$ --	$ --
NEW BUDGET AUTHORITY (GROSS) DETAIL			
40.00 Appropriation	$27,115.0	$90,147.0	$55,797.0
40.35 Appropriation rescinded	$ --	$ --	$ --
43.00 Appropriation (total)	$27,115.0	$90,147.0	$55,797.0
CHANGE IN UNPAID OBLIGATIONS:			
72.40 Obligated balance, start of year	$10,796.0	$10,987.1	$11,077.2
73.10 New obligations	$25,914.2	$90,147.0	$55,797.0
73.20 Total outlays (gross)	–$25,712.5	–$90,056.9	–$50,217.3
74.40 Obligated balance, end of year	$10,987.1	$11,077.2	$16,656.9
OUTLAYS (GROSS), DETAIL			
86.90 Outlays from new current authority	$23,313.8	$79,069.8	$39,140.1
86.93 Outlays from current balances	$2,398.8	$10,987.1	$11,077.2
87.00 Total Outlays	$25,712.5	$90,056.9	$50,217.3
NET BUDGET AUTHORITY AND OUTLAYS			
89.00 Budget authority	$27,115.0	$90,147.0	$55,797.0
90.00 Outlays	$25,712.5	$90,056.9	$50,217.3

SALARIES AND EXPENSES

Object Classification (in thousands of dollars)

Direct Obligation	2010 Actual	2011 Budget Request	2012 Estimate
11.1 Full-time permanent	$10,386.25	$13,225.00	$13,625.00
11.5 Other personnel compensation	$284.47	$150.00	$150.00
11.9 Total personnel compensation	$10,670.72	$13,375.00	$13,775.00
12.1 Civilian personnel benefits	$2,853.77	$4,083.00	$4,087.50
13.1 Unemployment compensation			
21.0 Travel and transportation of persons	$99.63	$70.00	$125.00
22.0 Transportation of things	$3.40	$3.00	$4.00
23.1 Rental payments to GSA	$2,100.00	$3,500.00	$3,605.00

SALARIES AND EXPENSES—Continued

Object Classification (in thousands of dollars)

Direct Obligation	2010 Actual	2011 Budget Request	2012 Estimate
23.2 Rental payments to others	$104.10	$120.00	$123.60
23.3 Communications, utilities, and miscellaneous charges	$149.97	$145.00	$170.00
24.0 Printing and reproduction	$23.35	$13.00	$20.00
25.2 Other services	$1,577.28	$1,793.00	$1,843.00
25.3 Purchases of goods and services from government sources	$757.53	$590.00	$620.00
25.4 Operation and maintenance of facilities	$41.00	$37.00	$45.00
25.7 Operation and maintenance of equipment	$89.50	$80.00	$92.00
26.0 Supplies and materials	$164.97	$193.00	$253.00
31.0 Equipment	$691.99	$325.00	$950.00
32.0 Land and Structures	$0.00	$62,000.00	$25,000.00
41.0 Grants, subsidies, and contributions	$1,820.00	$2,515.00	$2,726.36
43.0 Interest	--	--	--
94.0 Contributions to Trust Fund	$4,715.37	$1,305.00	$2.357.23
99.0 Total obligations	**$25,862.58**	**$90,147.00**	**$55,796.69**

JUDGES RETIREMENT FUND

The Judges Retirement Fund, established under 38 U.S.C. § 7298, is used for judges' retired pay and for annuities, refunds, and allowances provided to surviving spouses and dependent children. Participating judges pay 1 percent of their salaries to cover creditable service for retired-pay purposes and 2.2 percent of their salaries for survivor-annuity purposes. Additional funds needed to cover the unfunded liability may be transferred to this fund from the Court's annual appropriation. The Court's contribution to the fund is estimated annually by an actuarial firm retained by the Court. The fund is invested solely in government securities. The Court paid from fund assets one survivor annuitant and six retired judges in FY 2010. In FY 2011 and FY 2012, the Court anticipates these payments to retired judges to increase to seven retirees.

JUDGES RETIREMENT FUND

(in thousands of dollars)

Unavailable Collections Schedule:	2010 Actual	2011 Budget Request	2012 Estimate
Balance, Start of year:			
01.99 Balance, start of year	$19,039.00	$22,727.00	$23,657.00
Receipts:			
02.01 Earnings on investment	$52.22	$650.00	$80.00
02.02 Employer contributions	$4,715.37	$1,530.00	$2,357.00

JUDGES RETIREMENT FUND—Continued

(in thousands of dollars)

Unavailable Collections Schedule:	2010 Actual	2011 Budget Request	2012 Estimate
02.03 Employee contributions	$47.60	$50.00	$55.00
02.99 Subtotal, receipts	$4,815.19	$2,230.00	$2,492.00
04.00 Ofsetting Collectons (Outlays)	$1,124.17	$–1,300.00	$–1,474.00
88.03 Total: Balances and collections	$22,727.00	$23,657.00	$24,675.00
Appropriations:			
65.99 Judges Retirement and Survivor Annuity Fund	$1,124.17	$–1,300.00	$–1,474.00
88.99 Balance, end of year	$22,727.00	$23,657.00	$24,675.00

APPENDIX A

THE VETERANS CONSORTIUM PRO BONO PROGRAM

FY 2012 FUNDING REQUEST, BUDGET AND NARRATIVE

Overview

The Pro Bono Program is requesting an appropriation of new grant funds in the amount of $2,726,363 for FY 2012. This request represents an increase of $216,133 or 8 percent from the $2,515,229 pending authorization for the Program for the current FY 11. The Pro Bono Program has recently brought on a new Executive Director and taken steps to become a "stand-alone" entity. The 8 percent increase is due to the need to cover the additional costs associated with this goal.

The Program's proposed budget for FY 2012 is attached.

SIGNIFICANT PRO BONO PROGRAM, COURT, and BVA STATISTICS:

The Program sent program information to 2,320 pro se appellants in calendar year (CY) 2010, a slight decline over prior years. The Program received 671 requests for assistance in 2010. This continues to mirror the change in the Court's caseload; historically, the Court has received 2,200–2,400 new filings per fiscal year, until FY 2005, when the Court's caseload began to rise rather dramatically.

The Court's Annual Reports (available at www.uscourts.cavc.gov/documents/Annual_Report_FY_2009_October_1_2008_to_September_30_2009.pdf) indicate that the Court had 4,725 new pro se and represented cases filed in 2009; 4,128 new cases filed in FY 2008; 4,644 new cases filed in FY 2007; and 3,729 new cases filed in 2006. Preliminary Court statistics for FY 2010 indicate that the number of new cases filed with the Court in FY 2010 declined slightly from FY 2009, to 4,340.

The Program evaluated 669 cases in 2010, a decline over the 849 cases evaluated in 2009, the 818 cases evaluated in CY 2008 and the 737 cases evaluated in CY 2007. Of those 669 evaluated cases, 205 cases were accepted into the Program, the remainder being rejected for a variety of reasons (e.g., financial ineligibility, jurisdictional defects, lack of merit, retained own counsel, etc.).

We note, as we did in our FY 11 budget request, that the Court's statistics (reported on a fiscal year basis) show that the percentage of appellants unrepresented at the time of filing the appeal remained steady at 58–59 percent from FY 2002 through FY 2005. While the percentage decreased to 53 percent in FY 2007, it rebounded to 64 percent in FY 2008 and increased further to 68 percent in FY 2009 (a level not seen since FY 2000). However, the pro se percentage declined in FY 2010 to 57 percent.

The Program continues to provide free legal service to a significant number of unrepresented veterans with active appeals at the Court, as more and more veterans seek judicial review. The number of appeals decided by the Board of Veterans' Appeals increases annually, with the BVA issuing over 48,800 decisions in 2009 and 43,700 decisions in 2008 (see http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2009AR.pdf). Preliminary reports from the BVA indicate that the Board decided

some 49,100 cases in FY 2010, although the percentage of denials declined from 36.1 percent in 2009 to 28.1 percent in 2010, which necessarily impacts the number of appeals to the Court, and the number of appellants seeking Program services.

However, the number of claims filed by a rapidly growing number of returning Iraq and Afghanistan veterans can be expected to continue to increase. We believe that the BVA will continue to decide an even greater number of appeals and that, in turn, more cases will be filed with the Court, and that there will be a resultant increased demand for Program services in 2012 and beyond.

To meet that anticipated demand, we added a full-time administrative support person in January, 2009. We are requesting continued funding for this administrative support person in FY 2012, and continuation of funding for the remainder of the Program staff. In addition, the Legal Services Corporation, in a recent review of the Program, concurred in the decision of the Board of Directors to hire a full-time Executive Director. We are pleased to report that the new Executive Director, with an extensive background in nonprofit management, joined the program on January 10, 2011.

DETAIL

Personnel costs—salary and benefits of those individuals performing services for the Program that are reimbursed from grant funds—account for 57 percent of the proposed FY 12 budget. These costs include the time for part-time personnel who staff the Outreach and Education Components and the time of the full-time paid personnel who staff the Case Evaluation and

Table A

PRO BONO PROGRAM PERSONNEL AND FTE DISTRIBUTION

Component	Total Number of Personnel Providing Services to the Program FY 11	Total FTE Authorized by the Grant FY 11	Total Number of Personnel Providing Services to the Program FY 12	Total FTE to be Authorized by the Grant FY 12
Outreach	6	0.25	6	0.25
Education	13	0.92	13	0.92
Case Evaluation and Placement	11	11	11	11
Direct Representation	1	1	1	1
Administration	3	3	3	3
Total	**34**	**16.17**	**34**	**16.17**

Placement Component along with the three new additional personnel required to move the Pro Bono Program to a stand-alone entity. Staff who are reimbursed from grant funds for all or a portion of their salary and benefits are currently employees of either the National Veterans Legal Services Program (NVLSP) or the Paralyzed Veterans of America (PVA). It is anticipated that by the end of 2011, all of these personnel will be employees of the stand-alone entity.

Table A above shows in summary form the number of persons providing services for each component, and the number of Full Time Equivalent (FTE) positions to be paid out of grant funds in FY 11 and FY 12.

A detailed breakdown by Component follows.

I. Case Evaluation and Placement Component **$1,698,330**

The FY 12 funding request reflects a $168,132 (10.99 percent) increase over the FY 11 budget for the Case Evaluation and Placement. Personnel cost increased by $56,361 and non-personnel cost increased by $111,771 for this Component.

A. Personnel

There are three categories of personnel staffing this component—attorneys, non-attorney veterans law specialists, and other.

Three attorneys—the Director, the Deputy Director for Case Evaluation and the Deputy Director for Placement—function full time. Their personnel costs are currently fully reimbursed by the Program—one position to PVA and two positions to NVLSP. The attorneys are reimbursed from grant funds, in both FY 11 and FY 12. It is anticipated that all of these individuals will become full time employees by FY 12.

Veterans law specialists review the VA claims file and BVA decision in each case to determine whether the case presents an issue that justifies referral to a lawyer. Veterans law specialists are among the most experienced non-lawyer personnel in the veterans-law field. The Program requests funding for four full time veterans law specialists in FY 12, the same number as in FY 11. It is anticipated that all of these individuals will also become full time employees by FY 12.

We request funding for four full time administrative support staff. All are currently employees of NVLSP, and are all reimbursed out of Program funds. The other components in this increase represent the combination of a modest cost of living and merit raises.

The level of salaries and benefits paid by the Program for personnel provided on a reimbursable basis is governed by the personnel policies of the constituent organizations of which they are employees—i.e., NVLSP and PVA—and to which they may return in the event of termination of the Program or rotation of personnel by the organizations involved. Typically, the Program budgets a 5 percent increase in salary and benefits—3 percent for cost-of-living increases, and 2 percent for merit increases. The budget for FY 12 follows this formula. Such increases are reflected in the personnel costs of all four Components of the Program in the FY 12 budget.

B. Space-Rent

The largest single increase in the requested budget for FY 12 is associated with space-rental costs. The Program's current space lease will expire in November, 2012. Consequently, during FY 12, the Program will be entering into a new lease. It is expected that the Program will incur higher rental costs and moving costs related to the anticipated move. The FY 12 funding request reflects an $82,208 (33.39 percent) increase over the FY 11 budget for this line item.

C. Equipment Rental and Maintenance

The increase of $903 from FY 11 provides for a 5 percent rate adjustment for the maintenance contracts/service agreements on office equipment and telephone system.

D. Office Supplies & Expense

The increase of $12,122 over the amount budgeted for FY 11 reflects the increased cost for office supplies and the use of Priority Mail to expedite delivery of Program materials to an increased number of pro se appellants. Furthermore, due to the Court's change in the manner in which the cases are referred to the Pro Bono Program, i.e., from hard copy to electronically, the copying costs have risen significantly. This increase represents a 17.32 percent rise over the prior year.

E. Telephone

The increase of $540 over the amount budgeted for FY 11 provides for a 5 percent rate increase.

F. Travel/Continuing Legal Education

The increase of $1,060 provides for a 5 percent increase over FY 11.

G. Library

The increase of $381 over the amount budgeted for FY 11 provides for a 5 percent rate increase.

H. Insurance

The increase of $5,344 over the amount budgeted for FY 11 represents a 77.67 percent increase that is due to the Pro Bono Program having to acquire its own insurance. In prior years, the Pro Bono Program was able to rely on the NVLSP for insurance coverage. By moving to a stand alone entity, the Pro Bono Program's insurance costs have significantly increased.

I. Dues and Fees

There is a significant increase in expected costs associated with Dues and Fees over the prior year. The increase of $3,090 represents a 166.51 percent rise over FY 11 due, in large part, to costs related to becoming a stand alone entity.

J. Audit

The increase of $1,050 over the amount budgeted for FY 11 provides for a 5 percent rate increase.

K. Property Acquisition

The increase of $525 over the amount budgeted for FY 11 provides for a 5 percent rate increase.

L. Contract Services

The increase of $20,277 over the amount budgeted for FY 11 provides for a 5 percent rate increase in expected Contract Services.

M. Expense for Administration

The increase of $2,100 allows for a 5 percent rate increase for the cost of grant administration, which now must be procured from a third party, since NVLSP will no longer supply it at a reduced fee.

II. Direct Representation Component **$131,250**

Some cases require immediate attention by a lawyer experienced in veterans law. Previously, PVA committed to accepting 20 such cases and charging the Pro Bono Program just 75 percent of PVA's out-of-pocket costs, the remaining 25 percent being donated by PVA. It is unclear whether, when the Pro Bono Program becomes a stand-alone entity, these services will remain available at a discounted rate. Consequently, the FY 12 budget provides for the hiring of a full-time attorney to handle these cases and other items that may arise during the course of the year.

III. Outreach Component **$74,579**

The Outreach Component is provided on a fixed price contract by the NVLSP. Overall, the FY 12 budget calls for a $3,551 increase from the FY 11, a 5 percent increase. In addition to the prior outreach services, this budget component also provides for Web site maintenance and an annual report and brochure.

IV. Education Component **$300,828**

The proposed FY 12 budget for the Education Component reflects an increase of $14,325 (5 percent) over the budget for FY 11. Like the Outreach Component, for FY 12, these services are being provided by the NVLSP at a fixed price. Included in this budget component are the costs of volunteer reference materials of approximately $105,000.

V. Executive Administration **$501,375**

In accordance with certain suggestions made by the Legal Services Corporation in its 2009 *Program Quality Report* assessing the Pro Bono Program, the Program is in the process of becoming a "stand-alone" entity such that it will no longer be able to rely upon component veterans service organizations (The American Legion, Disabled American Veterans, National Veterans Legal Services Program and Paralyzed Veterans of America) for certain administrative and other assistance. The amount budgeted for FY 12 represents a 5 percent increase over FY 11, specifically $23,875.

VI. TOTAL BUDGET REQUESTED

Case Evaluation and Placement Component	**$1,698,330**
Direct Representation Component	**$131,250**
Outreach Component	**$74,579**
Education Component	**$300,828**
Executive Administration	**$501,375**
Total Budget	**$2,706,363**
LSC Oversight	**$20,000**
TOTAL Budget & Oversight	**$2,726,363**
LESS: ANTICIPATED FY 11 CARRYOVER	**($0)**
TOTAL FY 2012 FUNDING REQUESTED	**$2,726,363**

Pre-Hearing Budget Questions
The Honorable Jeff Miller, Chairman
U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012
February 17, 2011

General Questions

Question 1: The President's National Commission on Fiscal Responsibility and Reform issued its report in December 2010. In discussing possible solutions to our country's fiscal crisis the report highlighted that "everything must be on the table," to include the elimination of redundant, wasteful, and ineffective spending that may exist within every Federal agency.

Question 1(a): To what extent has VA undertaken a comprehensive effort to identify and eliminate redundant, wasteful, and ineffective spending consistent with the Commission report's mandate? If VA has not yet done so, will it?

Response: VA has conducted a review of the efficiencies to be gained, and the savings to be achieved within the agency. These improvements are estimated to total $745 million in FY 2011. Similar improvements are included in VA's budget request for 2012 at estimated savings of $1.2 billion.

The VA is firmly committed to increasing the value of every dollar entrusted by the Congress and the American taxpayer to this Department for the delivery of benefits and services to Veterans, their families and survivors. For example, in 2011, we are implementing several operational improvements in our medical care programs that will save money while improving the quality of health care. These include:

- Reducing indirect costs by adopting uniform standards for administrative and support services;
- Reducing the costs of non-VA provided dialysis by implementing Medicare's standard payment rates;
- Reducing acquisition costs by consolidating contracting requirements, adopting strategic sourcing and other initiatives;
- Reducing improper payments and improving operational efficiencies in the administration of the medical fee program; and
- Reducing payroll costs by increasing capabilities and productivity of health care professionals through more appropriate alignment of the mix of physician and nursing staff, and other non-physician providers, to meet patient demand.

In developing the 2012 budget, we also carefully reviewed requirements in our non-medical programs. As a result, we will reduce spending by $1.1 billion below current 2011 estimates in several program areas. For example, by prioritizing our most critical safety and security capital infrastructure needs, funding for major and minor construction will be reduced. Investments in information technology will begin to pay dividends as deployment of the Veterans Benefits Management System (VBMS) begins in 2012, allowing for increased productivity and reduced operating costs in processing disability compensation claims in the Veterans Benefits Administration. In addition, we are adopting new acquisition strategies to make more effective use of our information technology resources, including consolidating requirements into 15 prime contracts that will allow VA to leverage economies of scale and reduce IT spending.

VA has also instituted a number of innovative practices to improve our energy efficiency and make more effective use of our resources. For example, the National Cemetery Administration (NCA) has implemented creative approaches to cemetery operations: the use of pre-placed crypts, that preserve land and reduce operating costs; application of "water-wise" landscaping that conserves water and other resources; and installation of alternative energy products such as windmills and solar panels that supply power for facilities. NCA has also utilized biobased fuels that are homegrown and less damaging to the environment. NCA is developing an independent study of emerging burial practices throughout the world to inform its planning for the future.

In the past 2 years, we have established and created management systems, disciplines, processes, and initiatives that help us eliminate waste. Financial and performance metrics provide the foundation for monthly performance reviews that are chaired by the Deputy Secretary. These monthly meetings play a vital role in monitoring performance throughout the Department, and are designed to ensure both operational efficiency and the achievement of key performance targets. In addition, a new budget review cycle was established to further strengthen stewardship of our financial resources. This cycle has three components: pre-year review; mid-year re-

view; and post-year review. The Secretary chairs meetings in each review cycle to assess budget and operational efficiency and effectiveness.

We also demonstrated our ongoing commitment to effective stewardship of our financial resources by obtaining our 12th consecutive unqualified (clean) audit opinion on VA's consolidated financial statements. In 2010, we were successful in remediating 3 of 4 longstanding material weaknesses, a 75 percent reduction in just 1 year.

Question 1(b): What barriers exist, legal or otherwise, to eliminate any such wasteful spending?

Response: We have not identified any legal barriers to date. However, VA's authority to enter into private/public ventures to make better use of underutilized space and land through enhanced use leasing is scheduled to lapse at the end of calendar year 2011. The Administration remains committed to this important program, and a proposal to address the expiration will accompany the Department's legislative package through the President's program.

Question 2: The President's Commission highlighted the fact that Federal travel, printing, and vehicle budgets have ballooned in recent years and recommended these areas for fiscal restraint.

Question 2(a): Please outline for me VA-wide spending in each of these categories for each of fiscal years 2009, 2010, the current estimate for FY 2011, and what is proposed for FY 2012.

Response: VA medical personnel require frequent training to maintain clinical skills and medical knowledge. Similarly benefits raters require training to implement programs. Please see the table below:

Department of Veterans Affairs
Employee, Travel, Printing, and Fleet Services

($ in millions)

Appropriated	**2009**	**2010**	**2011**	**2012**
Employee Travel	193	228	259	252
Printing	27	40	46	56
Fleet Vehicles	69	73	80	86
Total	$289	$341	$385	$394

Question 2(b): What is your assessment regarding the Commission's recommendation in this area and its potential applicability to VA?

Response: The Commission made the following observations:

"1.10.5 Reduce Federal travel, printing, and vehicle budgets. Despite advances in technology, Federal travel costs have ballooned in recent years, growing 56 percent between 2001 and 2006 alone. Government fleets, meanwhile, have grown by 20,000 over the last 4 years. Printing costs are still higher than necessary despite technological advancement. We propose prohibiting each agency from spending more than 80 percent of its FY 2010 travel budget and requiring them to do more through teleconferencing and telecommuting. We also recommend a 20 percent reduction in the nearly $4 billion annual Federal vehicle budget, excluding the Department of Defense and the Postal Service. Additionally, we recommend allowing certain documents to be released in electronic-only form, and capping total government printing expenditures. This proposal will save $1.1 billion in 2015."

For VA, the key driver to savings in this area lies in government travel, which dwarfs the costs of government printing and fleet vehicles. In this important area, VA's 2012 budget proposes a reduction of $6M from the current estimate for 2011, which is a reduction of 2.3 percent. VA believes that these costs should be taken in context with the growth in complexity of the Department's mission and our initiatives to increase access to health care to Veterans residing in rural areas. In addition, travel costs have increased with the hiring and training of new staff, including additional disability claims processors.

Question 3: VA's budget request for fiscal year 2011 did not assume any unobligated balance, i.e., carryover, would be available from funds appropriated for fiscal year 2010. However, VA's Quarterly Status Report for the fourth quarter of fiscal year 2010 suggests an end-of-year unobligated balance for VA medical care accounts in excess of $1.5 B and additional unobligated balances in other accounts.

Question 3(a): What is VA's plan for this unanticipated carryover of funds?

Response: VA will use all of the carryover funds, from FY 2010 in FY 2011, to meet Veterans' health care needs.

Veterans Health Administration Unobligated Balances as of September 30, 2010 That Are Available for Obligation in FY 2011

Fund Account Number	Fund Description	Unobligated Balance
0152	**Medical Support & Compliance**	**$132 million**
• $48 million will be used to pay for supplies, equipment and contracts to provide health care services to veterans at VA medical centers. • $39 million will fund initiatives to expand access to and enhance health care services for rural veterans • $32 million will be used to fund initiatives including enhanced teleradiology capabilities, recruiting initiatives for scarce clinical specialists, training for clinical staff, and enhancements to the disability rating process for veterans. • $7 million was specifically designated by Congress for prosthetics for veterans that will be used for that purpose in FY 2011. • $6 million was specifically designated by Congress for pandemic influenza.		
0160	**Medical Services**	**$1,208 million**
• $700 million will be used to pay for supplies, equipment and contracts to provide health care to Veterans at VA medical centers. • $289 million will be used to fund activation costs of 55 major construction and lease projects providing new or enhanced VA health care facilities, including the cost of initial outfitting of each facility with equipment and supplies, as well as the cost of new workload associated with those new facilities that will begin to provide health care to Veterans during FY 2011. • $105 million will be used to implement provisions of Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010. • $30 million will fund the Homeless Veterans Supported Employment Program. • $24 million will fund pilot projects to provide dialysis care for Veterans and to enhance the process by which Veterans receive disability ratings. • $24 million will fund initiatives for recruitment and training of scarce clinical specialties. • $13 million will be used in FY 2011 for polytrauma centers to treat severely wounded and injured Veterans, as specifically designated by Congress. • $10 million will fund enhanced operations at the National Center for Post-Traumatic Stress Disorder. • $7 million was specifically designated by Congress for pandemic influenza prevention, treatment and staff protection at VA medical centers and will be used for that purpose in FY 2011. • $6 million will fund the DoD–VA Eye Center of Excellence.		
0161	**Medical & Prosthetic Research**	**$106 million**
These funds will be used for ongoing and new resesarch projects.		
0162	**Medical Facilities**	**$109 million**
• $103 million will be used to fund activation costs of 55 major construction and lease projects providing new or enhanced VA health care facilities, including the cost of initial outfitting of each facility with equipment and supplies. • $3 million was specifically designated by Congress for polytrauma centers to treat severely wounded and injured Veterans and will be used for that purpose in FY 2011.		

Veterans Health Administration Unobligated Balances as of September 30, 2010—Continued
That Are Available for Obligation in FY 2011

Fund Account Number	Fund Description	Unobligated Balance
	• $2 million is energy rebate collections that will be used to fund FY 2011 energy costs. • $1 million was specifically designated by Congress for pandemic influenza prevention, treatment and staff protection at VA medical centers and will be used for that purpose in FY 2011.	
Total		**$1,555 million**
Obligated as of January 31, 2011		**$660 million**

Question 3(b): In fiscal year 2010 VA used carryover funds from FY 2009 to begin new Information Technology initiatives and create new staff positions within the Office of the Secretary, initiatives and positions that were never justified in the FY 2010 budget submission. Has VA used any carryover funds from FY 2010 to begin initiatives, increase staff, or establish new offices that were never justified in the FY 2011 budget request? Does it plan to do so?

Response: The Department has used Information Technology carryover in implementing a new approach to managing the Department's IT investments in FY 2011 within the authorities previously provided. That new approach, the Project Management Accountability System (PMAS) is documented in detail in the Volume 2 of the FY 2012 President's Budget submission for the Department. The limited carryover available in the General Administration account has not been used to begin new initiatives, increase staff or establish new offices that were not included in the FY 2011 budget and there are no current plans to do so.

Question 4: In a July 30, 2011, letter to Congress, Secretary Shinseki stated that there currently is no authority to carry over unobligated balances made available in the FY 2011 advance appropriation and "[a]s a result, VA will be unable to use carryover funds in this manner in future years unless Congress extends carryover authority."

Question 4(a): Will the Department seek such carry over authority and, if so, how does this reconcile with VA's FY 2011 budget submission which assumed no unobligated carryover balances from fiscal year 2011?

Response: The legislative language to authorize this carryover was included in the 2011 President's budget that was submitted in February 2010, in sections 226, 227 and 228 of the Administrative Provisions. VA strongly recommends that Congress provide this authority in final appropriations action for FY 2011. The ability to carryover funding from 2011 into 2012 is a key building block of VA's 2012 budget. Without the authority for carryover funding at the end of 2011, increased appropriations would be required in the carryover amount over the 2012 budget request to meet the health care needs of Veterans.

Question 5: Public Law 111–322 included a 2-year freeze on Federal employee pay through December 31, 2012.

Question 5(a): What impact, if any, does this Federal pay freeze have on the Department of Veterans Affairs employees? Specifically, does this prohibit VA from implementing regularly scheduled step increases, bonuses, pay authorities for Veterans Health Administration physicians and dentists as provided for under Public Law 108–445 or other title 38 hybrid occupations?

Response: The Federal pay freeze has an impact on all Department of Veterans Affairs (VA) employees, including Veterans Health Administration (VHA) physicians and dentists and other employees in health care occupations who are normally entitled to statutory and administrative adjustments.

In accordance with the Office of Personnel Management's guidance regarding the pay freeze, VA will forgo general increases to all pay systems and pay schedules covered by title 38 whenever possible. However, we will authorize such administrative increases if extraordinary circumstances exist that compromise patient care. Consistent with the spirit of the President's memorandum regarding the pay freeze,

management officials will make any such adjustments in a prudent and strategic manner.

During the pay freeze, VHA physicians and dentists will continue to receive regular step increases based on longevity. Additionally, adjustments to market pay for individual physicians and dentists are not prohibited by the pay freeze, and may be used in a strategic effort to meet the recruitment and retention needs for a specialty or assignment of a physician or dentist at a VA facility. Physicians and dentists will also remain eligible to receive performance pay and special contribution awards during the pay freeze.

The pay freeze does not prohibit employees from receiving regularly scheduled step increases or bonuses. In regard to the VHA Physician and Dentist pay system, authorized by Public Law 108–445, the pay freeze did not affect employees from receiving scheduled increases on the Base and Longevity Pay Scale nor the receipt of Performance Pay, which is paid in a lump sum payment after the end of the fiscal year through the attainment of established goals.

Overall, the pay freeze may have an impact on retention for critical health care occupations or information technology positions that are in high demand in the private sector; however, having the ability to provide incentive pay and awards during the pay freeze will help in our efforts to retain high quality employees.

Question 5(b): What is the financial impact of the pay freeze and what is VA's plan for the excess appropriation?

Response: The 2011 advance appropriation for VA medical care included $213 million for the employee pay raise. VA plans to carry over this funding into 2012 to meet increased patient demand in our health care system. All other programs are operating under the funding provided by the current continuing resolution.

Question 6: VA frequently conducts national training and educational conferences for its employees at various locations throughout the country.

Question 6(a): For both the current fiscal year and fiscal year 2012, how much money is budgeted for such national conferences?

Response: $20,018,644 for FY 2011 and $22,020,508 for FY 2012.

Question 6(b): Does VA have a policy on the maximum per night cost for lodging and daily per diem payments when choosing conference locations?

Response: VA ensures that when selecting venues we are in compliance with the published FY 2011 GSA per diem rates that define the maximum for lodging and per diem.

Question 6(c): If so, what are those maximums and if not, why has VA not adopted such a policy in light of the current fiscal and economic climate?

Response: Maximum rates vary by locality and must comply with GSA schedule. Venues are selected based on compliance with GSA published per diem rates; we often rule some cities/venues out of contention based on "price unreasonableness" IAW FAR 14.408–2 and 15–404–1(b). In doing so, the contracting officer performs a price analysis before evaluating the venues. If a venue is not "price reasonable", it is automatically eliminated and is no longer considered for evaluation. If a venue is determined price reasonable, then it is evaluated based on "best value."

Question 7: Both VA and DoD operate overlapping programs and systems of benefits and care that have as their goal improving the lives of Servicemembers, veterans, and their families. Although much improvement has been made in this area, more can be done.

Question 7(a): How can both entities better partner on issues of relevance to both organizations in a manner that reflects better accountability and fiscal responsibility?

Response: The VA/DoD Joint Executive Council (JEC) was established by Congress in 2003 and provides opportunities for improved collaboration and coordination between the two Departments. The JEC has served as a mechanism for identifying policies, procedures, and practices that would promote the sharing or exchange of services and resources between VA and DoD. The JEC consists of separate Health and Benefits Councils with nineteen working groups focusing on finding better ways to partner on a wide range of health and benefits related issues. Two specific examples of JEC initiatives in FY 2010 designed to increase fiscal responsibility were:

- VA and DoD expanded the capabilities of the Medical Surgical Product Data Bank (MEDPDB) which provides VA and DoD the unique ability to analyze

spending, resource and standardize products, and determine best prices from a single system, resulting in a cost avoidance of over $13.2 million dollars in FY 2010.
- There were 98 VA and DoD pharmaceutical contracts and agreements that resulted in more than a $500 million in cost avoidance.

Additionally, the VA and DoD Deputy Secretaries chair monthly meetings of the Wounded, Ill, and Injured (WII) Senior Oversight Committee (SOC). The SOC was created to coordinate policies to improve the medical care, disability processing, and transition activities to the Department of Veterans Affairs for all military personnel, but particularly to improve the support of injured Servicemember's recovery, rehabilitation, and reintegration.

Health Care

Question 8: The Department recently announced the establishment of two new offices: The Office of Patient Centered Care and Cultural Transformation; and the Office of Tribal Government Relations.

Question 8(a): Given the state of the U.S. economy, what, if any, cost analysis did VA employ to determine the cost of operating these separate and distinct offices and the reason the stated responsibilities could not be assumed under current Veterans Health Administration business lines which have received substantial budget increases to improve outreach and coordination and quality of care? If such an analysis was done, please provide it.

Response: The Patient Centered Care effort is one of many transformation initiatives in the Department's Strategic Plan. These major initiatives are designed to improve the value of VA health care—safety, quality, efficiency, and the experience patients and their families have when they obtain VA health care services. The new Office of Patient Centered Care (PCC) consists of 10 employees, including its Director, and has an operating budget of $1.676 million for its first year. The Office is responsible for VA's effort to transform our clinical and business processes to be more Veteran-centric. This fundamental change in our systems will allow VA to engage patients and their families in mutually beneficial and respectful health care partnerships that improve health outcomes and patient satisfaction. They will be working directly with Network and Medical Center leadership to bring about these changes.

VA attempted a cost benefit analysis before undertaking the PCC initiative. A literature review indicated many private sector organizations with similar patient care principles have realized economic returns on that investment. Patient-centered care approaches are rapidly becoming the norm in private health care. The Joint Commission has recently published proposed standards that will be incorporated into their accreditation requirements. Recognizing the evolving industry standards and the needs of Veterans, VA took this initiative to craft standards and programs that are best aligned with our very unique mission and patient population. We expect that many of the necessary changes can easily be accomplished within existing resources and will improve patient satisfaction and quality outcomes.

The new PCC office will be responsible for developing, evaluating, and implementing broad strategies to change current practices and organizational culture consistent with our patient centered care goals. They will have a major role in ensuring that all these efforts are integrated and aligned with operational plans. Consequently, this new Office was created under the Deputy Under Secretary for Health for Operations and Management. This placement is consistent with the philosophy and intent of the Under Secretary for Health's plans for the realignment of VHA Central Office to create a more effective and efficient organizational structure.

American Indians and Alaska Natives are one of the highest per capita populations of Veterans in any ethnic group but are among the least likely to access VA services and benefits. The Federal Government has a unique relationship with Indian tribes derived from the Constitution of the United States, treaties, Supreme Court doctrine, and Federal statutes. It is deeply rooted in American history, dating back to the earliest contact in which colonial governments addressed Indian tribes as sovereign Nations. The Department of Veterans Affairs, as a Federal agency, recognizes the government-to-government relationship between the United States and Federally recognized Indian tribes and acknowledges Indian tribes as sovereign Nations with inherent powers of self-governance. This relationship has been defined and clarified over time in legislation, Executive Orders, Presidential directives, and by the Supreme Court. The determination was made that as the Office of Public and Intergovernmental Affairs, within VA, is responsible for VA's partnerships with State, county, municipal governments that it should also be home to the office re-

sponsible for partnerships with Federally recognized tribal governments (OTGR). These partnerships address not only issues related to health care, but the full spectrum of services and resources offered by VA including Veterans Benefits Administration and the National Cemetery Administration.

Question 6(b): Who do the new Directors of these offices report to and how many new offices, such as these, does VA plan to establish this year?

Response: The new Director of PCC reports to the Deputy Under Secretary for Health for Operations and Management. Presently, under the Veterans Health Administration's (VHA) new T21 Major Initiatives, there are no plans to open any new offices such as PCC.

The new Director of the Office of Tribal Government Relations reports to the Assistant Secretary for Public and Intergovernmental Affairs.

Question 6(c): Please provide the Committee with a detailed description of all Department of Veterans Affairs, and in particular, Veterans Health Administration, office operations that are leased or shared in and around the Washington, D.C. area.

Response: Below is a list of office operations that are leased or shared in and around the Washington, DC area:

VACO—810 Vermont Ave., NW
NWLAF Bldg.—811 Vermont Ave., NW
TechWorld—801 I Street, NW
1800 G Street, NW
Indiana Plaza—625 Indiana Ave., NW
Landover Warehouse—7100 Old Landover Rd.
1575 I Street, NW
1722 I Street, NW
1717 H Street, NW
1990 K Street, NW
7th and D Sts., SW
131 M St., NE

Question 9: In a July 30, 2011, letter to Congress, Secretary Shinseki stated that VA expected new funding requirements as a result of passage of Public Law 111–148, the Patient Protection and Affordable Care Act (PPACA).

Question 9(a): What additional costs does VA expect for fiscal year 2012 as a result of the PPACA?

Response: The Indian Health Service (IHS) is initiating implementation of sections 2901(b) and 10221 of the Patient Protection and Affordable Care Act (Public Law 111–148). Section 2901(b) establishes IHS, Indian tribes, tribal organizations, and Urban Indian organizations as the payer of last resort for services provided by such entities to eligible individuals (25 U.S.C. 1623(b)). Section 10221 includes two provisions relating to Veterans and VA; the first relating to sharing arrangements between IHS, Indian tribes and tribal organizations and VA and the Department of Defense (DoD) (25 U.S. C. 1645) and the second pertaining to "eligible Indian Veterans" (25 U.S.C. 1647). The estimated cost in 2012 is $52 million.

Question 10: The statutory deadline for full implementation of the family caregiver program mandated by the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163) was January 30, 2011. However, not only is the program not implemented yet, no initial plan for the new program was submitted on November 1, 2010, also a statutory mandate.

Question 10(a): What is the delay attributable to?

Response: Drafting and policy discussions related to this unprecedented legislation, which directs the payment of a stipend directly to caregivers, has caused the VA to miss the mandated submission date. VA's planning and work on regulations has been ongoing since before the Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law. This work has continued throughout the time the implementation plan was under development.

The Implementation Plan was provided to Congress on February 9, 2011 and can be accessed at http://www.caregiver.va.gov/docs/Caregivers__part1.pdf.

The requirements of this legislation will take time to implement. Important requirements include determining eligibility, designating and approving primary and additional family caregivers, and providing stipends and health care coverage to primary family caregivers. VA must draft regulations defining specified benefits, and this process will provide Veterans and their caregivers an opportunity to provide

comments before those regulations are finalized. VA advised Committee staff during the consideration of the bill of its concerns with the proposed effective date, based on the mandatory periods involved in drafting regulations and submitting them for public comment. VA is working as quickly and responsibly as possible to deliver these enhanced benefits to eligible Veterans and their caregivers and will keep the Committee closely apprised of its progress.

Not all of the benefits in the law are complex. New benefits will be phased in with many enhanced support, training and counseling services already available. The new Caregiver Support Line (1–855–260–3274) and other support, training, and counseling services are available to all caregivers of Veterans. As of February 11, 2011, the Caregiver Support Line has already received well over 1,000 calls since it launched on February 1, 2011. Each VA medical center has designated caregiver support coordinators who will assist eligible Veterans and caregivers in understanding and applying for the new benefits, as well as accessing other existing support services. VA also has a Caregiver Support Web site, www.caregiver.va.gov, which will provide general information once final regulations are published.

Question 10(b): What funding in fiscal year 2011 has VA set aside for the caregiver program and what funding proposed for fiscal year 2012 will be devoted to it?

Response: VA has set aside $132 million in 2011 and $208 million in 2012 for implementation of all sections of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163); of these amounts, $30 million in 2011 and $66 million in 2012 are for implementation of the enhanced programs for caregivers found in Sections 101–104 of that law.

Question 11: As you know VA has a substantial backlog of pending projects designed to ensure that health care delivery is rendered in a modern setting. Among the options VA has to consider to achieve its goal of providing 21st century health care in modern, state-of-the-art facilities is to (1) renovate existing facilities; (2) build new facilities; (3) lease new facilities; (4) contract for care or (5) some combination of some or all of the above.

Question 11(a): What cost-benefit analysis does VA conduct before making decisions on how best to deliver modern health care to veterans.

Response: All capital (major, minor, non-recurring maintenance and leases) business case applications are reviewed and prioritized by a Department-wide Strategic Capital Investment Planning (SCIP) Board and approved through the VA governance process. VA Policy, the Capital Programming Guide in OMB Circular A–11, and OMB Circular A–94 all require a cost benefit or cost effectiveness analysis be completed. The VA SCIP process utilizes a cost-effectiveness analysis (CEA) that provides a life cycle cost comparison of alternatives including: Build, renovate, lease, and contract out for services. A detailed cost effectiveness analysis must be completed for each capital solution included in the OMB exhibit 300 business case. For SCIP projects, the benefits of each are provided in the business case justification and by the project's impact on closing specific gaps in access, space, utilization, safety and security.VA capital projects are required to complete business cases for capital projects which include alternatives analysis and a comparison of the net present value (NPV) of up to four options: status quo; construct new/renovate; lease space; and contract out services where appropriate.

Please outline the methodology VA uses to determine whether one approach should be advanced over another.

Response: The first step in deciding which capital solution should be chosen is to establish the type and level of the health care services needed and their appropriate location(s). VA's Health Care Planning Model provides data on the projected Veteran population, demographics, utilization, and access that assist in this determination.

The second step is to determine the best solution to meet the need (including SCIP identified infrastructure gaps) to provide that care—with a new facility, leased facility, renovated facility, or contract care where appropriate. All capital (major, minor, non-recurring maintenance and leases) business case applications are reviewed and prioritized by a Department-wide SCIP Board and approved through the VA governance process.

Other factors, such as the need for additional space, the ability to build on medical center campuses or renovate existing buildings, the requirement for quick implementation or flexibility to terminate a contract, and budget constraints, all go into determining the best solution for providing the best quality health care. For example, a medical center campus that is landlocked, with no excess space would need to pursue leasing or contracting out because building on campus or renovating exist-

ing space to provide additional care is not feasible. A campus with excess building space or acreage could more easily renovate space or build new space on the campus.

- Each Administration reviews their need to fill gaps in service, space, or condition and which capital project is the best solution.
- All business case applications are reviewed by a Department-wide SCIP Board, with assistance of the SCIP Panel. For a complete business case, capital projects (Construction and Lease) are required to conduct an alternatives analysis, including a comparison of the net present value (NVP) of four options: status quo; construct new/renovate; lease space; and contract out services.
- Project business case applications are scored and ranked on several SCIP criteria, one of which is called the "Best Value Solution," which provides an analysis of which option has the best NPV. If the chosen option does not have the best NPV, an explanation of why it is the chosen option is required.

Question 11(b): How is buy vs. lease determined?

- Many factors, such as the need for additional space, the capacity to build on medical center campuses or renovate existing buildings, the requirement for quick implementation or flexibility to terminate a contract, the most cost effective alternative, all go into the buy vs. lease determination. Each acquisition decision is considered and reviewed on an individual basis.

Question 11(c): Is a Cost Benefit Analysis (CBA) completed and by whom for every new construction project or lease agreement?

- VA utilizes the cost-effectiveness analysis for each construction and/or lease business case application to help ensure an accurate analysis the status quo and viable options. These cost-effectiveness analyses (CEA) are completed by the business case preparers and reviewed by the Department as part of the SCIP process.

Benefits and Memorial Affairs

Question 12: According to VBA's most recent Monday Morning Workload Report, the backlog of pending compensation and pension claims is currently at 775,552. This is an increase of 289,081 claims, or about 59 percent, from this time last year and is an increase of 390,410, or a 101 percent increase since President Obama took office. Congress has invested heavily in improving the claims process over the years, nearly tripling the number of claims processing staff since 1997 and making hundreds of millions in IT investments, yet the same problems persist.

Question 12(a): Can you please reflect on the goal of "breaking the back of the backlog" by reducing the average days to complete to 125 days with a 98 percent accuracy rate as listed as integrated objective 1 for the Compensation and Pension Service in the FY 2011 budget request?

Response: VA's commitment to "breaking the back of the backlog" relies on a three-tiered approach that addresses people and culture, re-engineered business practices, and technology improvements. Our backlog today is a symptom of fundamental problems in our capabilities and processes—problems we are now aggressively solving. We remain dedicated to providing timely service with the highest quality to our Nation's Veterans. By 2015, we intend to have no Veteran wait longer than 125 days for a quality decision (98 percent accuracy).

To date, we have passed clear milestones on the path to success. VA has developed two rules-based calculators to streamline and improve decision quality, and together with VHA, developed the Agent Orange (AO) Miner Tool that links AO-related databases together and facilitates data search in developing Veterans' AO claims. Additionally, VA completed the Virtual Regional Office (VRO), which was the first major milestone in the Veterans Benefits Management System (VBMS) initiative. VBMS integrates technological advances to streamline the disability claims process and establish a paperless processing environment. It is being developed in three 6-month phases that continue to build on the previous phase and expand functionality. Information gained from the VRO helped create the specifications and requirements for the VBMS Phase 1 software solution now being developed and tested at the Providence Regional Office. Phases 2 and 3 of VBMS development will be undertaken at two additional regional offices. Deployment of the system to all regional offices begins in 2012.

In addition to the VBMS initiative, the Veterans Relationship Management (VRM) initiative is building a multi-channel gateway for Veterans to securely access VA health care and benefits information and provide self-service capabilities that

will put Veterans in control of their relationship with VA. VRM will provide Veterans with rapid access to high quality benefits and services when and how they choose, whether through telephone, web, email, social media, or in person.

Question 12(b): Do you still believe this goal is attainable and how does the President's budget approach the problem in a way that doesn't repeat past failures?

Response: We believe this goal is attainable. The President's FY 2012 budget proposal sustains our FY 2011 growth in personnel devoted to claims processing at a time that earlier hires are becoming fully trained and more productive. Additionally, the budget bolsters an investment in strategic planning, IT development and execution, continued acquisitions support, and project management. For both IT and acquisitions, past weaknesses have stemmed from overly decentralized control, lack of enterprise-wide information and, in some cases, improvised policies.

One of the most important steps VA has taken to ensure accountability was the establishment of the Project Management Accountability System (PMAS). PMAS is a disciplined approach to information technology (IT) project development whereby we hold ourselves and our private-sector partners accountable for cost, schedule and performance. In just 1 year, PMAS tripled the success of meeting project milestones.

Our holistic approach to transformation changes our culture, improves our processes, and integrates innovative technologies. This approach as outlined in the 2012 budget ensures different results from our past efforts. VA's transformation strategy for the claims process integrates the power of 21st Century technologies applied to redesigned business processes so that the overall service we provide is more efficient, timely and accurate. Additionally, we continue to partner with Veteran Service Organizations and business partners from the private sector to deliver services faster. As we transform VA, we will closely monitor our progress in achieving our strategic goals and integrated objectives. We will continue developing an annual performance plan, which we submit with the President's budget each year. We will report to Congress and other stakeholders each year in our VA Performance and Accountability Report. We will monitor each of our major initiatives through a quarterly Operational Management Review team, chaired by the Deputy Secretary, to ensure that cost, schedule, and performance targets are being met, and that corrective action is taken where necessary, and with Monthly Performance Review meetings to monitor progress in meeting our annual performance plan.

Question 13: Please provide the Committee with an update on VBA's efforts to improve training and require skills certification for claims examiners and managers as required by section 225 of P.L. 110–389.

Response: To ensure VA has highly proficient claims examiners, we have developed a National Training Curriculum with input from the Compensation and Pension (C&P) Quality Assurance Staff and managers and subject matter experts working in the field. As the Quality Assurance Staff identify national error trends through quality reviews, we create or revise training products to address knowledge gaps. This National Training Curriculum establishes a consistent and uniform standard for training quality across VA, and is updated based on feedback each year. For example, analysis of national error trends in FY 2010 led to the inclusion of mandatory training topics in the curriculum for FY 2011. The C&P Service Training Staff uses the results from these studies and analyses of error patterns to generate interactive training lessons. All training material is reviewed and updated on a continuing basis as changes are made to policy and procedures and knowledge gaps from the field are identified.

VBA's managers are responsible for ensuring that claims processors accomplish the minimum annual training requirement of 85 hours. Training requirements were recently written into Veterans Service Representative (VSR) performance plans, and VBA plans to incorporate training requirements into other claims-processor performance plans.

VBA improved its capability to monitor the quantity and type of training by establishing the lessons in a VA LMS (Learning Management System) curriculum. Managers at all levels are held accountable for their subordinates' completion of training requirements. If employees do not meet the requirement of 85 hours per year, it is reflected in both the managers' and employees' performance evaluations.

In 2008, VBA created the position of Training Manager for each regional office. The Training Manager uses LMS to track training and ensure each regional office is compliant with requirements. VBA fielded an on-line evaluation tool in February 2010 to collect employees' evaluations of the usefulness, relevance, and quality of national training. As of February 11, 2011, 8,560 evaluations have been submitted for FY 2011. Every regional office has access to the evaluations so that feedback can be used to improve the training. On a national level, the evaluations are reviewed

to enhance the content of the training and identify additional topics for the National Training Curriculum.

Prior to FY 2010, four skill certification tests were implemented—Veterans Service Representative (VSR), Pension Maintenance Center (PMC) VSR, Basic Rating VSR (RVSR) and Journey-Level RVSR. In FY 2010, the skills certification operational tests for supervisory VSRs (coach level) and decision review officers (DROs) were completed. Testing was held on January 13, 2010 for coaches and June 16, 2010 for DROs. VBA plans to offer each test twice a year.

The VSR skill certification test began in 2003. Since that time, 2,084 VSRs have been certified. In 2008, the PMC VSR test and the Basic RVSR test were introduced. The numbers of employees certified for these two tests are 84 and 1,212 respectively. The Journey-Level RVSR test was first given in 2009 and there have been 413 employees certified under this test. The 2010 test for coaches certified 70 employees, and the DRO test certified 88 employees.

A Skills Certification Readiness Guide is available on the training Web site that includes references and job aids to assist in test preparation. Under a recently awarded contract, an on-line preparatory tool is being developed to provide additional training materials.

Question 14: In a tough economy it is imperative that VA provide the highest level of support to veterans seeking employment, especially veterans with service-related disabilities.

Question 14(a): How many professional level Vocational Rehabilitation and Employment staff will the proposed FY 2012 budget support?

Response: The Vocational Rehabilitation and Employment budget request for FY 2012 supports 1,286 direct FTE, an increase of 132 over the FY 2010 FTE level.

Question 14(b): What will be the resulting average caseload, and what performance improvements will the budget detail, to include successful job placement services?

Response: VR&E expects an average caseload per rehabilitation counselor of 135 in FY 2012. VR&E projects a 77 percent national rehabilitation rate and a 77 percent employment rehabilitation rate in FY 2012, up from the 76 percent national rehabilitation rate and 73 percent employment rehabilitation rate achieved in FY 2010. The employment rehabilitation rate refers to the number of disabled Veterans who successfully complete VA's vocational rehabilitation program and acquire and maintain suitable employment. The national rehabilitation rate also includes Veterans with disabilities for which employment is infeasible but who obtain independence in their daily living with assistance from the program.

Increased staffing will also support 9 additional VetSuccess on Campus locations and expansion of VR&E services to include early intervention through integration with the Integrated Disability Evaluation System (IDES) program.

Question 14(c): As a point of comparison, what did VA accomplish in FY 2010 in these areas and what is expected in the current fiscal year?

Response: In FY 2010, VR&E rehabilitated 10,041 Veterans, of which 8,161 were placed in employment and 1,880 successfully completed Independent Living services. VR&E achieved a national rehabilitation rate of 76 percent and an employment rehabilitation rate of 73 percent in FY 2010. In FY 2011, VR&E projects a national rehabilitation rate of 77 percent and an employment rehabilitation rate of 75 percent.

Question 15: VA hired nearly 1,000 temporary and full time education claims processors as a result of passage of the Post 9/11 GI Bill.

Question 15(a): With the fielding of the new Post 9/11 IT system, how does the proposed budget reflect those employees?

Response: The Post-9/11 GI Bill required VA to significantly increase staffing in the short term until a new, robust IT environment is developed, deployed, and proved successful. To support the implementation of the Post-9/11 GI Bill, VA hired 530 temporary claims examiners with funds from the Supplemental Appropriations Act of 2008, and 428 temporary claims examiners with American Recovery and Reinvestment Act (ARRA) funding. While the ARRA employees were retained through FY 2010, VA anticipated the remaining temporary claims examiners would be retained through the end of FY 2011.

Public Law 111–377, the Post-9/11 Veterans Educational Assistance Improvement Act of 2010, modifies aspects of the Post-9/11 GI Bill. In order to implement the new law, changes need to be made to the Long Term Solution (LTS) for processing Post-

9/11 GI Bill claims. As a result, automation of end-to-end processing for some re-enrollments, functionality planned for release in June 2011, will not be available until the third quarter of FY 2012. This delay increases the number of FTE needed to process education claims. Our budget request of 1,429 FTE reflects the need for 324 of the 530 temporary claims examiners to remain through FY 2012 to maintain current claims processing efficiencies.

Question 16: Foreclosures continue across the country at record levels, making VA efforts to assist veterans with VA-guaranteed loans to avoid foreclosure extremely important.

Question 16(a): Please detail VA's progress in fiscal year 2010 in helping veterans avoid foreclosures.

Response: When a VA-guaranteed home loan becomes delinquent, VA provides supplemental servicing to help cure the default. VA's focus is working with borrowers and mortgage servicers to ensure every effort is made to help Veterans avoid foreclosure.

Assistance that VA and servicers can offer Veterans/Servicemembers includes:

- *Repayment Plan*—The borrower makes the regular installment each month plus part of the missed installments.
- *Special Forbearance*—The servicer agrees not to initiate foreclosure to allow time for borrowers to repay the missed installments. An example of when this would be likely is when a borrower is waiting for a tax refund.
- *Loan Modification*—The servicer agrees to reamortize the loan to include delinquent payments and establish a new payment schedule.
- *Additional Time to Arrange a Private Sale*—The servicer agrees to delay foreclosure to allow a sale to close if the loan will be paid off.
- *Short Sale*—A borrower sells his/her home for a lesser amount than owed. VA recently instituted a "Relocation Assistance" program where servicers may pay $1,500 to borrowers upon successful sale to help them obtain alternate housing.
- *Deed-in-Lieu of Foreclosure*—The borrower agrees to deed the property to the servicer instead of foreclosure. VA recently instituted a "Relocation Assistance" program where servicers may pay $1,500 to borrowers.
- *Refunding*—When VA believes a borrower may be able to retain his/her home through an aggressive loan modification, but the servicer has decided to proceed with foreclosure, VA may purchase the VA-guaranteed loan from the servicer.
- *Servicemembers Civil Relief Act (SCRA)*—VA discusses SCRA eligibility and protections with defaulted borrowers, and advises them of their rights and responsibilities to request relief.
- *Financial Guidance*—VA has a toll-free number Veterans can call for financial guidance, whether or not they have a VA-guaranteed loan (1–877–827–3702).
- *Relocation Assistance*—For properties conveyed to VA after loan termination, VA offers the occupants relocation assistance (cash-for-keys) to vacate the property and to assist in their transition.
- *Homelessness Assistance*—Veterans potentially at risk for homelessness are directed to VA's Call Center for Homeless Vets 1–877–4AID VET (877–424–3838).

In FY 2010:

- VA helped 76 percent (66,030) of all borrowers who defaulted on their VA mortgage loan retain their home or avoid foreclosure.
- Of that 66,030, 60,816 were able to remain in their homes. 5,214 voluntarily completed a deed-in-lieu of foreclosure, or a short sale.
- VA made 137,982 contacts with Veterans on delinquent VA loans, and 199,749 contacts with their servicers.

Question 16(b): What is the funding devoted to reducing the number of foreclosures in the current fiscal year and what is proposed for FY 2012?

Response: The Loan Guaranty funding level is $137.1 million in FY 2011 and 2012. This funding level includes all Loan Guaranty staff to support our mission to help Veterans obtain, retain, and adapt homes. Included are loan administration staff members who help Veterans in default avoid foreclosure.

The VA Loan Electronic Reporting Interface (VALERI) is the Web-based system that supports VA employees and loan servicers in assisting veteran borrowers in default on their VA home loans. For FY 2011 and 2012, the funding allocated for the VALERI contract is $4.8 million.

Question 17: Please detail for me National Cemetery Administration's capability to train not only its own employees at the NCA Training Academy in St. Louis, but

also personnel from Arlington National Cemetery and the National Parks Service. Will that capability remain intact in the current fiscal year and the next?

Response: NCA's Training Academy was established in 2004 to ensure training for cemetery directors and assistant directors. The curriculum has expanded over the years to provide training for a wide range of NCA employees including cemetery directors, equipment operators, foremen, caretakers and cemetery representatives. Training is focused on all aspects of national cemetery operations and management. Subjects include supervisory skills, use of NCA's electronic databases for recordkeeping, grounds maintenance, burial operations and resource allocation. Experienced and successful national cemetery employees are called upon to share their expertise as classroom instructors. The training academy is located in 3,000 square feet of leased space in St. Louis, MO. The location was selected because it is near Jefferson Barracks National Cemetery, where employees can receive practical experience. A training session is usually comprised of 20–25 employees. Since 2006, NCA has conducted 95 courses in 24 training areas.

A Memorandum of Agreement (MOA) is in place between the Department of the Army and the Department of Veterans Affairs to support the Army through NCA training programs. The MOA is in effect through September 30, 2013. As of December 2010, four Arlington National Cemetery (ANC) employees participated in NCA training: two employees in cemetery representative training and two employees in supervisory training. Two ANC employees are scheduled for supervisory training in the spring 2011. The Department of Army pays for each ANC employee's travel and accommodations while at the training center.

The National Park Service (NPS) has sent one employee to NCA's training center who attended cemetery representative training and a course on using NCA's electronic databases for recordkeeping. Another NPS employee plans to enroll in the same courses.

NCA can accommodate ANC and NPS employees who enroll in NCA training programs. NCA will sustain its current level of support without compromising the Training Academy's operations.

Committee on Veterans' Affairs
Washington, DC.
March 16, 2011

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled, "U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012," that took place on February 17, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 20, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Diane Kirkland at diane.kirkland@mail.house.gov. If you have any questions, please call 202–225–3527.

Sincerely,

JEFF MILLER
Chairman

JT/dk

Questions for the Record
The Honorable Jeff Miller, Chairman
House Committee on Veterans' Affairs
U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012
February 17, 2011

Question 1: According to VA's response to question 2, VA's 3-year increase for employee travel will exceed 30 percent.

Question 1(a): If the President's Fiscal Commission recommendation was adopted and VA had to manage an employee travel budget that was 80 percent of FY 2010 levels, how could that be accomplished without degrading services to veterans?

Response: If VA were held to the travel limitation of 80 percent of the FY 2010 level, this would have an adverse impact upon VA's ability to deliver health care services to veterans and deliver training to VBA claims examiners. This would amount to a $69 million (27 percent) reduction in the overall employee travel costs across VA for FY 2012. This magnitude reduction would impact VA's ability to relocate health care staff, to properly train benefits claims examiners, and delay continuing education of our health care and service providers. This reduction would also limit the number of times staffs can meet face-to-face to share best practices, a technique which allows VA to improve service delivery to veterans.

Question 1(b): Has this question been examined in full by VA?

Response: Yes, VA's travel requirements were fully evaluated as VA considered its resource needs to meet its commitments to deliver services to veterans. These requirements are reflected in the estimates included in the President's budget request.

Question 2: According to VA's response to question 2, VA's 3-year increase in its printing costs will be 100 percent.

Question 2(a): If the President's Fiscal Commission recommendation was adopted and VA had to manage a printing costs budget that was 80 percent of FY 2010 levels, how could that be accomplished without degrading services to veterans?

Response: If VA were held to the printing limitation of 80 percent of the FY 2010 level, this would amount to a $24 million reduction across VA. This would mean that fewer documents would be available to inform veterans of their benefits and how to access them.

Question 2(b): Has this question been examined in full by VA?

Response: VA printing requirements were evaluated and are reflected in the estimates included in the President's budget request.

Question 3: According to VA's response to question 2, VA's 3-year increase in its vehicle fleet costs will be approximately 25 percent.

Question 3(a): If the President's Fiscal Commission recommendation was adopted and VA had to manage a vehicle fleet budget that was 80 percent of FY 2010 levels, how could that be accomplished without degrading services to veterans?

Response: A 20 percent reduction on the vehicle fleet budget is expected to impact on the services to veterans. The vast majority of the VA fleet is used for direct services to veterans. These services primarily include transportation services to bring veterans and staff to medical care facilities, transportation to bring care to veterans in the home-based health care and rural outreach programs, transitional programs for veterans such as the Compensated Work Therapy program, home visits to veterans by benefits counselors and field examiners, facility/campus maintenance, security and emergency services (ambulances and fire trucks), and interments at cemeteries. A 20 percent reduction of the vehicle fleet budget will also limit VA's ability to fully implement the outreach initiatives to underserved veterans.

Some VA medical centers also rely on donations of vehicles from veterans service organizations, but these vehicles are normally not as fuel-efficient as the vehicles that we buy or lease. A reduction in our fleet budget would require both greater reliance on donated vehicles, and retain VA-owned vehicles beyond their economical life span. Greater use of older vehicles would further hamper our ability to meet petroleum reduction mandates and increase the cost of maintaining the fleet.

Question 3(b): Has this question been examined in full by VA?

Response: VA reviews its vehicle utilization annually, and is closely monitoring growth in our fleet. Vehicle utilization reviews have improved usage rates of fleet vehicles to the point of reaching optimum levels. New initiatives have been put in place by VHA to review and approve all fleet acquisitions, and additional measures are being considered across VA to identify additional ways to meet the fleet petroleum reduction mandates without compromising services to our veterans.

Question 4: In response to question 3, VA suggested that $105 million of money carried over from FY 2010 into FY 2011 will be used to implement provisions of the new Caregiver Law (P.L. 111–163).

Question 4(a): Please detail those provisions and how the $105 million will be (or has been) allocated among the provisions of P.L. 111–163.

Response: VA will be updating the cost estimates for the implementation of the Caregiver Act. These costs cannot be finalized while the Interim Final Rule is pending. VA will continue to keep the Committee informed, including providing our final estimate, once the process is completed.

Question 4(b): Please detail how the request for FY 2012 and FY 2013 is allocated among the provisions of P.L. 111–163.

Response: The specific eligibility criteria that will be adopted in the final publication of the Interim Final Rule are still under review. A change in these criteria that resulted in a different population of eligible veterans would also change VA's cost estimates. VA will continue to keep the Committee informed, including providing our final estimate, once the process is completed.

Question 5: In response to question 3b VA states that carryover funding from FY 2010 into FY 2011 in the General Administration account was not used to begin new initiatives, increase staff or establish new offices.

Question 5(a): What, then, was the carryover used for?

Response: In our original response we stated, "The limited carryover available in the General Administration account has not been used to begin new initiatives, increase staff or establish new offices that were not included in the FY 2011 budget and there are no current plans to do so."

The carryover is being used to support initiatives to transform the Department by improving accountability, efficiency and veteran safety throughout the system. Initiatives that will help transform the way we provide services include: VA's Human Capital Investment Plan (HCIP), which will re-engineer VA's human capital framework and provide a corporate strategy to improve training throughout the system; VA/DoD collaboration efforts and Corporate Analysis and Evaluation, which will produce better data that drive corporate level decisions; Facilities-wide transformation to maximize life cycle performance, increase on-site project management, and reduce project costs; and implementation of VA's Emergency Preparedness and Homeland Security Presidential Directive 12, which will lead to improvements in veterans' safety as well as security of VA employees and all of our facilities.

Question 6: In response to question 5 VA stated that VA will only authorize administrative pay increases under "extraordinary circumstances" and that management officials will make any such adjustments in a "prudent and strategic manner."

Question 6(a): Have any adjustments been made thus far? If so, when, where, and under what circumstances?

Response: We have not processed any schedules for which we applied the "exceptional circumstances" authority. We have processed several new nurse Locality Pay Schedules effective on/after Jan 2, 2011 based on new assignments that have been created; these actions are considered to be an exception and are not covered by the pay freeze. There have been no adjustments to pay scales since the pay freeze has been implemented. VHA medical centers and other human resource offices have been apprised that discretionary pay adjustments are not permitted until guidance is received through the Human Resource Management Letter (HRML), which is pending concurrence.

Question 6(b): Please provide any guidance as to what qualifies as an "extraordinary circumstance" for purposes of providing a pay increase.

Response: When higher non-Federal rates of pay in a local labor market are causing extraordinary recruitment or retention problems a facility may establish or increase a special rate schedule or nurse Locality Pay schedule. Examples of some factors that may be relevant in determining the existence of extraordinary cir-

cumstances include a turnover rate of more than 40 percent, a "quit for pay" rate of more than 30 percent, a job acceptance or staffing success rate of less than 50 percent, a vacancy rate of more than 30 percent, a large number of declinations for positions, unsuccessful recruitment activity, a large number of employees having received bona fide job offers, etc.

Nurse Locality Pay Schedules (LPS):

- Some factors that may demonstrate an extraordinary circumstance or critical staffing or retention problem include increases in turnover rates, "quits for pay", decreased job acceptance or staffing success due to pay. Facilities authorizing an increase to an existing LPS schedule must provide detailed staffing data that supports the percentages provided above as well as detailed information regarding recruitment efforts, to include information on vacancy announcements (i.e. number of advertisements placed or job fairs attended during a specific period of time) how long a position(s) has remained vacant despite recruitment efforts, and the use of appropriate incentives. Increases to existing rates may also be authorized in instances where a facility anticipates extraordinary recruitment or retention problem. An adjustment made under this assumption must be fully documented; for example, the facility must provide information on the number of employees that have received bona fide job offers; information on how the facility has used all available incentives and other flexibilities to alleviate the likelihood of losses; what external factors contribute to the belief that a critical retention problem exists, etc.

Physician and Dentist Market Pay Adjustments:

- All market pay adjustments that result in an increase, excluding those that result from a change in assignment, must include information that addresses the following criteria/justification in addition to the seven market pay criteria as prescribed in VA Handbook, Part IX, paragraph 9e:
  - (a) The individual possesses unique skills and competencies for a particular specialty or assignment that are essential to recruit or retain. This may include information regarding the extent to which the employee's departure would affect VA's ability to provide quality patient care or information on how the employee's skills and competencies uniquely contribute to the organization; or
  - (b) The individual is in a scarce specialty or assignment, or possess skills and competencies that are hard-to-find, or in high demand within the local labor market area. This may include information that the local labor market is in a less than desirable location (i.e. in a rural area, a high cost of living area, etc.); or
  - (c) The availability and quality of candidates. This may include information on past recruitment activity, the length of time a position(s) have remained vacant and the affect on patient care, or the likelihood of being able to recruit should the individual decide to leave the VA; or
  - (d) Information on salaries typically paid for similar specialties within the local labor market. This may include information regarding unique opportunities or benefits that exist in the private sector that affect VA's ability to recruit and/or retain high quality physicians and dentists; or
  - (e) Other situations or unique circumstances, as deemed appropriate, that indicate an increase to market pay is necessary.

Question 6(c): Please provide the guidance released to the field on this matter.

Response: A Human Resources Management Guidance Letter was developed by the Office of Personnel Management and the Office of Management and Budget and has been determined to fully comply with law and the President's Memorandum. We expect it to be released soon and will provide it to you at that time.

Question 7: In response to question 6 VA stated that it complies with GSA per diem rates defining the maximum for lodging and per diem, and that maximum rates vary by locality.

Question 7(a): Does VA have a policy concerning which locality to choose after it determines that the localities among those available for selection all comply with the GSA strictures, i.e., is there a policy steering VA to localities or venues that are the lowest cost option allowing VA to accomplish the purpose of the conference (even though other options may be permissible under GSA's strictures)?

Response: Yes, VA has drafted policy to govern the financial policies and procedures relating to conference planning. Currently under internal review, the policy

is intended to implement and supplement those portions of the Federal Travel Regulation (FTR) pertaining to Temporary Duty Travel (TDY) and provides specific guidance on cost control procedures, such as conference planning and technical evaluation factors pertaining to location and price, among others.

Question 7(b): Should there be such a policy?

Response: As previously stated, VA is currently reviewing draft policy relating to conference planning and financial controls.

Question 7(c): If authorizations for national conferences were capped at 80 percent of fiscal year 2010 levels, would that encourage such a policy being adopted? What efforts have there been to reduce costs in this area through the use of lower-cost venues or technology?

Response: VA has implemented efforts to reduce cost (venues and technology) while maintaining quality service for our customers. For example, VALU's training (i.e. Supervisory and Management, Leadership Development, Transformation Leadership, etc) is facilitated by the trainers that deploy to the location where the VA employees are located as opposed to the employees traveling to a venue. Secondly, VA is currently working on recording/videotaping training sessions to reduce the overall costs required of the vendors. As previously stated, VA is currently reviewing draft policy pertaining to conference planning and financial controls.

Medical Care

Question 1: Secretary Shinseki's February 17, 2011, testimony suggests that certain operational improvements will result in savings of over $1 billion. However, VA proposes that Congress still provide money in the amount VA says it will save so that it may then carry those funds over into a subsequent fiscal year. This seems to be a "pay us now, we'll account for the savings later" approach to budgeting.

Question 1(a): Why does that make sense? Why, if VA asserts it can save money through a variety of management efficiencies, should Congress provide that money anyway?

Response: Estimated savings from management improvements to be achieved in 2011 and 2012 will be carried forward into the following years to reduce the new appropriations needed in 2012 and 2013.

Question 1(b): Wouldn't accounting for the management efficiencies up front actually create the pressure and incentive necessary to realize them?

Response: VA accounted for the savings up front. VA has conducted a review ofthe efficiencies to be gained, and the savings to be achieved within the agency through improved management actions. VA is implementing several operational improvements in our medical care programs that will save money while improving the quality of health care. These savings are in six separate areas listed in the budget submission. These savings are estimated to total $746 million in FY 2011 and $1.2 billion in FY 2012 and FY 2013. We are confident that these are achievable savings.

Question 1(c): Which of the management improvements resulting in savings would otherwise be reflected in data captured by the Enrollee Health Care Projection model estimates?

Response: None of the management improvements resulting in savings would be reflected in data captured by the Enrollee Health Care Projection model estimates. Enrollee Health Care Projection model for the 2012 President's submission is based on FY 2009 (base year). The effects of the operational improvements are anticipated beginning in FY 2011.

Question 2: It would appear that a cursory look at budget requests spanning multiple administrations that carryover of unobligated balances for medical care was a normal element of the request. Only in the past several years has VA not assumed such a carryover, although with the President's FY 2012 request there is, again, a carryover assumption.

Question 2(a): Please clarify why carryover of funds is a necessary management tool that should be available to VA.

Response: The Medical Services, Medical Support and Compliance, and Medical Facilities appropriations have historically had a small portion of their total appropriation available for obligation for two fiscal years. The purpose of this authority is to provide the flexibility to make the most appropriate procurement decisions as the end of the fiscal year approaches without being forced to simply obligate any available funds on less critical requirements. Forced year-end spending incentivizes

organizations to spend funds in order to protect the following year's budget request. Congress has historically granted this carryover authority and we believe that it has enabled good stewardship of the Nation's resources and ensured that our veterans receive the best possible health care.

Question 2(b): Is carryover necessary because VA, at times, can't prudently spend all the money it is given in a fiscal year? Or, is carryover evidence that VA doesn't need all of the money appropriated to it? Or, is carryover evidence of some combination of the above?

Response: In addition to the response to Question 2a, it is also a reflection of the complexities associated with acquisition in the health care industry. In the Medical Facilities appropriation, protests of contract awards also frequently delay final obligation of funds, and long lead times associated with executing major leases sometimes cause award dates to slip across fiscal years. This authority also provides additional assurance that unforeseen delays in implementing new authorities may be addressed without requiring supplemental appropriation requests.

Question 3: One of the new accounting features of this budget is a proposed $953 million "contingency fund" for medical care. Secretary Shinseki's testimony suggests this money is based on an economic variable that was incorporated into VA's actuarial model, and that the money may or may not actually be needed.

Question 3(a): In the heart of the economic recession when VA submitted its resource requests for medical care for fiscal years 2010 and 2011, was there an economic variable used to inform VA's budget request?

Response: The 2008 VA Enrollee Health Care Projection Model (Model), which supported VA's 2010 Budget Submission, did not include an economic variable because it was developed early in the economic downturn cycle. In response to indicators that the economic downturn could deepen into a recession, VA initiated a study to assess the potential impact of a recession on enrollee reliance on VA health care. This study was complex and time consuming since economic conditions were relatively stable during the last decade. As the recession deepened, and with an understanding that the impact would continue throughout the recovery, an economic variable was included in the 2010 Model, which supports VA's 2012/2013 Budget Submission.

Question 3(b): Even though no carryover of funds was expected in VA's budget submissions for 2009 through 2011, VA carried over substantial sums of money in each of those years, and it expects to carry over a substantial sum of money from 2011 into 2012. This would suggest that VA's actuarial model worked as designed, even without incorporating an economic variable, and even though the model used data on utilization that predated the recession. Is this correct?

Response: The Model is updated annually to reflect the most current data, updated analyses, new policies and regulations, and evolving experience, such as the economic downturn. As a result, the Model is successfully accounting for the changing dynamics of veteran demand for VA health care.

Question 3(c): If that's the case, why did VA decide to incorporate an economic variable into the FY 2012 submission, especially for a year when the President is expecting job recovery?

Response: Historically, unemployment rates have not returned to prerecession levels for 5 years following the recession. While both the Administration and the Congressional Budget Office are projecting that the unemployment rate will improve this year, both are projecting that unemployment rates will remain above prerecession levels through 2015.

Question 3(d): What assumptions regarding unemployment in 2012 were used for the economic variable, and do the assumptions track the President's own forecasts for unemployment in 2012?

Response: VA's FY 2012/2013 Budget Submission is based on the Office of Management and Budget's July 2010 Mid-Session Review unemployment rate projections.

Question 4: Page 1A–3 of the VA FY 2012 Budget Submission reads "Based upon experience in 2010, the need for this [contingency fund] funding will be carefully initiated in 2012. This cautious approach recognizes the impact of economic conditions as estimated by the model while acknowledging the uncertainty associated with estimates."

Question 4(a): Please describe what 2010 experience contributed to the development of the Contingency Fund and a description of how the Department addressed that experience.

Response: VA saw a 4.4 percent increase in unique patients and a 3.7 percent increase in unique enrollees from FY 2009 to FY 2010. VA was able to meet all of its commitments to treat veterans and Servicemembers in 2010. The $953 million contingency fund, estimated in the VA's Enrollee Health Care Projection Model, was created to address the potential demand increase for medical care services due to changes in economic conditions. The fund will only become available for obligation if the Administration determines the anticipated changes in economic conditions, as estimated by the Model, materialize in 2012.

Question 4(b): What methodology was used to determine that $953 million was the appropriate amount to account for changes due to economic change?

Response: The actuarial estimates that were used to develop the budget request included estimates of unemployment rates and how they are expected to influence veterans reliance on VA for care. This methodology resulted in the estimated $953 million amount.

Question 5: Is the Contingency Fund a one-time request or does the Department expect to continually require a bank of reserve funds to respond to economic fluctuations?

Response: This economic impact was incorporated into the Model for the first time this year. Based upon experience from 2010, the need for this funding will be carefully monitored in 2012. This cautious approach recognizes the potential impact of economic conditions as estimated by the Model while acknowledging the uncertainty associated with the estimates. VA's experience with the relative reliability of the model forecast for economic conditions will help determine the need for a contingency fund in future years.

Question 6: If the Contingency Fund funds are not utilized in FY 2012, will they be returned to the Treasury, re-allocated to patient care, carried over as an offset in FY 2013, or used for some other purpose?

Response: These funds will be returned to the Treasury.

Question 7: How confident is VA in the accuracy of its FY 2013 advance appropriations request? Are economic conditions or other factors expected to impact that estimate? If so, how?

Response: The FY 2013 advanced appropriations request is based largely on our actuarial estimates using FY 2009 data as the base year. The request does not include additional resources for any new initiatives that would begin in FY 2013, Strategic Planning Major Initiatives other than Homeless or Rural Health Initiatives. Obligations for these categories will be addressed in the FY 2013 budget submission.

Question 8: It is my understanding that VA retains "virtual" central office employees at the VISN level.

Question 8(a): Provide a detailed list for all virtual employees that includes: the number of employees at each VISN; title and job description for each position; and GS pay associated with each position.

Response: VHA does have Central Office employees that perform their duties at locations other than Washington, DC. The attached spreadsheet provides a listing of individuals that have a duty station outside VHA Central Office. [The attached spreadsheet will be retained in the Committee files.]

Question 9: The budget submission estimates savings of $275M in FY 2011 and $315 million in FY 2012 by moving the fee care program payments to be consistent with that of Medicare payments.

Question 9(a): What are the underlying assumptions for these savings estimates?

Response: The underlying assumptions for these savings were based on use of the multiple pricing schedules covered under the regulation. VA has had authority to pay inpatient hospital claims and physician services utilizing the Centers for Medicare & Medicaid (CMS) payment methodologies for many years. Effective for non-VA treatment on or after February 15, 2011, VHA adopted CMS payment methodologies for outpatient services. This aligns VHA with standard Federal payment schedules and assures these payments from VA utilize the same structure. Prior to

adopting CMS payment methodologies VHA processed payment for outpatient services for facility charges using a "VA Fee Schedule" which is based on billed charges and reimbursement was based on the 75th Percentile of those charges, significantly higher than standard CMS pricing. The estimated savings were developed using the difference between the 75 Percentile from the VA Fee Schedule and the CMS rates extrapolated from actual payment data from the first 6 months of calendar year 2008. VHA contracted with an outside vendor to complete a comparison to identify cost savings under this regulation. The analysis compared CMS rates with VA Fee Schedule rates to make this estimate. A sampling of lab, ESRD, and other Medicare methodologies was used to estimate an average savings based on these rates.

Question 9(b): What is the status of upgrading the IT infrastructure to process the new fee payments at the Medicare rate? Please provide a timeline for this process.

Response: The current claims processing system, Fee Basis Claims System, is scheduled to be updated with CMS rates by mid-year FY 2012. To assure accurate pricing, VA developed an interim solution utilizing a contract service to price claims submitted to VHA for authorized services by non-VA providers. This service will initially be manual, with a move to a web-based solution by the end of April. VA will continue to utilize this service until such time as the appropriate technology is in place to accurately price these claims.

Question 9(c): How can VA realize savings in 2011 if there is not a system currently and fully in place to handle electronic processing of payments?

Response: VHA contracted with an outside vendor to price claims at Medicare rates for all claims submitted for treatment dates on or after February 15, 2011. VA facilities were instructed to hold those claims until the contractor was ready to accept those claims for pricing. It is anticipated the contractor will be ready to receive those claims effective March 28, 2011. Claims will be printed and mailed to the contractor for pricing. A web based portal will be available for pricing by sites in late April. VA is working towards an electronic mechanism to transmit the claims via Electronic Data Interchange (EDI) later this year once the IT solution is developed.

Question 9(d): Are the savings estimates in the budget submission the same as what VA projected when developing the regulations to move the fee program to Medicare rates? Please explain any changes in assumptions that resulted in an adjustment to the savings estimate.

Response: No, the savings are less due to delay in publication of the regulations. The savings were adjusted because the implementation date was delayed to February 15, 2011. The estimated savings are included below. The FY 2012 budget request utilizes the same cost savings estimates documented in the Final Rule.

Year	**Estimated Projected Savings**
FY 2011	$274,700,000
FY 2012	$314,700,000
FY 2013	$361,800,000
FY 2014	$405,800,000
FY 2015	$452,700,000
5-year total	**$1,809,700,000**

Question 10: Describe the mission of the Chief Business Office (CBO) and if and how this mission has changed since the office was established.

Response: The VHA Chief Business Office provides national leadership for advancing business practices that support patient care and the efficient delivery of health benefits.

Question 10(a): Do the current activities of the CBO directly align with the original mission?

Response: Yes. Established in 2002, the CBO's original mission was to develop and implement policy, processes, information and business solutions to support high quality service delivery to veterans, enhance employee development and demonstrate effective stewardship. The CBO Mission Statement supported the Vision which was to provide quality veteran focused services with smart business solutions. In 2006, the CBO reorganized functionally to more effectively carry out the mission. The reorganization resulted in realigning the existing executive positions subordinate to the Chief Business Officer to lead each of the three functional areas—Revenue Operations, Member Services and Purchased Care.

Question 10(b): What are the three primary areas of responsibility for each of the three deputy directors?

Response:

- The Deputy Chief Business Officer for **Revenue Operations** is accountable for the development of administrative processes, policies, regulations, and directives associated with revenue activities. The incumbent serves as primary advisor to the field on revenue collections and is responsible for developing quality products whose business processes and outcomes are measurable and effectively managed.
- The Deputy Chief Business Officer for **Purchased Care** supports and augments the delivery of health care benefits through enterprise program management and oversight of Purchased Care services, including programs such as Fee Basis, CHAMPVA, State Home Per Diem and others.
- The Deputy Chief Business Officer for **Member Services** provides veterans and their families with respectful, timely, accurate and efficient service. Member Services supports "front-end" elements of interaction with VA's Health Care System such as enrollment, contact management, beneficiary travel and transportation.

Question 10(c): Please provide a comprehensive list that includes the following related to the CBO: total number of employees; title and job description for each position; and GS pay associated with each position.

Response: See attachment. [The attachment is being retained in the Committee files.]

Question 11: What is the status of the establishment of seven consolidated patient account Centers (CPACs)?

Response: An integral part of VHA's strategy for increasing collections is deployment of industry best practice Consolidated Patient Account Centers (CPACs). VHA is deploying CPACs by FY 2012, 1 year earlier than required by Public Law 110–387. Four CPACs have been completed to date: North Central (VISNs 10/11/12); Mid South (VISNs 9/16/17); Mid Atlantic (VISNs 5/6/7); and Florida/Caribbean (VISN 8). Three CPACs are in progress for completion in FY12: West (VISNs 18/20/21/22); North East (VISNs 1/2/3/4); and Central Plains (VISNs 15/19/23). CPACs have demonstrated success in improving collections through process standardization and internal controls to mitigate risks.

Question 12: How will the CPACs be funded? If funded through the use of VISN resources, what is the formula for determining individual VISN contributions?

Response: Each CPAC's annual operational cost is funded by the VISNs to which it provides services based on each VISN's percentage of the Medical Care Collection Fund (MCCF) goal assigned to that CPAC. Initial start up costs for each CPAC are paid by the VHA Central Office. This funding approach will continue through FY 2012. Once all CPACs are operational in FY 2013, both the operational cost and any recurring lease costs will be paid by the VHA Central Office, with no charges to the VISNs. The rationale for this funding approach during the start up of the CPACs is to not place those VISNs not yet supported by a CPAC at a financial disadvantage because they currently pay all costs of collection activities within their VISN.

Question 13: What is the total number of VA and total number of contracted employees expected to staff each CPAC?

Response: The number of staff authorized for each CPAC is determined by the estimated workload from the serviced VISNs assigned to that CPAC. Contractors are only used to handle small balance claims once the CPAC is fully operational. The number of VA employees expected to staff each CPAC are as follows:

- Mid-Atlantic CPAC: 539
- Mid-South CPAC: 583

- North Central CPAC: 461
- Florida Caribbean CPAC: 324
- Central Plains CPAC: 515
- West CPAC: 483

Question 14: How will the staffing and functional responsibilities that are currently in place at the Veterans Integrated Service Network be transferred to the CPACs? Will any functions be duplicated at the VISNs? What will happen to VISN employees whose current responsibilities will be assumed by the CPACs?

Response: Prior to the start of the national CPAC deployment, VHA developed a detailed implementation plan grounded in industry best practices and lessons learned from previous transitions. The plan for each CPAC is organized around four main phases of transition:

- *Readiness Planning:* A team of evaluators assess VAMC operations to determine overall readiness for transition and develop site specific implementation plans based on assessment results.
- *Transition of Host VISN/Expansion VISNs***:** Ownership for designated revenue cycle function is officially transferred from VA medical centers to CPAC. Typically, the host VISN of each consolidated center is transitioned first following the implementation of the new business model and deployment of CPAC business tools. Expansion VISNs are scheduled for transition following sustainment of the host network.
- *Stabilization:* CPAC business analysts and industry experts conduct further assessments of transitioned sites, resolve identified issues with field leadership, and further stabilize operations following the transition period.
- *Sustainability:* Based on observed operational performance and the results of internal controls and quality assurance monitoring activities, CPAC business processes are continually enhanced, and staff is provided with targeted professional development to optimize business performance.

Each element of the implementation plan contains thousands of activities, which are carefully managed and reported on by our implementation coordinator and team of project management professionals.

The CPAC business model was carefully crafted by industry experts to ensure that CPAC-owned business processes complement supporting functions that remain at the medical centers (registration, charge capture, coding, etc.) There is no duplication of effort expected as a result of the national CPAC deployment.

VHA is working diligently to minimize the impact of this reorganization on employees and will provide as smooth a transition as possible. Impacted employees are strongly encouraged to apply for CPAC positions and are notified as soon as the positions are announced. Additionally, these employees are in the first area of consideration for facility-based and CPAC-based positions. Impacted staff remaining after CPAC positions are filled will be placed in comparable positions at their current duty station based upon their requisite knowledge, skills, and abilities. Local facility management is responsible for the placement of remaining impacted employees at each medical center. The placement process is unique for each facility given their individual circumstances and staff. VHA has also received concurrence for both Voluntary Early Retirement Authority (VERA) and Voluntary Separation Incentive Payment (VSIP) from the U.S. Office of Personnel Management (OPM) to assist with the transition of impacted staff.

Question 15: Medical collections goals have been adjusted downward for FY 2011 and FY 2012.

Question 15(a): What is the reason?

Response: The reduction is a result of VA revising assumptions from the collections forecasting model to incorporate the following factors:

- **Poor economic conditions—**Growth in national unemployment (from 7.7 percent in the First Quarter of FY 2009 to 9.8 percent at the end of the First Quarter of FY 2011) continues to impact both first party collections (veteran out-of-pocket costs) and third party collections (unemployment and resultant loss of health insurance coverage).
- **Hardship waivers and exemptions from copayments are increasing—** veteran first party copayment economic hardship waivers and exemptions were at their highest levels in FY 2010 (the most recent completed year) and this is expected to continue with the current poor economic conditions.
- **Third party "Collections to Billings" (CtB) ratios are down nationally—** CtB ratios are expected to continue a downward trend, reducing third party col-

lections. CtB decreased from 43.1 percent in January 2009 to 39.1 percent in January 2011, influenced by the continued shift by insurance companies of payment responsibility to the patient (i.e., higher deductibles, increased copayments, etc.). Section 1729 of title 38 prevents VA from billing veterans if insurance companies do not pay. Each 1 percent decrease in CtB represents a $55 million revenue loss.

- **Veterans aging to 65 years and older—**FY 2012 begins to reflect the shift in workload for Vietnam Era veterans aging to 65 years and older. Once a veteran is Medicare-eligible, Medicare becomes the primary insurance coverage and VA can bill insurance companies only for the portions Medicare does not cover (typically their deductibles). This significantly reduces the amount VA can collect.
- **Priority Group migration from lower to higher status—**National Priority Group migration over the past 2 years has shown a sharp decrease in collections for veterans in Priority Group 8 which is the primary driver of both first and third party collections.
- **Shift in Service Connected Workload vs. Non-Service Connected Workload—**As veterans migrate from lower to higher status, there is also a shift in workload from Non-Service Connected (Non-SC) care (which could be billable if the veteran has insurance) to Service Connected (SC) care (regardless of insurance coverage VA does not bill for SC care). From FY 2009 to FY 2011 the total number of outpatient encounters has seen an increase of 2 percent nationally in SC care, with an equal decrease of 2 percent in Non-SC care, which has impacted Third Party collections.

Question 15(b): Have you identified specific obstacles that impede meeting the collections goals? If so, what is being done to address these problems?

Response: Specific obstacles that impede meeting the collection goals, as noted in the response to (15a) are primarily tied to economic market conditions. However, VA also recognizes that focused efforts must be implemented to optimize available revenue opportunities and several initiatives are underway to improve results aside from the deployment of Consolidated Patient Account Centers described in question 11 including:

- **Improving Recoveries from Non-VA (FEE) Care:** VA can bill third party payers for veterans receiving non-service-connected Fee care with insurance. In an effort to enhance charge capture for these services, a workgroup has been formed to develop monitoring metrics to assist in identifying best-practice performers and opportunities for improvement. As part of this effort, a pilot is currently underway at two medical centers in VISN 9 (Mountain Home and Huntington) to reengineer business processes.
- **Revenue Cycle Enhancement Teams (RCET):** RCET visits identify opportunities to improve revenue cycle performance at lower performing facilities by developing action plans to increase collections. During FY 2011, RCET will conduct 32 sites reviews.
- **Payer Relations and Business Practices:** VHA is conducting an in depth analysis of managed care contracts, billing practices and rates/charges in an effort to optimize revenues. The outcome of this work will be a 5 year strategic roadmap with short, medium and long-term project deliverables.
- **Regulatory and Policy Changes:** Currently, third party payers unilaterally offset payments on claims without notification to VHA. A Final Rule barring offsets by third party payers and establishing a process by which they will submit a request for a refund on claims for which there is an alleged overpayment is in review within VA. Eliminating these offsets will positively impact VA by ensuring accounting records accurately reflect any necessary adjustments to accounts and speeds processing of claims. VA also recently (March 18, 2011) implemented a new methodology for billing third parties for outpatient prescriptions. VA's actual costs for each drug dispensed, plus an administrative fee are now being billed instead of using a national average drug cost.
- **Enhanced Business Systems:** VA continues to develop electronic business transaction capabilities including insurance verification, billing, and payments. Benefits from electronic transmissions include faster payments.

Question 15(c): What is the total potential medical collections number (as opposed to what VA actually collects)?

Response: CBO utilizes the Integrated Collections Forecasting Model (ICFM) to produce a 20-year collection forecast at the MCCF fund and Station levels. ICFM incorporates the VHA Office of Policy & Planning Enrollee Health Care Projection

Model (EHCPM) workload projections as a starting point of the model. ICFM accounts for several factors in determining a collections forecast including: service volume, Priority Group status, demographics, economic market conditions, insurance coverage, and historical billings and collections performance. Additional considerations are made for any legislative or regulatory policy changes that may impact collections.

The goal of establishing Expected Results (ER) is to set reasonable and achievable medical collections targets. The current published President's Budget for FY 2011, FY 2012 and FY 2013 represent collection targets that challenge each Medical Center to achieve their revenue potential.

Published President's Budget	**FY 2011**	**FY 2012**	**FY 2013**
MCCF Collections (in millions)	$2,817	$2,925	$3,134

Question 16: The Secretary stated that the cost of caring for a homeless veteran is three and a half times the cost of caring for a non-homeless veteran in the VA health care system. Please provide a detailed cost comparison of what and how the care and services differ for a homeless veteran and non-homeless veteran.

Response: See table below.

Description	**Dollars in Thousands**	
	Non-Homeless Veteran	**Homeless Veteran**
Inpatient Medical/Surgical	$10,084,130	$410,372
Inpatient Pyschiatric	$1,068,085	$459,553
Residential Rehabilitation	$190,496	$488,478
PTSD Residential Rehabilitation	$73,902	$29,056
Nursing Home	$3,861,526	$93,106
Primary Care Clinic	$3,230,059	$111,807
Medical/Surgical Cliics	$6,577,896	$296,831
Mental Health Clinics	$1,845,179	$586,882
PTSD Clinics	$249,706	$21,826
Other Clinics	$7,653,696	$276,571
Diagnostics	$2,719,443	$113,336
Pharmacy	$5,150,716	$140,782
Readjustment Counseling	$147,211	--
State Home	$701,936	--
Miscellaneous Contracts	$131,683	--
Total	$43,685,664	$3,028,600
Number of Veterans	$5,332,093	$108,966
Cost Per Veteran	$8,193	$27,794 = 3.4 times greater

Question 17: What changes, if any, have been made this year to improve the analysis capabilities of VA's Enrollee Health Care Projection Model? How much confidence does VA have in the model's estimates?

Response: VA is confident in the Model's estimates of veteran demand for VA health care. The Model is supported by an extensive array of in-depth analyses of

the factors that drive demand for VA health care, including those listed below. These analyses and the study methodology are updated annually or as new data become available.

- Impact of income, unemployment rates, distance from VA facilities on enrollment rates
- Impact of unemployment rates on enrollee reliance on VA health care
- Impact of enrollee age, gender, morbidity, and geographic migration patterns
- Enrollee transition between enrollment priorities, i.e., movement into service-connected priorities and transitions due to changes in income
- Reliance on VA versus other health care providers
- Unique utilization patterns of Operating Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
- Enrollee attitudes towards VA health care.

As a result of these analyses, the Model supporting VA's 2012/2013 Budget Submission included an assumption to reflect the unique utilization pattern of enrollees in the first year of enrollment. This will improve the Model's capability to model for enrollee cohorts with significant new enrollment.

Question 18: What is the total number of new Priority 8 veterans enrolled in the VA health care system whose income exceeds the geographic HUD index threshold, but were able to enroll as a result of the relaxed income restrictions?

Response: As of February, 2011 the total count is 19,810.

Question 18(a): Please provide a breakdown of the number of new priority 8's who have come into the system since Secretary Shinseki relaxed the income restrictions.

Response: There is a total of 65,760new Priority Group 8 enrollments since 6/15/2009. A breakout by Fiscal Year (FY) is as follows: FY09—18,858, FY 2010 — 33,231, FY 2011 through February—13,671.

Question 18(b): What is the assumption for new priority 8's in FY 2011? What is the assumption for FY 2012 and 2013?

Response: The projected number of new Priority 8 enrollees is approximately 40,000 in FY 2011. The projected number of new Priority 8 enrollees is approximately 26,000 and 86,000 for FY 2012 and FY 2013, respectively, according to the 2010 Enrollee Health Care Projection Model (Base Year 2009).

Question 18(c): How do the assumptions VA used for the number of new priority 8's compare with the actual number enrolled in FY 2009, FY 2010, and thus far in FY 2011?

Response: Previously, we projected a surge in enrollment when the suspension on Priority 8's was lifted and veterans who had not been able to enroll took advantage of the new opportunity. In light of recent experience, this assumption has been significantly scaled back in the 2010 Model. The projected number of new Priority 8 enrollees coming into the system was approximately 21,000 for FY 2010 per the 2010 Model (Base Year 2009), where the actual number of new Priority 8 enrollees closely mirrored that at approximately 17,000 for FY 2010.

Question 18(d): What resources were budgeted for FY 2009, FY 2010, and FY 2011 for health care services for new priority 8's and how do the actual amounts obligated compare? What is budgeted for new priority 8's in FY 2012 and FY 2013?

Response: See table below.

	FY 2009	**FY 2010**	**FY 2011**[1]	**FY 2012**	**FY 2013**
Budget	$74	$66	$161	$203	$432
Actual	$61	$92	$58		

[1] Actuals as of end of January 2011.
FY 2009 Budget Estimates: 2008 Base, 2011 President's Submission.
FY 2010–FY 2013 Estimates: 2009 Base, 2012 President's Submission.

Question 19: GAO Report 11–205 regarding the model used to develop the VA health care budget indicated that OMB provided VA with estimates of the savings associated with a Presidential initiative for a government wide emphasis on reduc-

ing operating costs associated with maintaining surplus property for fiscal year 2011.

Question 19(a): What was the OMB estimate of the savings associated with reducing these operating costs and did VA achieve those savings?

Response: The estimated real property operating costs reduction in FY 2011 was $7 million. VA is in the process of implementing this initiative and intends to fully achieve the projected savings.

Question 20: Has VA conducted a long-term analysis of the impact the Patient Protection and Affordable Care Act (Public Law 111–148) will have on the VA health care system? Please share that analysis, if any.

Response: VA has not conducted a long-term analysis of the impact of the Patient Protection and Affordable Care Act (Public Law 111–148) will have on the VA health care system. A task force was assembled to conduct a preliminary assessment. The task force has recommended that VA conduct an in depth analysis to quantify the law's effect on veterans and the VA health system.

Inspector General

Question 1: What was the rationale for flat lining the budget request for the IG given the government-wide emphasis on reducing wasteful and fraudulent spending?

Response: The VA Inspector General (IG) has received a $20.6 million (23 percent) increase in 2012 compared to 2009. This is an average increase of 7.7 percent per year, which is comparable to the General Administration staff office 3-year average increase of 8.8 percent when excluding the President's government-wide acquisitions initiative. In addition, employment for the VA OIG has increased by 103 FTE over the 2009 level (20.2 percent).

Benefits & Memorial Affairs

Question 1: Have any of the National Cemeteries ever undergone an energy audit to review the energy usage and look for more efficient ways to conduct operations?

Response: Energy audits were conducted at national cemeteries between 2007 and 2009. Energy audits will be conducted at the national cemeteries every 4 years, and new audits began in July 2010. Cemeteries will be reviewed to identify additional energy reduction measures.

Question 2: What steps is NCA taking to reduce energy costs at national cemeteries?

Response: Energy improvements at the national cemeteries include the following actions:

- Programmable thermostats.
- Replacing incandescent bulbs with compact florescent bulbs.
- Replacing older 4-foot florescent tubes with newer, more efficient ones.
- Replacing older electronic devices with more efficient ones (Energy Star rated), such as computers, printers, fax machines, copiers, and hot water heaters.
- Tuning up furnaces and air conditioning.
- Replacing older furnaces and air conditioning systems with more efficient systems (Energy Star rated).
- Installing programmable irrigation controllers to reduce irrigation water use, which lowers water pumping costs.

NCA has implemented the use of pre-placed crypts, that preserve land and reduce operating costs, and water-wise landscaping that conserves water and other resources. Photovoltaic solar systems have been installed at Calverton (Long Island) and San Joaquin Valley National Cemeteries. Two additional photovoltaic solar systems are under contract for Riverside and Sacramento Valley National Cemeteries, and a system is planned for Fort Rosecrans (San Diego) National Cemetery. A wind turbine has been installed at Massachusetts National Cemetery.

Geothermal heat pumps, using heat stored in the ground instead of air, are being evaluated for new and existing cemetery buildings. Geothermal heat pumps save approximately 40 percent of energy consumption compared to regular heat pumps.

Question 3: Please explain Integrated Objective 1(A)(1), "Percentage of applications for headstones and markers that are in processed within 20 days for veterans who are not buried in a national cemetery," which suggests a reduction in performance from 93 percent in FY 2009 to 74 percent in FY 2010.

Question 3(a): What accounts for the deterioration in performance?

Question 3(b): How will requested funds for FY 2012 improve performance to that achieved in FY 2009?

Response: FY 2010 performance was impacted by staff vacancies and intermittent system network issues which contributed to reduced performance. NCA has hired staff to fill the vacant positions and used overtime to reduce the number of days to process applications. We have worked to minimize system disruptions. Additionally, there were some weather-related events that shut down operations temporarily at several satellite offices. An alternative worksite initiative has now begun to ensure a continuity of operations when future weather related closures occur. Current FY 2011 performance is slightly above the target of 90 percent. NCA expects to maintain current performance in FY 2011 and expects to meet the target in FY 2012 of 90 percent.

Question 4: With a near flat line funding for the NCA Operations and Maintenance accounts in FY 2011 and in the FY 2012 request, how will NCA meet its Integrated Objective 1(A)(4) "Percent of headstones, markers, and niche covers that are clean and free of debris or objectionable accumulations" by increasing performance from 85 percent in FY 2010 to the planned 90 percent in FY 2011 and FY 2012?

Response: In addition to the funding included in the FY 2010 budget and funding provided by the American Recovery and Reinvestment Act, the FY 2011 budget includes $36.9 million and the FY 2012 budget request includes $32.9 million for gravesite renovation projects that include cleaning headstones/markers. The impact of these funds on performance will be realized within 2 years of contract award as projects are completed. With this funding, NCA expects to increase performance to the planned 90 percent in FY 2011 and FY 2012.

Question 5: Please explain the reasoning for the increase in Senior Executive Service Level employees at NCA from four in FY 2010 to 11 in the FY 2012 request.

Response: The new SES positions reflect the growing scope and complexity of NCA operations. We are not requesting any additional funding or FTE for the positions.

Five of the seven positions are for our regional office directors. Workload has increased considerably in the field. For example, in the last decade NCA has opened 15 new national cemeteries, a national training center, and a national scheduling center.

Another of the new positions is for the Memorial Programs Service (MPS) director. In FY 2010, this office processed nearly 400,000 headstone/marker applications and over 800,000 Presidential Memorial Certificates. MPS responsibilities have expanded to include the First Notice of Death function and the new medallion benefit.

The final position restores an SES management slot that was available to NCA prior to FY 2010.

These new positions are necessary to reflect current management requirements and will ensure the recruitment and retention of top managers.

Question 6: What is the reasoning of increasing the appropriation for Headquarters staff and operations by $327,000 from FY 2010 level to the FY 2012 request?

Response: The increase represents estimated payroll changes associated with grade and step increases for existing employees. The comparison is less than a 1-percent increase and does not reflect an increase in Headquarters FTE.

Question 7: What is the reasoning for increasing the employee travel budget by $191,000 from FY 2010 level to the FY 2012 request?

Response: The increase of $191,000 (7.5 percent) is due to projected cost increases associated with all modes of transportation. NCA is a national organization with 131 cemeteries in 39 states and Puerto Rico; State cemeteries in 38 states, Guam and Saipan; a national training center; and a national scheduling center. Travel funding is critical to ensure appropriate operational oversight, training, and organizational communication. Employee travel is approved based on program and training requirements. Approximately 480 NCA employees travel in a year.

Question 8: How will NCA define the "urban core" in regards to planning for the new urban initiative?

Response: NCA developed a set of criteria for establishing urban initiative facilities in densely populated areas. These "urban core" areas were identified by using the top 50 metropolitan areas by population as defined by the U.S. Census Bureau.

NCA used this list to identify high population, urban areas currently served by a national cemetery. We identified existing national cemeteries that were 50 miles or more from the urban core of the top 50 cities by population. Additional urban initiative requirements included travel time of 1 hour or more from the urban core, documented veteran utilization rates of less than 20 percent for at least two of the last 3 years, and documentation that clients cite travel time and/or distance as an access barrier at least 5 percent above the national average on the Survey of Satisfaction with National Cemeteries for at least two of the last three surveys.

Question 9: The FY 2012 budget request listed four cemeteries that would be eligible for expansion at an urban core under a new urban initiative yet the minor construction budget only contains funds for the Chicago cemetery in FY 2012.

Question 9(a): How was Chicago selected over the other sites?

Question 9(b): What is the timeline for construction of the other sites?

Response: Two of the urban initiative sites will be funded from the major construction budget. The FY 2011 budget includes funding to construct a columbarium expansion project at Los Angeles National Cemetery, which is currently a closed cemetery. This project will serve the Los Angeles area. The FY 2011 budget also includes design funding for a columbarium at Alameda Point, California, which will serve veterans in the San Francisco/Oakland/San Jose area. Construction funding for the Alameda project will be requested in a future budget request.

Minor construction funding for the Chicago area is included in the FY 2012 budget request, and minor construction funding for the New York City area will be requested in a future budget request. Chicago was selected for FY 2012 funding because it is believed that property will be easier to acquire in that area than in New York City. VA is currently advertising for land in New York City. VA will consider adjusting its plan if circumstances warrant.

Question 10: How has NCA used the appropriation for the land acquisition account since its inception? Please describe if and when there has ever been a carryover in this account in the last three fiscal years.

Response: Funding for the land acquisitionline item was first requested in 2009 to provide the flexibility to acquire land when an opportunity arises. Carryover funds are available in this account; however, they have been allocated for land purchases.

VA is currently pursuing land for two existing cemeteries: an expansion of Willamette National Cemetery in Oregon and a replacement cemetery for Puerto Rico. Specific parcels have been identified and the acquisition process is underway.

Land acquisition for five new national cemeteries is also in progress: Southern Colorado; Tallahassee, Florida; Central East Florida; Omaha, Nebraska; and Western New York. Funds have been obligated for due diligence. Using funds in the land acquisitionline item, NCA plans to purchase land for these new cemeteries in 2011 and 2012.

Question 11: What is your view of expanding the State Cemetery Grant Program to eligible local and municipal governments who have shown that they have the financial resources to maintain to NCA standards of upkeep at these cemeteries after construction?

Response: Any expansion of eligibility for the State Cemetery Grants Program would require legislation. If such legislation is introduced, VA will respond to the Committee's request to provide views.

Question 12: Please explain the reason that the FY 2012 request anticipates a drop of $2.5 billion in survivor benefits.

Response: This decrease in survivor benefits is primarily due to the expectation of paying the Agent Orange retroactive veteran and survivor claims in 2011 in addition to the veterans currently receiving compensation and potential veteran and survivor accessions. Discounting the effects of Agent Orange claims in 2011, caseload and average payment for both veterans and survivors resume the normal annual trend in 2012.

Question 13: Please explain the projection of a $3.2 million increase in clothing allowances.

Response: Based on historical data, VA assumes that 2.85 percent of veterans on the rolls will receive a clothing allowance. Applying this percentage to the estimated FY 2012 veteran caseload results in an increase of 3,589 clothing allowance recipients over the FY 2011 level. This increase in caseload results in an additional

cost of $2.6 million in FY 2012. A cost of living adjustment of 0.9 percent in 2012 increases the expected clothing allowance cost by an additional $0.6 million.

Question 14: What factors contribute to the 12 percent rise in veterans who received an increased disability rating in FY 2010 compared to FY 2009?

Response: In 2009, of the total veterans on the rolls for compensation benefits, approximately 5.6 percent, received an increase in their disability rating. In 2010, this percentage increased to 6 percent of the total veterans receiving compensation. Contributing factors are increasing average age of veterans from earlier war periods, additional regulations, legislation, and the increasing numbers of issues per claim.

Question 14(a): Does this budget predict a similar outcome for FY 2011 and FY 2012.

Response: Based on historical data, the average degree of disability is forecasted to increase through 2012 and the outyears. The budget request considers the increasing average degree of disability in conjunction with estimated VA workload projections.

Question 15: Please elaborate on how P.L. 111–377 will affect the budget account estimates for programs under:

Question 15(a): Chapter 30 of title 38, United States Code.

Question 15(b): Chapter 33 of title 38, United States Code.

Question 15(c): Chapter 35 of title 38, United States Code.

Response: The impact of Public Law 111–377 to the Readjustment Benefits account is currently being assessed by VA staff and will be fully incorporated into the release of the 2012 Mid Session Review Budget.

Question 16: Since the President has taken office the backlog of disability claims has grown by 103 percent, and this budget projects that the average days to complete a claim will rise from 165 days in FY 2010 to 230 days in FY 2012. With the knowledge that it takes new claims examiners close to 2 years to become fully productive, and the Veterans Benefits Management System is years away from being completed, what is the short term plan to address this increasing backlog?

Response: VA is not waiting for the implementation of the Veterans Benefits Management System (VBMS) to take aggressive action toward the goal of completing all claims within 125 days at 98 percent accuracy. VA's multi-tiered approach for addressing the dramatically increasing volume of incoming claims includes a number of innovations. VA deployed two rules-based calculators to streamline and improve decision quality, with more tools in the pipeline. Providing veterans with improved online access to claims status information and other self-service options (such as ordering copies of discharge records) increases client satisfaction while freeing VA staff to work on claims. The Agent Orange (AO) Miner Tool links AO-related databases together and facilitates data search in developing veterans' AO claims. New evidence-gathering tools such as the Disability Benefits Questionnaires sharpen the focus in medical examinations to ensure all information needed to rate the claim is gathered the first time in the medical examination process and is presented succinctly. The Fully Developed Claims (FDC) program puts veterans in the driver's seat for submitting claims that are ready to rate when received by allowing them to certify that their claim includes all available evidence in exchange for expedited processing by VA.

It is estimated that in late 2012, production will begin to outpace receipts. At that same time, we plan to begin the deployment phase of VBMS. VBMS will provide powerful new tools to claims examiners to boost efficiency and productivity. Gains in accuracy through rules-based processing will reduce re-work and appeals. Rules-based processing and calculator tools also speed the rating process, which will increase employee productivity and provide more staff hours to rate other claims.

Question 17: Can you please address reports that in several regional offices that all pending disability benefits claims have been put aside to work Agent Orange claims?

Response: In response to VA Secretary Shinseki's announcement of October 13, 2009, which added three new presumptive conditions to disabilities currently presumed service-connected based on exposure to herbicides in the Republic of Vietnam (ischemic heart disease, Parkinson's disease and Hairy Cell (B–Cell) leukemia), VBA shifted the mission of the 13 Resource Centers (RC) in addition to a few employees

at the St. Paul Regional Office. The mission of these nationwide processing centers, originally established to review, develop, and promulgate pending claims for service-connected benefits, shifted to focus on processing decisions on the 94,000 cases that fall under the *Nehmer* Readjudication Project.

This work is necessary to comply with VA's obligations under the *Nehmer* Stipulation and Order, and judicial decisions issued in this class action lawsuit.

Over the last several years, these Resource Centers have been allocated additional staff to allow them to work the national missions separate and apart from the local regional offices' workload. These resource centers were designed to improve the timeliness, consistency, and accuracy of national workload while allowing regional offices to focus more resources on processing local disability compensation claims. VA currently has over 1,300 employees at these resource centers around the country devoted to the readjudication of *Nehmer* claims. The current workload and mission (*Nehmer* Readjudication) of the Resource Centers will be national and temporary in scope, but will also service local veterans with pending *Nehmer* claims.

In addition, approximately 1,800 VA employees across VA's 57 regional offices that have been adjudicating the numerous new *Nehmer* Agent Orange claims received between October 13, 2009 and August 31, 2010. These regional office employees continue to process local pending disability claims, in addition to the new *Nehmer* claims.

Question 18: We have also heard reports that medical appointments are being rescheduled so Agent Orange related disability rating exams can take place. Is this true and if so could you please explain the rationale for this decision?

Response: VHA has not issued any guidance giving *Nehmer* claimants priority for compensation and pension appointments. Veterans' scheduled compensation and pension appointments are not being cancelled. To cut down the backlog of pending compensation and pension disability examination requests, one VISN is reassigning clinicians in VHA primary care clinics to perform disability examinations 1 week per month. This exercise is taking place from March 2011 to May 2011. They will perform all C&P disability examinations, not just those related to *Nehmer* claims. However, primary care is still being provided. The decision to reassign clinicians is within the individual authority of the VISN.

Question 19: Please discuss VA's current efforts to standardize the private medical questionnaires for disability benefits claims and how these forms will have an impact on the backlog of disability benefits claims.

Response: VA is developing Disability Benefits Questionnaires (DBQs) to streamline the process by which veterans submit relevant medical evidence to VA. The targeted questions in the DBQs will improve the quality and timeliness of medical evidence necessary to support a veteran's claim for disability benefits, which will enable VA to adjudicate claims faster. Use of the streamlined medical questionnaires by private physicians, at the request of veterans, as well as by VA contractors and VHA physicians, will create an aggregate timeliness advantage for claims processing and thus help alleviate the claims backlog. It also offers the long-term potential for VBA to electronically pull the data directly into its systems to aid in the claims process.

Question 19(a): How many of these questionnaires have been approved for use?

Response: VA developed the first three DBQs related to the new Agent Orange presumptive service-connected conditions of ischemic heart disease, Parkinson's disease, and hairy cell and B-cell leukemias. They were released to the public on October 6, 2010.

Question 19(b): How many of these questionnaires are under review?

Response: VA is working on an additional 81 DBQs, in four stages of development. Fourteen DBQs were published in the Federal Register on February 15, 2011, for the initial 60-day public comment period. We estimate that they will be available for public use in September 2011. The remaining DBQs are in the process of development, review by Veterans Service Organization representatives and physicians, amendment, and formal public comment, with the plan for final publication of all DBQs by June 2012.

Question 19(c): What is the cost or savings associated with using these questionnaires?

Response: The savings related to this initiative will be impacted by how many VHA initial exams are no longer needed due to exams being completed by private physicians. To date, VBA has received 2,441 DBQs from outside of the traditional

VA disability examination process. Savings will be further impacted by how many follow-up VA exams can be avoided by increasing the adequacy of initial VA examinations. VA is assessing potential savings in a field study based on the DBQs currently in use. The long-term savings will potentially increase as VA is able to pull exam information electronically directly into its systems to assist in the eligibility determination process.

Question 19(d): What is the timeline for the rollout of these questionnaires?

Response: The remaining DBQs are in the process of development, review by Veterans Service Organization representatives and physicians, amendment, and formal public comment, with the plan for final publication of all DBQs by June of 2012.

Question 19(e): Has there been any external feedback from the private medical community on the effectiveness of the questionnaires?

Response: There has been no external feedback to date from the private medical community. VA currently is working on an electronic portal for the private medical community to submit DBQs and provide feedback. This iterative process will assist veterans and physicians in providing evidence that meets the requirements of the VA Schedule for Rating Disabilities, helping VBA to increase consistency and timeliness of disability decisions.

Question 19(f): How will you measure success in this program?

Response: VBA is conducting a field study to quantify the time differential between utilizing DBQs compared to traditional medical examination templates by both VHA examiners and VBA rating veterans service representatives. It is also evaluating the adequacy of the examinations and consistency of disability determinations.

Question 20: What steps is VBA taking to provide better customer service for veterans who live overseas and have a claim pending for disability benefits?

Response: VA provides benefits information and assistance to veterans and their families residing overseas through the American embassies and consulates under the Foreign Services Program (FSP).

The Pittsburgh Regional Office has jurisdiction of claims from veterans residing in Europe, Asia, Australia, and Africa. The Pittsburgh RO has a designated telephone line that veterans residing in foreign countries may use to contact the RO about their claims. A second shift was established at the beginning of fiscal year 2010, with the goal of providing better service and greater access for veterans residing in foreign countries.

Additionally, the Pittsburgh RO is assisting the Veterans Health Administration (VHA) in the coordination of a pilot program in which VHA clinicians will travel to foreign countries to conduct VA medical examinations in order to expedite the examination process.

Question 21: When will all of the *Nehmer*-related cases be completed and what are the mandatory and discretionary costs associated with re-adjudicating these claims?

Response: For mandatory benefits, VA estimates that the majority of the approximately 94,000 Vietnam beneficiaries, whose claims require readjudication under *Nehmer,* and the many claimants who have filed new *Nehmer* claims (approximately 50,000), will have their claims readjudicated or adjudicated in 2011. This amounts to an estimated $12.3 billion in *Nehmer* retroactive payments.

VA has devoted extensive resources to the task of adjudicating and readjudicating the approximately 144,000 *Nehmer* claims involving ischemic heart disease, Parkinson's disease, and hairy cell and other chronic B-cell leukemias. VA is continuously reevaluating this process to ensure that we adjudicate claims as quickly and accurately as possible.

Secretary Shinseki established a goal of adjudicating the approximately 144,000 *Nehmer* claims by September 30, 2011; however, there are many factors affecting VA's ability to meet that goal. The complexity of the workload and the resources required to be devoted to completion of the project may impact VA's ability to fully adjudicate every *Nehmer* claim by that date.

VA currently has over 1,300 employees at 13 resource centers around the country devoted to the readjudication of *Nehmer* claims. In addition, approximately, 1,800 VA employees at the 57 VA regional offices have been adjudicating the new presumptive claims that VA received between October 13, 2009 and August 31, 2010 that are also subject to the *Nehmer* provisions. As of March 22, 2011, VA has proc-

essed over 68,000 *Nehmer* claims. VBA does not separately track the discretionary costs related to *Nehmer* claims processing.

Question 22: What funds will VBA need to implement the provisions of P.L. 111–377? How much of that need is part of the FY 2012 request?

Response: In FY 2012, VBA has requested $17.5 million to fund the discretionary costs associated with implementing the provisions of P.L. 111–377. The Post-9/11 GI Bill required VA to significantly increase staffing in the short term until a new, robust IT environment is developed, deployed, and proved successful. To support the implementation of the Post-9/11 GI Bill, VA hired 530 temporary claims processors. Public Law 111–377 modifies aspects of the Post-9/11 GI Bill. In order to implement the new law, changes need to be made to the Long Term Solution (LTS) for processing Post-9/11 GI Bill claims. As a result, automation of end-to-end processing for some reenrollments, functionality planned for release in June 2011, will not be available until the third quarter of FY 2012. This delay increases the number of FTE needed to process education claims. Our budget request reflects the need to retain 274 of the claims examiners to remain through FY 2012 to maintain current claims processing efficiencies.

Question 23: What automation enhancements for education claims processing have been delayed because of the enactment of P.L. 111–377 and what is the new timeline for deploying these enhancements?

Response: Public Law 111–377, the Post-9/11 Veterans Educational Assistance Improvements Act of 2010, modifies certain aspects of the Post-9/11 GI Bill. The enactment of this law impacts the development of the Long Term Solution (LTS) for processing Post-9/11 GI Bill claims and our ability to fully automate the delivery of benefits. The capability to conduct automated end-to-end processing on some reenrollments was tentatively planned for June 2011. This capability would create a subset of claims that do not require manual intervention. Because all efforts will now be directed to implementing the changes in the new law, we anticipate this functionality will not be available until the third quarter of fiscal year (FY) 2012.

Question 24: How will the Vet Success on Campus program differ or interact with the centers of excellence for veteran education pilot program that is being run by the Department of Education?

Response: The VetSuccess on Campus program places a full-time VA Vocational Rehabilitation Counselor (VRC) on campus. The counselor is trained and proficient in all aspects of VA benefits, and provides adjustment counseling, career counseling, assistance with benefits, or referrals for other services to the student veteran population. The VetSuccess on Campus program also includes a part-time Vet Center Coordinator, who provides peer-to-peer counseling services and referrals. The Centers for Excellence for Veteran Education pilot program, run by the Department of Education, is a grant program that provides funding to colleges interested in setting up a Center of Excellence on campus to provide comprehensive services to veteran students. The primary difference between the two programs is that, while there are standard criteria for a college to receive funding for a Center for Excellence, the universities receiving the funding do not have a standardized setup or staffing model for the centers, nor are the centers staffed by VA employees. The VetSuccess on Campus program provides a standardized program across each college campus that is staffed with VA employees who can provide direct VA benefits assistance and support to the veteran students. VR&E is interacting with the Department of Education to determine how best to collaborate with the Centers for Excellence program.

Question 25: What type of faith-based organizations is the VR&E service planning to partner with under the budget request?

Response: The VR&E Faith-based and Neighborhood Partnerships (FBNP) Program is working diligently with the Center for FBNP. Four veterans roundtable events are facilitated each year at different VA regional offices. VR&E collaborates with FBNP organizations such as non-profit social service, charitable, and religious organizations in the community. These organizations complement VR&E services by providing ancillary support services to veterans. FBNP organizations also work with VR&E counselors and employment coordinators to recruit and hire veterans into their program vacancies.

Question 26: What is the explanation for the apparent promotion of the following VBA employees from certain GS ratings?

- A loss of 131 GS–5 level employees with an increase of 131 GS–7 level employees

- A loss of 991 GS–9 level employees with an increase of 934 GS–10 level employees
- A loss of 100 GS–11 level employees with an increase of 103 GS–12 level employees

Question 26(a): Was this step made to provide these employees with an increase in salary before the President but a freeze on civil service raises?

Response: No, these promotions reflect the normal career progression of claims assistants (career path of GS 5 to 7), veterans service representatives (career path of GS 7–9–10, test for GS 11), and rating veterans service representatives (career path of GS 9–10–11, test for GS 12).

Question 26(b): Are promotion rates of what is outlined above typical?

Response: Yes, these are the normal career paths for the majority of VBA's claims processors.

Question 27: How many regional office directors are not SES level employees?

Question 27(a): Which offices do not have a SES level employee as a director?

Response: The following ROs have a GS–15 director:

- Hartford, CT
- Manchester, NH
- Newark, NJ
- Providence, RI
- Togus, ME
- Huntington, WV
- Des Moines, IA
- Fargo, ND/Sioux Falls, SD (combined as the Dakotas RO)
- Wichita, KS
- Boise, ID
- Honolulu, HI
- Reno, NV
- Albuquerque, NM

Question 27(b): How are the regional offices chosen to have SES level director vs. a GS–14 or GS–15 level director?

Response: In determining whether an SES director is needed to lead a regional office, the factors that are considered include workload, programs administered, number of employees, complexity and scope of operations, and special national missions, such as the resource centers previously mentioned, the consolidated processing of specific categories of claims (e.g., Camp Lejeune water contamination claims and radiation claims), the National Call Centers, and the Tiger Team for claims from veterans over 70 years old or pending over 1 year.

Question 27(c): Is there a different level of training for an SES level director vs. a GS–14 or GS–15 level director?

Response: There are no GS–14 directorships. The first assignment for our newest directors is frequently a GS–15 directorship. This allows newly appointed directors to gain experience in managing a less complex office before taking on the challenge of managing one of our larger and more complex regional offices at the SES-level. Most of our newly appointed directors, whether appointed to a GS–15 or SES position, have participated in VA's SES Candidate Development Program, through which they receive extensive training, mentoring, and development opportunities that include temporary assignments to SES-level positions. Many of them have also completed VBA's Assistant Director Development Program and have served as Assistant Regional Office Directors.

Question 28: Please provide the average GS level for the following positions at a VBA regional office:

Question 28(a): Director

Response: On average, Directors are at the SES level.

Question 28(b): Assistant Director

Response: On average, Assistant Directors are at the GS–15 level.

Question 28(c): Service-Center Manager

Response: On average, Service-Center Managers are at the GS–15 level.

Question 28(d): Vocational Rehabilitation Counselor

Response: On average, Vocational Rehabilitation Counselors are at the GS–12 level.

Question 28(e): Unit Chiefs

Response: On average, Unit Chiefs are at the GS–13 level.

Question 29: With the renewed efforts to remove VBA from paper-based systems and VA's constant overestimation of this account for the past three fiscal years, why is the budget line for VBA printing costs under General Operating Expenses for VBA going up by $608,000?

Response: Printing costs increase primarily for Education Service to develop a Post-9/11 pamphlet/booklet for national distribution. Also, in continued efforts to standardize training information provided to School Certifying Officials (SCOs), Education Service is developing a comprehensive School Certifying Official Guide to be the official handbook for all SCOs. Distribution will be to all institutions of higher learning (IHLs) and non-college degree institutions (NCDs), as well as State Approving Agencies and Education Liaison Representatives.

Question 30: What is included in the "other services" line item under VBA's General Operating Expenses and what is the justification for increasing this amount by $95 million?

Response: The other services budget category funds service and maintenance contracts, Homeland Security and GSA services, and other miscellaneous contracts and agreements. The $95 million increase funds a $60.8 million increase for contract exams, $27.8 million for the Claims Transformation Plan, $5 million for the Integrated Disability Evaluation System (IDES) initiative, $2 million for a business process reengineering contract for the VR&E program, and $600,000 in miscellaneous reductions.

Question 31: Please explain the $300,000 drop in rent, communications, and utilities for the Insurance Service.

Response: Insurance Services is co-located with the VA Regional Office in Philadelphia; therefore, Insurance's rent, communications, and utilities consist of Insurance's share of the building-wide amenity spaces in addition to the cost per square foot for the space that it occupies.

Rent, communications, and utilities decrease by $300K from FY 2010 to FY 2012 due to lower standard level user charges (SLUC) associated with the projected decline in the ratio of Insurance to building-wide FTE.

Question 32: For FY 2011 the budget shows that Compensation and Pension Service was given (or is expected to be given under a full-year CR) an additional appropriation for total administrative obligations over the FY 2011 request. Please explain why the FY 2012 request shows a re-estimate of Direct FTE for the Compensation and Pension Service of 1,109 FTE under the "CR" when compared with the FY 2011 request. If C&P plans to spend more money than budgeted, but on fewer staff, what is that money going towards?

Response: In FY 2011, VBA will realign approximately $57 million from personal services to other services and apply $19 million in carryover funding for the exploration of alternatives to FTE to assist in eliminating the claims backlog.

Question 33: Please provide a detailed summary of the type of work and GS level that the new 109 Management Direction and Support FTE's from the FY 2010 level for the Compensation and Pension Service will be providing under the request.

Response: The additional FTE, ranging in grades from GS–5 to SES, will perform mission-essential functions, primarily in support of VBMS, VRM, the Claims Transformation Plan, and outreach. Duties range from senior oversight, supervision, program management and analysis, project development and oversight, change management and implementation, process analysis and refinement, and administrative support.

Question 34: What changes does this budget request support to account for the estimated reduction in the average days to complete pension entitlement claims from 125 days under the "CR" to 90 days in FY 2012?

Response: Contractor support is being acquired to assist in reengineering business processes at the Pension Management Centers (PMCs). This project, known as the Pension Transformation Plan, will document the distinct workflows in place at

the PMCs. The contractor will analyze these workflows, along with other inputs (stakeholder interests, policies, procedures, regulations) and produce a common, optimized "to be" process that will be implemented at all three PMCs.

In addition to the Pension Transformation Plan, the "average days to complete" for pension entitlement claims in 2012 will be influenced by the rollout of the Rules-Based Processing initiative. Under this initiative, new tools will process some claims actions end-to-end, outside of the current people-centric system. These rules-based tools will deliver results by streamlining pension claims processing.

Additionally, the pension program policy and oversight functions are being separated from the compensation program functions in the VBA Headquarters organization. A separate Pension and Fiduciary Service is being created to give greater oversight and management attention to the pension and fiduciary programs.

Question 35: Why do you believe that the number of cases claiming eight issues or more has expanded from 22,776 in 2001 to 70,620 during 2010?

Response: Several factors likely contribute to the growth of the number of issues claimed by veterans and Servicemembers. We believe that the increase stems from a general increased awareness of the availability and importance of disability compensation.

Improved and Expanded Outreach: The Department of Veterans Affairs (VA), Department of Defense (DoD), Department of Labor (DoL), and other Federal agencies have combined outreach efforts to Servicemembers recently released from active duty, or those not yet released. Benefit programs for those injured during service are discussed in such programs as:

- Federal Recovery Coordinator Program
- Wounded Warrior Program
- The Army Reserve Family Program
- DoD's Transition Assistance Program (TURBOTAP) Web site, which contains links, application forms, information, phone numbers, etc.
- Yellow Ribbon Reintegration Program
- VA teams that attend demobilization briefings

Increase in VA Programs Focused on Transition: VA and DoD have joint initiatives to help Servicemembers apply for VA disability benefits early in their transition process. Pre-discharge programs like Benefits Delivery at Discharge (BDD), Quick Start, Very Seriously Injured/Seriously Injured (VSI/SI) case management, and the Integrated Disability Evaluation System (IDES) begin the claims process before discharge, so that the benefits can be paid promptly after release from active duty. Examinations and exchange of medical evidence between the agencies also promote quicker service and encourage the filing of disability claims prior to release from active duty.

Media: The Internet provides Servicemembers with access to benefits information through VA and DoD Web sites. News programs discuss the current wars, their effect on the health of Servicemembers and veterans, and benefit programs available. Military installations distribute brochures and other outreach materials to explain VA benefits. veterans service organizations, as well as other transitioning Servicemembers and veterans, also discuss and share disability benefit information.

Question 35(a): Do you have any data on how many of these eight issue cases have been granted or denied?

Response: In FY 2010, 91 percent of all claims with eight or more issues were granted service-connection for one or more disabilities. For the same group of claims, 54 percent of all claimed issues were granted.

Question 36: What steps have been taken to finalize the skills certification testing requirements for all claims adjudicators and managers under P.L. 110–389?

Response: VBA leadership is scheduled to meet with AFGE representatives for mid-term bargaining the week of April 11, 2011. The purpose of these negotiations is skills certification issues, to include the statutory requirement for VBA to provide for examinations of appropriate employees and managers who are responsible for processing claims for compensation and pension benefits. After conducting predecisional involvement with our labor partners, VBA will finalize a policy to require all claims adjudicators and managers to participate in skills certification.

Question 36(a): What steps have been taken to provide remediation to approximately 3,432 employees who have not passed the skills certification?

Response: In addition to the standard training curriculum for new claims processing employees, Veterans Service Representatives (VSRs) are provided an addi-

tional 20 hours of training conducted within 60 days prior to the test date that includes a review of the VSR Skills Certification Training Guide and the Boot Camp Training test. The expectation is that VSRs at the GS–10 level will sit for certification. However, it has been determined that there is a sufficient amount of work at the VSR GS–10 level for those employees who are not successful in the skills certification testing since they continue to add value to the organization. Rating Veterans Service Representatives (RVSRs) are now required to pass the Basic RVSR skills certification as a condition of employment in the position. RVSRs who have completed the RVSR training curriculum, are meeting the local trainee performance standard, and have been in the position for a minimum of 6 months and a maximum of 24 months are eligible to take this test. More recent skills certification testing for experienced RVSRs, Decision Review Officers, and managers are currently utilized to identify training concerns and increase proficiency. Feedback is provided to all employees on the areas where questions were answered incorrectly. The intent of skills certification is to require that employees demonstrate a certain level of proficiency. However, in requiring that a certain level of proficiency be demonstrated, VBA has to consider and provide for the possibility that some employees will be unable to demonstrate proficiency on a test even though they may be performing successfully on the job. Thus, skills certification feedback is given and used for training purposes.

Question 36(b): If a person does pass the skills certification test do they receive a GS rating promotion?

Response: If an employee was hired into a position that requires passing the skills certification to reach full promotion potential, they are promoted upon passing the skills certification test along with meeting time in grade requirements.

Question 36(c): What types of skills certification tests are required for new employees who have completed the basic standardized training before they can begin working live cases?

Response: VBA has developed and implemented a standardized training curriculum for new claims processing employees, referred to as the Challenge training program. The Challenge program is a national technical training curriculum that provides new Veterans Service Center employees the skills they need to function effectively in their positions as Veterans Service Representatives (VSRs) or Rating Veterans Service Representatives (RVSRs). The Challenge program is delivered in a blended learning fashion in three phases. These phases require completion of knowledge-based prerequisite training at home stations using lectures, demonstrations of computer applications, and team-learning through VBA's Training and Performance Support Systems (TPSS), along with centralized classroom training. Centralized training provides hands-on training with computer applications and advances the new employees through progressively more challenging practice claims. Every new employee handles sample claims just as they will when they return to their home stations. Additionally, post-tests are built into TPSS to confirm learning achievement. As part of the continued training, new employees working live cases do so under the constant guidance of experienced employees.

Question 36(d): Does VBA provide the skills certification to all direct FTE or just ones that want to move up a GS rating?

Response: Employees recently hired as Rating Veterans Service Representatives (RVSRs) are required to pass the Basic RVSR skills certification test as a condition of their retention in the position. Veterans Service Representatives (VSRs) must pass the VSR skills certification test to be promoted to the GS–11 level. The results of recently established testing for experienced RVSRs, Decision Review Officers, and Managers is used for feedback and training.

Question 37: The Committee has received many complaints about the level of service and performance of many of VA's assigned fiduciaries. What non-workload performance metrics are in place for this budget for fiduciaries and how can this system be improved?

Response: VA has established three key components for FY 2012 to address fiduciary performance.

- *Training:* Centralized training for fiduciary personnel is anticipated to begin in FY 2012. The centralized training will provide field examiners and legal instruments examiners with the knowledge and skills to better select and instruct fiduciaries. Additionally, this standardized training will provide fiduciary per-

sonnel with the tools necessary to identify and address any performance issues with fiduciaries earlier in the process.

- *Technical Support*: VA will undertake activities to support the replacement for the Fiduciary Beneficiary System (FBS) in FY 2012. FBS is the computer program used by the fiduciary program to manage workload and track fiduciary performance. The new version of FBS is being designed to significantly enhance workload management and provide a historical record of fiduciary performance. This tool will allow for greater oversight of fiduciaries and better selection based on valid data.
- *Communications*: In FY 2011, VA launched a fiduciary Internet site. This site provides fiduciaries with information regarding their duties and responsibilities, references, forms, and frequently asked questions. Plans for FY 2012 include enhanced communications to veterans and beneficiaries who have been determined unable to manage their financial affairs. These communications will include written information regarding their rights and responsibilities and increased sharing of information regarding estate balances. Future plans for the Internet site include incorporating online training and eventually a certification process for professional fiduciaries.

Question 38: Please provide a detailed account of how the $29,929,000 in requested funding for the Claims Transformation Plan will provide accountability and oversight over the 40 pilots that are underway to test policies and procedures to increase timeliness and accuracy for disability benefit claims.

Response: The $29,929,000 is requested to support non-IT requirements associated with the Claims Transformation Plan. It includes funding for 10 FTE for the Office of Strategic Planning to oversee initiative development, testing, assessments, and deployment; travel associated with deployment and oversight of all 40+ initiatives; contract support of the initiatives (private medical records vendor, project management support, strategic and communications support services); and supplies, materials, and equipment.

Question 39: How will the enactment of P.L. 111–377 and delaying of certain automation for processing Chapter 33 claims affect the performance measures for adjudicating original and supplemental education claims?

Response: We expect to have most of the automation to support P.L. 111–377 in place prior to the fall semester of school year 2011–2012 and therefore expect minimal impact on performance measures. As with any change, training and experience are required to administer benefits. We anticipate a slight increase in timeliness for processing Chapter 33 claims due to the enactment of P.L. 111–377, but expect timeliness rates to return to current levels by the end of the fall semester. While delaying previously scheduled automation enhancements to support implementation of P.L. 111–377 will not impact current processing timeliness, it will delay realization of the efficiency and processing timeliness gains we expect to achieve through the fully automated functionality to be developed in the LTS.

Question 40: P.L. 110–389 required VA to conduct two studies, a study on the completion of VR&E training programs and a 20-year longitudinal study of three cohorts of veterans.

Question 40(a): Was funding allocated for either of these studies in FY 2011?

Response: Due to the fact that P.L. 110–389 was passed after the FY 2011 budget request was submitted, both studies were identified as unfunded requirements.

Question 40(b): What is the status of those studies?

Response: Section 333 (Study on Measures to Assist and Encourage Veterans in Completing Vocational Rehabilitation) was completed and submitted to Congress on June 18, 2010. In response to Section 334 (Longitudinal Study), VR&E Service is currently preparing the July 2011 Longitudinal Study report using limited VA data from the FY 2010 cohort.

Question 40(c): Has funding been allocated in the FY 2012 budget and, if so, what will that funding provide?

Response: VA has included $1.2 million in the FY 2012 budget request for implementation of P.L. 110–389. These funds will allow VR&E Service to begin the longitudinal study. The study will enable VR&E to analyze trends among veterans receiving services and respond with forward-looking initiatives that adapt services to the changing needs of veterans.

Question 41: Counting the time to receive a disability rating and to be evaluated for Vocational Rehabilitation, it takes nearly a year for a veteran to begin receiving VR&E benefits. Page 4E–6 of the President's budget mentions Business Process Reengineering (BPR) as a means to shorten that time and to simplify administration. Please provide some examples of changes that have been made under BPR and the results of those changes?

Response: The Business Process Reengineering (BPR) project is designed to identify process improvements and reduce cycle time; review and revising staffing roles and performance metrics; and enhance case management with new technologies. All efforts of the BPR are focused on improving veterans' experiences and increasing successful outcomes through the VR&E program.

As of mid-February, the following accomplishments have been achieved:

- Knowledge Management Portal (KMP)—An inventory and mapping of program reference materials that include a VR&E Central Office workflow component. It is scheduled to be released for VR&E field and Central Office use on March 31, 2011. The KMP will allow VR&E counselors to more quickly research the answers to regulatory and procedural questions, thus streamlining the delivery of benefits to veterans.
- Remote Counseling—VR&E Service identified and tested equipment to conduct remote counseling services via a secure video connection. The equipment was successfully pilot-tested in 3 regional offices. VR&E Service is developing an expansion plan to roll out remote counseling nationally. Remote counseling will allow veterans in rural and remote areas to receive more timely counseling and case management services by eliminating the travel requirement.
- Integrated Disability Evaluation System (IDES) ratings—VR&E Service revised policy to allow IDES Proposed Ratings to be utilized in lieu of memorandum ratings, allowing transitioning Servicemembers to receive VR&E services in an expedited fashion.

Question 42: The 2004 VR&E Task Force made about 120 recommendations to improve the VR&E program. How many of the recommendations have been implemented, how many remain, and what are VA's intentions on the remaining recommendations?

Response: The 2004 VR&E Taskforce made 110 recommendations. The VR&E Service implemented 100 of the 110 VR&E Task Force recommendations. Three additional recommendations are being further developed for implementation. VR&E Service determined that 7 of the recommendations were not feasible for implementation.

Question 43: Since 2005, the number of veterans completing the Independent Living program has dropped from 2,693 to 1,880, a 30 percent drop. That seems counter-intuitive with aging of Vietnam-era veterans and the current wars in Iraq and Afghanistan (and resulting injuries). Has there been a decrease in applications for the Independent Living Program? If not, to what do you attribute the decrease?

Response: VR&E Service anticipates that as new veterans continue to return from combat with complex injuries and Vietnam veterans suffer additional disabilities determined related to Agent Orange exposure or exacerbations of existing disabilities, we will continue to focus on providing IL services to veterans who are unable to work due to the most significant service-connected disabilities.

Over the past 3 years, VR&E Service has given significant attention to ensuring the IL program is being appropriately administered to provide the best services possible to the most deserving veterans. Last year 2,456 IL plans were initiated.

In addition, as assistive technologies continue to progress, enabling veterans with more significant disabilities to enter the world of work; we are developing more employment plans that include independent living services as part of our holistic approach to rehabilitation. Employment plans, even when independent living services are included, are not counted separately under the independent living track.

Question 44: Please provide the following data:

Question 44(a): Number of veterans who were receiving VR&E benefits and/or services on October 1, 2010.

Response: As of October 1, 2010, 105,253 veterans were receiving VR&E benefits and services across all statuses, including applicant status.

Question 44(b): Number of veterans you estimate who will be determined to be eligible for VR&E benefits and/or services from 1 Oct 2010 to Sep 30, 2011.

Response: VBA estimates that 70,053 veterans will be found eligible in FY 2011. Approximately 43,157 of these eligible veterans will complete their evaluations and be found entitled, and approximately 29,299 of the entitled veterans will begin participation in a rehabilitation plan during the same time frame

Question 45: The Department of Education funds a grant program called Veterans Centers of Excellence which competitively funds programs on college campuses that are similar to the Vet Success on Campus program. Is VA coordinating the Vet Success on Campus program with the Department of Education?

Response: Where Veterans Centers of Excellence exist, VR&E counselors coordinate with these programs to provide Veteran-students with referrals for tutors, remedial classes, and the development of computer skills. As VetSuccess on Campus sites are established, coordination occurs with the college veterans services centers, including Veterans Centers of Excellence. Coordination ensures that services are complementary as opposed to duplicative.

Question 46: How many professional level VR&E staff will the proposed budget support, what will be the resulting average caseload, and what performance improvements will the budget provide? Will those performance improvements include job placement services?

Response: The FY 2012 budget request supports a professional counseling staff of 893 FTE. The projected average caseload for each counselor in FY 2012 is 136 cases. VR&E Service estimates the increase in FTE will lead to improvements in the national rehabilitation and national employment rates and the speed of entitlement decisions, as well as support the implementation of the Integrated Disability Evaluation System (IDES) and VetSuccess on Campus (VSOC) initiatives.

Question 47: VA hired nearly 1,000 temporary and full-time education claims processors as a result of passage of the Post-9/11 GI Bill. With the fielding of the new Post-9/11 IT system, how does the proposed budget reflect those employees?

Response: The Post-9/11 GI Bill required VA to significantly increase staffing in the short term until a new, robust IT environment is developed, deployed, and proven successful. To support the implementation of this bill, VA hired 530 temporary claims examiners with funds from the Supplemental Appropriations Act of 2008, and 428 temporary claims examiners with American Recovery and Reinvestment Act (ARRA) funding. While the ARRA employees were retained through FY 2010, VA anticipated the remaining temporary claims examiners would be retained through the end of FY 2011.

Public Law 111–377, the Post-9/11 Veterans Educational Assistance Improvement Act of 2010, modifies aspects of the Post-9/11 GI Bill. In order to implement the new law, changes need to be made to the Long Term Solution (LTS) for processing Post-9/11 GI Bill claims. As a result, automation of end-to-end processing for some reenrollments, functionality planned for release in June 2011, will not be available until the third quarter of FY 2012. This delay increases the number of FTE needed to process education claims. Our budget request of 1,429 FTE reflects the need for 324 of the 530 temporary claims examiners to remain through FY 2012 to maintain current claims processing efficiencies.

Question 48: What is the funding devoted to reducing the number of foreclosures of homes purchased with a VA-guaranteed loan and does that funding support any new initiatives?

Response: Total funding of $28.56 million will be devoted to reducing the number of foreclosures in 2012. This includes $23.63 million for FTE with responsibilities related to loan servicing activities and $4.93 million for VA Loan Electronic Reporting Interface. This funding does not support any new initiatives.

General Administration

Question 1: At the Committee's February 17, 2011, budget hearing Secretary Shinseki testified that the budget for the Office of the Secretary had increased significantly since 2009 due, in large part, to the fact that staff formerly detailed to the Secretary's Office (and accounted for elsewhere within VA) were now being accurately reflected as employees working within that Office.

Question 1(a): How many detailed employees now work within the Office of the Secretary full time? Please provide the number of detailed employees who have worked within that Office for each of the last 5 years.

Response: As of March 30, 2011, two persons are currently on short-term detail to the Office of the Secretary. Over the past 5 years, 12 persons were on detail to

the Office of the Secretary in 9 distinct positions. Duration of these details varied. Three of these detail positions were converted to full time positions in the Office of the Secretary, and six of the detail positions were eliminated. The 4-person Center for Faith-Based and Neighborhood Partnerships was also transferred from the Office of Public and Intergovernmental Affairs to the Office of the Secretary during this 5-year period. This transfer also involved temporary detailing of Center employees until funding adjustments were coordinated. All Center employees now work in, and are funded by, the Office of the Secretary.

Question 1(b) Please provide a breakdown of the salaries of the formerly detailed employees now converted to full-time employees working within the Office of the Secretary.

Response: Two detail positions were transferred and reassigned to the OSVA in FY 2010 and one in FY 2011. These positions were included in the OSVA FTE total for that fiscal year. The respective salaries for each of the employees reassigned in FY 2010 were approximately $124,000 and $85,000 and $141,000 for FY2011.

Question 1(c) When detailed employees are transferred back to their primary office, how are they reflected in the budget? Or, have they always been reflected and, therefore, there is no net effect of FTE increase or decrease?

Response: Employees on detail are and continue to be reflected in the FTE numbers of their original office.

Question 2: Please explain the justification for the following proposed 3-year budget increases (FY 2009 to FY 2012), then detail the performance measures used to justify these increases:

Question 2(a): 23.1 percent for the Office of Management

Response: The balance of the increases during this period went (or will go) to VA-wide financial management initiatives in the areas of financial systems, audit readiness and enterprise-wide cost accountability; a VA-wide Integrated Operating Model; OMB A–123 audits; VA's enhanced use lease program; and greening and renewable energy projects. Included in the 2012 request is $1.6 million for audits for the non-VA care (fee) program.

VA has made significant progress in financial management performance. Most notable is the elimination of three longstanding material weaknesses.

Question 2(b): 20.1 percent for the Office of Human Resources

Response: The $12.4 million increase in the budget for the Office of Human Resources (HR&A) from FY 2009 to FY 2012 is primarily due to payroll ($3.1 million), other services ($1.5 million), rent, communication and utilities ($4.4 million), and the change in unobligated balances ($2.9 million).

The payroll increase reflects costs associated with the pay raise in FY 2010 and the salary requirements for 302 FTE funded through General Operating Expenses. This FTE level includes 16 FTE hired in FY 2010 for the Office of Resolution Management for several initiatives aimed at increasing the effective use of Alternative Dispute Resolution (ADR) throughout VA. Additional full-time employees to serve as conflict coaches, facilitators, mediators and trainers were deployed to VISNs 4, 8, 12, 15, 16, and 23 to provide more ADR access at the facility level, meet the increased utilization of ADR to address workplace disputes, and maintain satisfaction with the process. These dedicated resources have improved the efficiency and effectiveness of the ADR program by reducing average processing time for ADR requests in three of the six VISNs and increasing the ADR participation rate in four of the six VISNs. Due to these efforts, VA employees had increased opportunities for early resolution of complaints and grievances. Also, ORM staff stood up a full-service hotline, designed to provide employees and managers a forum to ask general questions or questions related to Transformation-21 initiatives, and learn about avenues to address workplace conflict and disputes. In 2010, the call center answered over 1,000 calls and 200 emails. This new service is a separate and distinct service from the EEO complaint processing toll-free line. It is not designed to replace the complaint hotline or bypass other dispute resolution avenues (local union, facility program manager, workplace ADR). Benefits of the call center include increased use of ADR, decreased EEO complaint activity, increased opportunities to market and distribute accurate information about T–21 initiatives, and improved ability to educate employees and managers on a variety of issues that often result in workplace disputes.

The increase in other services is for increased funding of contracts, including establishing contracts to maintain the ADR Call Center and for an EEO/ADR dashboard. The EEO/ADR Dashboard was developed to provide VA leadership an access

panel to EEO data that can serve as a barometer of the work environment. The dashboard leverages technology by pulling from various data systems to display key indicators that provide valuable, real time information for managers to determine if there are opportunities for intervention that will improve the work climate. A 90-day dashboard pilot was implemented on September 30, 2010, at VISNs 8, 9 and 16. It will be evaluated and measured using customer surveys, customer feedback from dashboard links and monthly usage reports. The intended goal of the dashboard is to provide a management tool that identifies trends and affords managers the opportunity to align strategies and organizational goals that ultimately impact the quality of services VA provides to veterans. In 2011, an Executive Dashboard will be developed to provide executive level staff a snapshot of the aforementioned information, while providing restricted access for highly sensitive information.

ADR participation in the EEO complaint process in the last fiscal year has increased from 48 percent in 2009 to 52 percent at the end of 2010, significantly avoiding costs to the Department. The cost of handling a discrimination case through the formal complaint process ranges from $18,000 per complaint to $60,000, excluding the cost of damages that may be payable in the event of a finding of discrimination. In 2010, participation in the ADR process resulted in the resolution of 1,094 disputes outside of the traditional EEO complaint process, resulting in 86 percent of these workplace disputes being resolved using ADR. The overall resolution rate for ADR to include its use before, during, and in lieu of the EEO complaint process increased from 54 percent in 2009 to 60 percent in 2010. VA estimates cost avoidance of $82 million as a result of increased use of ADR to resolve workplace disputes.

The rent, communication and utilities increase is primarily related with ongoing rents and other services required to operate VA headquarters. Rent includes payment to GSA for buildings occupied by VA and its employees. Office space rental estimates are based on the amount prescribed by GSA in accordance with established fair annual rental appraisals and are in accordance with GSA's current projections. The obligation increase is for estimated rental costs beyond the normal non-payroll inflation increase.

Question 2(c): 96.2 percent for the Office of Policy and Planning

Response: Since 2009, staffing increases and funding have allowed the Office of Policy and Planning (OPP) to establish the Office of Corporate Analysis and Evaluation (CA&E) and the Transformation and Innovation Service (TIS). We have also dedicated additional resources to the National Center for Veterans Analysis and Statistics (NCVAS) and the VA/DoD Collaboration Service.

As a result of these additional resources, OPP has been able to improve outcomes to veterans during fiscal year (FY) 2010 and FY 2011 in support of the four key integrated strategies articulated in the VA Strategic Plan.

a. Enhance our understanding of veterans' and their families' expectations by collecting and analyzing client satisfaction data and other key inputs.

• Completed the **National Survey of Veterans,** a comprehensive nationwide survey of veterans, active duty Servicemembers, activated National Guard and Reserve members and family members and survivors. Data collected through the National Survey enables VA to compare characteristics of veterans who use VA benefits and services with those of veterans who do not; and study VA's role in the delivery of all benefits and services veterans receive.

• Established VA **data governance policy and processes** to ensure VA enterprise data and information are available, current, reliable, readily accessible, and useful. Developed and implemented business intelligence capabilities and tools to transform data into information to support data-driven planning, analysis, and decision-making activities.

b. Anticipate and proactively prepare for the needs of veterans, their families, and our employees.

• Improved VA policy toward **Gulf War veterans** by advocating for the implementation of recommendations made by the Advisory Committee on Gulf War veterans. Produced a comprehensive annual report on the use of selected VA benefits and services by pre-9/11 Gulf War Era veterans. The recommendations included presumptive criteria for a number of serious illnesses for which veterans will now be eligible to receive treatment from VA.

• Completed the **Program Evaluation of VA's Mental Health Program**. This study provided VA with information about the services it provides, the impact on veterans, how VA compares to the private sector, patient outcomes, and costs. Study

findings and recommendations are used to refine and improve VA services by suggesting policy and operating changes.

c. Create and maintain an effective, integrated Department-wide management capability to make data-driven decisions, allocate resources, and manage results.

• Began the implementation of **planning, programming, budgeting, and evaluation (PPBE)** capabilities to implement multi-year strategic resource allocation system across the Department and independent analysis to inform senior level decision-making on resource options. CA&E is an independent body dedicated to aligning VA resource allocations with investments that best serve our veterans, their families, dependents, and survivors.

• Implemented the new **strategic management process** for VA. This process uses strategy to drive the budget and performance plans, and aligns the execution of VA strategy with performance management and organizational and individual accountability in an iterative way. This process centers on implementing the strategic goals, integrated objectives, and integrated strategies throughout VA.

• Ensured the **success of Departmental transformation initiatives via collaboration, oversight, and monitoring** of the $2.5 billion portfolio of 16 major transformation initiatives (list of initiatives at end of this response) and 20 supporting initiatives. This included assisting in the development of operating plans, intensive mid-year reviews, and problem solving sessions with the 16 major initiatives that provided independent assessment of progress, identified barriers to success, helped define solutions, and elevated issues to senior leadership, as required.

d. Create a collaborative, knowledge-sharing culture across VA and with DoD and other partners to support our ability to be people-centric, results-driven, and forward-looking at all times.

• Contributed to transforming **VA/DoD Collaboration** by coordinating the development and implementation of joint programs such as the expansion of the virtual lifetime electronic record (VLER) pilots; the expansion of the integrated disability evaluation system (IDES) pilot to worldwide deployment; the development of the integrated mental health strategy (IMHS) and its 28 joint strategic actions; the increased access of Servicemembers to VA benefits and service information through e-Benefits; the development of joint policy for the implementation of separation health assessments for all Servicemembers; and significant improvements to the transition assistance program (TAP).

Additionally, OPP continued to provide ongoing services and capabilities to the VA and to veterans that included the following outcomes:

- Provided **statistical and geospatial analysis** to support recurring and ad-hoc reporting. Examples of these statistical products include the Geographical Distribution of VA Expenditures Report, the Unemployment Rate of veterans Report: 2000 to 2009, the Labor Force Participation Rates of veterans Report: 2000 to 2009, The VA Information Pocket Guide; the Gulf War Era veterans: pre-9/11 Report, and the VA–DoD Disability Evaluation System Trend Analysis.
- Provided **actuarial services** to the Department on an ongoing basis. FY 2010 efforts included development of the VA compensation and pension liability model.
- Updated **VA's official estimates and projections of the veteran population** by State, county and congressional district from 2009 to 2039. Veteran population estimates are projected with characteristics such as: age, gender, period of service, race, ethnicity, rank (officer/enlisted), and branch of service.
- Conducted a nationwide **management analysis/business process reengineering study** of sanitation operations (8,831 FTE) and biomedical engineering (990 FTE) services across VHA and monitored the implementation of the recently reengineered plant operations and grounds maintenance (7,269 FTE) functions.

The nine FTE within CA&E in FY 2011 are not sufficient to implement a Department-wide programmatic efforts, conduct independent assessments of resource requirements needed to meet planned veteran outcomes, and fully integrate PPBE across a 300,000 person organization with three distinct administrations (VBA, VHA, and NCA).

The additional 12 FTE to bring the budget authority FTE to 105 in FY 2012 are requested to meet the emerging requirements identified above. First, to fully integrate and establish the PPBE methodology in the Department, it is necessary to expand the CA&E office from nine to 13 personnel. CA&E is still an exceptionally lean and efficient, operation in relation to comparable governmental agencies. For exam-

ple, CA&E staffing of 13 provides strategic resource management and independent analysis and oversight of a program budget in excess of $132 billion and a workforce in excess of 300,000. By comparison, the Office of Program Analysis and Evaluation (PA&E) at the Department of the Army is staffed with approximately 100 personnel and supports a similar sized program/budget of $149 billion in FY 2012. Second, the VA/DoD Collaboration Service is expanding from 13 to 16 personnel to address the growing number of issues associated with VA/DoD collaboration including IDES, VLER, electronic health records, IMHS, TAP, etc. Finally, we are establishing a new capability within the Office of Policy to conduct long-term policy analysis and alternative futures development in coordination with DoD and other Federal agencies.

The additional 12 FTE requested for 2012 will enhance capabilities primarily in three areas:

- The **Office of Corporate Analysis and Evaluation** will continue implementation of a Department-wide strategic resource management system to help inform VA leadership with analysis and options for future funding of veterans' needs. CA&E provides the Secretary, and VA senior leadership with independent and objective analysis of resource requirements and options for funding veterans' needs across the spectrum of health care, benefits, and memorial services. Through independent analysis and evaluation, CA&E provides an added level management insight on the effectiveness and efficiency of VA programs and budgets and measurable impact to the veteran.
- The **Office of VA/DoD Collaboration** will expand its development and monitoring of joint policies and programs such as the expansion of the VLER pilots; the expansion of the IDES pilot to worldwide deployment; the development of the IMHS and its 28 joint strategic actions; the increased access of servicemembers to VA benefits and service information through e-Benefits; the development of joint policy for the implementation of separation health assessments for all servicemembers; and significant improvements to TAP. These activities will protect the equity of veterans as they transition from servicemembers; producing better outcomes in health care delivery and benefit service for veterans, servicemembers, military retirees, and eligible dependents.
- Finally, we are establishing a new capability within the **Office of Policy** to conduct long-term policy analysis and alternative futures development in coordination with DoD and other Federal agencies. It will develop policy analysis capability to evaluate range of future policy issues and requirements over next 10 years, i.e. policy challenges due to population trends, changing demographics and implications to VA infrastructure and capabilities such as the impact of health care reform on veterans, and implementation of Caregivers Legislation.

16 Major Initiatives

1. Eliminate veteran homelessness.
2. Enable 21st century benefits delivery and services.
3. Automate GI Bill benefits.
4. Create Virtual Lifetime Electronic Records.
5. Improve veterans' mental health.
6. Build VRM capability to enable convenient, seamless interactions.
7. Design a veteran-centric health care model to help veterans navigate the health care delivery system and receive coordinated care.
8. Enhance the veteran experience and access to health care.
9. Ensure preparedness to meet emergent national needs.
10. Develop capabilities and enabling systems to drive performance and outcomes.
11. Establish strong VA management infrastructure and integrated operating model.
12. Transform human capital management.
13. Perform research and development to enhance the long-term health and well-being of veterans.
14. Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process.
15. Health Care Efficiency: Improve the quality of health care while reducing cost.
16. Transform health care delivery through health informatics.

Question 2(d): 50.4 percent for the Office of Congressional and Legislative Affairs

Response: The Office of Congressional and Legislative Affairs (OCLA) has a critical role in keeping Congress informed of VA's work on behalf of veterans. OCLA is the lead VA office responsible for maintaining open communications with Con-

gress through briefings, meetings, calls, hearings, site visits, written communications, reports, and responses to member and Committee requests for information. OCLA also maintains constituent casework offices on Capitol Hill to support Congressional offices' veterans, dependents, and survivors casework. Additionally, OCLA is responsible for liaison with the U.S. Government Accountability Office (GAO) and coordinates all meetings and correspondence with the agency. For a number of years OCLA was not staffed sufficiently to keep pace with Congress' increasing requests for information. OCLA's budget requests over the last 3 years were focused at placing additional personnel towards accomplishing the office's mission and meeting the needs of Congress.

During FY 2010, OCLA supported 105 hearings, 322 information briefings, coordinated the responses to over 1,240 questions for the record, responded to over 7,100 written and over 15,000 telephonic requests for information, and countless e-mails, and supported approximately 100 oversight visits. In FY 2010, OCLA also coordinated the VA response to 50 GAO reports that focused on VA issues.

In October 2010, OCLA produced its Operating Plan which implemented performance measures and metrics for the office for FY 2011–2013. These measures and metrics were created to improve OCLA's responsiveness to Congressional requests for information and set goals for the office to achieve in the out years that support VA's Strategic Plan. These measures and metrics will be the standard to measure OCLA's progress and are reviewed on a monthly, quarterly, and annual basis. OCLA also published a new Standard Operating Procedures (SOP) Manual that followed a comprehensive review of all of the office's internal processes. Since the implementation of the Operating Plan, and publication of the SOP, OCLA has improved its responsiveness to Congressional requests for information. As an example, OCLA has revitalized the questions for the record process. OCLA assigned new program analysts to assist with implementing the new collaborative processes outlined in the SOP that streamlined the overall QFR process and turned an underachieving performance throughout FY 2010 into a process that is exceeding its targeted goal in FY 2011. In FY 2010, OCLA submitted 16 percent of the QFRs on time. Through the first 5 months of FY 2011 OCLA has submitted a 100 percent of the QFRs on time. OCLA supported 322 congressional briefings in FY 2010. These briefings are predominantly in response to Committee or member office requests. Through the first 5 months of FY 2011, OCLA coordinated 173 briefings, which is a 60 percent increase over the same period last FY. The added briefings were a result of the greater depth and breadth on issues staffed by the additional congressional relations officers and congressional liaison officers. These new personnel have also contributed to ensuring OCLA improved its performance submitting VA witness written testimony on time. In FY 2010, OCLA submitted only 60 percent of testimony on time. Through the first 5 months of FY 2011, OCLA has submitted 100 percent of testimony on time. VA is committed to providing Congress accurate and timely information and the increase in personnel are necessary to achieve that goal.

There are two main indicators that suggest increased staffing is required. OCLA monitors the feedback members of Congress and Congressional staffs provide on the timeliness and completeness of the information VA delivers to Congress. While OCLA has made significant improvement, there are still additional improvements to be made to decrease the time it takes to respond to requests for information. The other main indicator is OCLA's All Employee Survey results. These results indicate additional personnel are needed to balance workload within the office. The results of the survey indicated employees realize the importance of their jobs, but are impacted by the high volume of work and the very dynamic environment they operate in. These factors were considered in reorganizing OCLA's structure to provide greater depth and breadth on issues, adding positions to support the most over-worked areas, and rebalancing existing duties and responsibilities. OCLA requested additional funding and staff to accomplish these actions. However, in FY 2009 and FY 2010, OLCA was unable to achieve its authorized number of employees due to high employee turnover. In FY 2009, OCLA was authorized 38 FTEs, only 34 were in fact filled. In FY 2010, OCLA was authorized 42 FTEs, and only filled 36. As of March 2011, OCLA has increased the number of personnel to 43 and should be able to achieve our authorized strength of 46 employees before the end of the fiscal year. In FY 2012, OCLA requests additional funding to support three additional personnel, which includes the Office of Advisory Committee Management. In the FY 2012 budget request, OCLA will assume the funding for the Office of Advisory Committee Management, which is responsible for supporting the VA's advisory committees. The Office of Advisory Committee Management supported 23 advisories committees and 54 advisory committee meetings during FY 2010. As a result of the office's grade structure, FY 2012's requested funding would increase the office's overall FTE to 49 vice 52.

In FY 2010, OCLA added four positions to its organizational structure.

Congressional Relations Officer—GS–14
Congressional Relations Officer—GS–14
Congressional Liaison Officer—GS–13
Congressional Liaison Officer—GS–13
In FY 2011, OCLA will add four positions to its organizational structure.
Director, Benefits Legislative Affairs—GS–15
Program Analyst—GS–9
Program Analyst—GS–9
Congressional Liaison Assistant—GS–8

In FY 2012, OCLA is requesting to add three positions to its organizational structure.

Director, Health Legislative Affairs—GS–15
VA Advisory Committee Management Officer—GS–14
VA Advisory Committee Program Analyst—GS–11

Questions for the Record
The Honorable Jeff Denham

Question 1: In your budget request, you requested $10 million for the National Cemetery Administration Acquisition Fund. Can you elaborate on where these additional cemeteries will be constructed and the timeline in which you expect to see the completed?

Response: VA is currently pursuing land for two existing cemeteries: an expansion of Willamette National Cemetery in Oregon and a replacement cemetery for Puerto Rico. Land acquisition for five new national cemeteries is also in progress: Southern Colorado; Tallahassee, Florida; Central East Florida; Omaha, Nebraska; and Western New York. Using funds in the land acquisition line item, NCA plans to purchase land for these cemeteries in 2011 and 2012. Funding is available for advance planning, and construction funds for the cemeteries will be requested in future budget requests.

Question 2: According to the Veterans Affairs budget request, the VA has asked for an increase in operating expenses over the 2010 budget. What is the Department of Veterans Affairs doing to increase efficiency in the administrative offices as a means to reduce the General Operations budget? Additionally, what is being done to reduce the Secretary's office operating costs?

Response: VA is committed to increasing the value of every dollar to which we are entrusted by Congress and the American taxpayer. In developing the 2012 budget, we have carefully reviewed requirements in our non-medical programs. VA has implemented a systematic process to evaluate and prioritize our most critical safety and security needs in our capital program. In addition, we are working to implement the best long-term IT solutions and are adopting new acquisition strategies for goods and services, including consolidation and economies of scale.

In the staff offices area, all initiatives included in the budget were developed to provide direct support to veterans or VA's core mission. All initiatives in the General Administration budget will improve efficiency, accountability, veteran and employee safety, and security of VA facilities. A list of the staff office initiatives are identified on page 5A–6 in Volume 3 of VA's 2012 Budget Submission.

We have also closely examined appropriated funding for travel and other supplies. The 2012 General Administration travel estimate of $8.4 million is less than the 2008 travel level of $10 million. In addition, the 2012 General Administration estimate for supplies and equipment are both less than the levels in 2010 ($556K and $107K respectively).

For the Office of the Secretary, the 2012 request reflects a reduction from the 2011 estimate in all non pay categories, including travel, contractual services and supplies. The only increase is in payroll—to support the existing on-board staff of 89. In addition, the 89 FTE in the Secretary's 2012 President's budget is 5 FTE less than the original 2011 request.

Question 3: The amount of $953 Million has been requested for the medical contingency fund so that this money can be used when needed. Why has the VA adopted this new process for additional funds instead of using the appropriations process? Additionally, what process would the VA utilize to obtain additional funding if all the money in the contingency fund is spent within the fiscal year?

Response: The $953 million contingency fund, estimated in the VA's Enrollee Health Care Projection Model, was created to address the potential demand increase

for medical care services due to changes in economic conditions. The fund will only become available for obligation if the Administration determines the anticipated changes in economic conditions, as estimated by the Model, materialize in 2012. This economic impact was incorporated into the Model for the first time this year. Based upon experience from 2010, the need for this funding will be carefully monitored in 2012. This cautious approach recognizes the potential impact of economic conditions as estimated by the Model while acknowledging the uncertainty associated with the estimates.

Question 4: Given the current economic conditions of our country, how is the VA prepared to handle the potential increase in veterans seeking care and usage of VA benefits while reducing the VA's operating costs?

Response: Claims for disability compensation and pension benefits continue to dramatically increase, and economic conditions are only one of numerous factors contributing to the increase. Annual claims receipts increased 51 percent from 2005 to 2010. VA's transformational initiatives now in progress will enable VA to meet that growing demand. Production will begin to outpace receipts beginning in late 2012. Through its Claims Transformation initiatives, VBA is laying technological and business transformation groundwork to streamline claims processing and eliminate the claims backlog. VA's end goal is a smart, paperless, electronic claims processing system.

Our approach to transformation is a holistic approach that changes our culture, improves our processes, and integrates innovative technologies. While we work to develop the paperless system, we are making immediate changes to improve the efficiency of our business activities. New calculators guide claims decision makers with intelligent algorithms similar to tax preparation software or through simple spreadsheet buttons and drop-down menus. A growing body of evidence-gathering tools, called Disability Benefits Questionnaires, brings new efficiencies to collection of medical information needed to rate each claim. The Fully Developed Claims program speeds the decision process by empowering veterans and helping them submit claims that are ready for a VA decision as soon as they are received.

See response to Question 3. VA's FY 2012 Medical Care appropriation request of $50.851 billion includes a contingency fund of $953 million. The $953 million contingency fund, estimated in the VA's Enrollee Health Care Projection Model, was created to address the potential demand increase for medical care services due to changes in economic conditions. The fund will only become available for obligation if the Administration determines the anticipated demand materializes in 2012. The FY 2012 total appropriation request will provide services for over 6 million veterans and assumes over $1.2 billion in operational improvements. In FY 2013, VA's Medical Care appropriation request is $52.541 billion to provide services for over 6.3 million veterans.

Question 5: How will the Veterans Affairs Administration work to better reach military personnel who have returned home from service to notify them of the services the VA can provide them?

Response: The Department of Veterans Affairs created the National Outreach Office within the Office of Public and Intergovernmental Affairs (OPIA) in FY 2010 to standardize how outreach is being conducted throughout the department and have made considerable progress in researching and analyzing VA's outreach programs and activities. The National Outreach Office has developed a framework to guide us through creating a more efficient and effective approach to boost our reach to veterans and returning military personnel, in support of VA's major initiatives.

The Department's outreach activities purpose is to increase access to VA health care and benefits by optimizing linkages to VA services for all new veterans through targeted programs. VA reaches out to veterans at 7 different venues throughout the deployment cycle from pre-deployment, immediately at demobilization, and post-deployment. Each of these initiatives is described below. The initiatives provide the opportunity to engage veterans and families with a face to face encounter at 7 different points to deliver the One-VA message within the first 6 months of returning home and as they separate from service. Using in-person outreach events as well as the Web and phone-based resources, VA works to enroll and register veterans for their health care services as soon as they separate from active duty. Getting enrolled quickly is critical to accessing important benefits. For instance, National Guard and Reserve members returning from combat are entitled to 5 years of free VA health care for any condition related to their service in the Iraq/Afghanistan theater and have 180 days to obtain an appointment for a one-time dental evaluation and treatment.

Combat veterans are always eligible to access services at VA Vet Centers located in communities and through mobile vans.

1. Reserve Component Demobilization Initiative at 63 Demobilization Sites

In May 2008, VA created an initiative to inform demobilizing reserve component (RC) combat veterans of their enhanced VA health care and dental benefits during their mandatory demobilization separation briefings. The purpose is to provide and offer Servicemembers assistance with the completion of their enrollment forms for VA health care. Servicemembers returning from the combat zone are introduced to VA during the out processing period at the demobilization sites. They receive a standardized 46-minute briefing on VA services and benefits and are encouraged to enroll into the VA health care system. All members leave the demobilization site for home with the names of their local OEF/OIF Program Managers to contact or who will contact them to set up their initial health and dental appointments at the VA Medical Center (VAMC) nearest to their homes. As of October 2009, this initiative has been implemented at 15 Army, 4 Navy, 5 Marine Corps, 36 Air Force and 3 Coast Guard Reserve demobilization sites. In collaboration with the Veterans Benefits Administration, VHA developed a standardized slide presentation, and staff provides educational materials to all new veterans. VA staff has reached out to 152,204 returning Servicemembers and enrolled 143,448 (94 percent) into the VA health care system since May 2008.

2. Individual Ready Reserve Muster (IRR) Initiative for U.S. Marine Corps and U.S. Army Reserve Veterans

In May 2009, VA created an initiative to inform Individual Ready Reserve (IRR) Army Reserve soldiers and Marines of their enhanced VA health care and dental benefits during their mandatory IRR Muster. Prior active duty members who are in the IRR are introduced to VA during this event. VA staff has 20 minutes to brief on VA services and benefits and provide assistance with the completion of enrollment forms for the VA health care system. VA encourages 100 percent enrollment of all those attending the IRR Muster. All members leave the IRR muster with the names of their local OEF/OIF Program Managers to contact or who will contact them to set up their initial health and dental appointments at the VAMC closest to their homes. VA has reached out to 22,596 members and enrolled 6,712 (30 percent) since May 2009.

3. Post-Deployment Health Reassessment (PDHRA) Initiative for the National Guard and Reserve Components

In early 2005, DoD mandated the Post Deployment Health Reassessment (PDHRA), a health care screening (DD–2900), for all National Guard & Reserve Servicemembers returning from deployment. The PDHRA is a global health assessment, with an emphasis on behavioral health and service-related conditions that is designed to be conducted between 90 and 180 days post-deployment. The intent of the PDHRA is to identify deployment-related physical health, mental health and readjustment concerns, and to identify the need for follow-up evaluation and treatment.

VA has been an active partner in this outreach initiative. RC Units conduct the PDHRA through three primary modes: on-site events conducted by DoD contract health care providers; on-site call center events; and from a 24/7 Call Center operation. VAMC and Vet Center staff conduct briefings, staff table-top information displays, enroll veterans in the VA health care system and arrange follow-up appointments at VAMCs and Vet Centers. VA has supported over 2,200 PDHRA events and the DoD PDHRA 24/7 Call Center since November 2005, resulting in over 70,000 referrals to VAMCs and over 27,000 referrals to Vet Centers.

4. Combat Veterans Call Center Initiative

On May 1, 2008, VHA began the Combat Veteran Call Center initiative help OEF/OIF combat veterans become aware of the available VA services and benefits. Veterans are provided information about VA benefits, services, and employment opportunities. They are also offered the opportunity to be assigned a care manager. In FY 2010, 91,833 calls were placed and VA staff spoke with 9,679 veterans. Of that, 2,294 requested and were sent information packets.

5. Department of Defense Yellow Ribbon Reintegration Program Support Initiative for National Guard and Reserve Components

The DoD Yellow Ribbon Reintegration Program (YRRP) is a DoD-wide effort to support National Guard and Reserve Servicemembers and their families with information on benefits and referrals throughout the entire deployment cycle, before, during and after deployments. YRRP events are hosted by military units and held throughout the year in every State.

VA is a major support partner of the YRRP. VA staff attends YRRP events to provide support and information on benefits, services, and programs available to Guard and Reserve members; enroll veterans in the VA health care system; and coordinate referrals to other VA services and/or programs. VA staff may also provide specialized briefings on issues like PTSD and TBI upon request. Additionally, VA has placed a dedicated, full-time liaison in the YRRP Office at the Pentagon.

6. VA, National Guard, and the Transition Assistance Advisors (TAAs) Initiative

VHA assists the National Guard (NG) in the training of their 62 National Guard Transition Assistance Advisors (TAAs) that serve as liaisons in the field at the State level to assist NG Servicemembers, veterans, and their families with questions; and provide assistance to access VA benefits and services, VA Medical Centers, and VBA Regional Offices.

7. OEF/OIF Internet Web Page Initiative

To support VA programs and services, VA developed a new internet webpage for OEF/OIF veterans. In addition to providing information about VA benefits and services, the site contains blogs and other social media tools to engage this new generation of veterans. There is also a section on the Web site for family members. There have been over 1 million visits to this site. The Web site is: *www.oefoif.va.gov*.

Question 6: What legislative or regulatory limitations are preventing the VA from being able to successfully reach out to returning servicemembers? How is the VA limited in conducting its outreach due to the budget?

Response: None at present. VA is currently conducting and the Budget request allows for the following ongoing efforts to be able to be sustained:

Since FY 2010, OPIA has awarded several marketing/public relations contracts to assist the Department of Veterans Affairs in developing outreach plans and campaigns. The campaigns cover topics from Paralympic sport to veteran homelessness, and suicide prevention and target various generations of veterans. For example, VA launched a national advertising campaign in the fall of 2010 with two commercials, "What Lies Ahead" and "Care Package," which targeted returning OEF/OIF/OND veterans and their families and highlighted VA services such as health care, education, job assistance, and home loans. Through the continuance of these campaigns and other outreach initiatives, OPIA plans to increase veteran awareness, improve education, and increase client confidence using specific and targeted outreach activities and communication materials and products.

Questions for the Record
The Honorable Jon Runyan

Question 1: Mr. Secretary, since the President has taken office the backlog of disability claims has grown by 103 percent, and this budget projects that the average days to complete a claim will rise from 165 days in FY 2010 to 230 days in FY 2012. With the knowledge that it takes new claims examiners close to 2 years to become fully productive, and the Veterans Benefits Management System is years away from being completed, what is the short term plan to address this increasing backlog?

Response: VA is not waiting for the implementation of the Veterans Benefits Management System (VBMS) to take aggressive action toward the goal of completing all claims within 125 days at 98 percent accuracy. VA's multi-tiered approach for addressing the dramatically increasing volume of incoming claims includes a number of innovations. VA deployed two rules-based calculators to streamline and improve decision quality, with more tools in the pipeline. Providing veterans with improved online access to claims status information and other self-service options (such as ordering copies of discharge records) increases client satisfaction while freeing VA staff to work on claims. The Agent Orange (AO) Miner Tool links AO-related databases together and facilitates data search in developing veterans' AO claims. New evidence-gathering tools such as the Disability Benefits Questionnaires sharpen the focus in medical examinations to ensure all information needed to rate the claim is gathered the first time in the medical examination process and is presented succinctly. The Fully Developed Claims program puts veterans in the driver's seat for submitting claims that are ready to rate when received.

It is estimated that in late 2012, production will begin to outpace receipts. At that same time, we plan to begin the deployment phase of VBMS. VBMS will provide powerful new tools to claims examiners to boost efficiency and productivity. Gains in accuracy through rules-based processing will reduce re-work and appeals. Rules-based processing and calculator tools also speed the rating process, which will increase employee productivity and provide more staff hours to rate other claims.

Question 2: Mr. Secretary, given the historic budget increases in the past 5 years and the important oversight and accountability role of the Inspector General (IG), what was the rationale for flat lining the budget request for the IG?

Response: The VA Inspector General (IG) has received a $20.6 million (23 percent) increase in 2012 compared to 2009. This is an average increase of 7.7 percent per year, which is comparable to the General Administration staff office 3-year average increase of 8.8 percent when excluding the President's government-wide acquisitions initiative. In addition, employment for the VA OIG has increased by 103 FTE over the 2009 level (20.2 percent).

Question 3: Mr. Secretary, can you please address reports that in several regional offices that all pending disability benefits claims have been put aside to work Agent Orange claims? We have also heard reports that medical appointments are being rescheduled so Agent Orange related disability rating exams can take place. Is this true and if so could you please explain the rationale considering that you have highlighted in your testimony the new on-line application and processing system for these claims?

Response: There are three categories of disability claims related to VA Secretary Shinseki's announcement of October 13, 2009, which added three new presumptive conditions to disabilities currently presumed service-connected based on exposure to herbicides in the Republic of Vietnam (ischemic heart disease, Parkinson's disease and Hairy Cell (B–Cell) leukemia), *Nehmer* readjudication claims, *Nehmer* adjudication claims, and new or non-*Nehmer* classified claims. *Nehmer* readjudication claims are under the court orders and final stipulation and order of the U.S. District Court for the Northern District of California (the "Court") in *Nehmer* v. *U.S. Department of Veterans Affairs,* 712 F. Supp. 1404, 1409 (N.D. Cal. 1989). As a result of the *Nehmer* litigation, VA must readjudicate previously denied claims for IHD, PD, or HCL filed by *Nehmer* class members (Vietnam Veterans and their survivors) and provide retroactive benefits pursuant to 38 C.F.R. § 3.816. This requirement involves claims filed or denied from September 25, 1985, to the date of Secretary Shinseki's announcement of October 13, 2009. Approximately 94,000 cases were identified as fitting this criteria, and approximately 50,000 new *Nehmer* claims have been received between the Secretary's announcement of his decision to add these three new presumptive diseases and the issuance of VA's final regulation adding those diseases to its list of conditions which qualify for presumptive service-connection based on exposure to herbicides used in Vietnam. Due to the complexity of readjudicating claims in this category, all *Nehmer* readjudication claims are currently being reviewed and readjudicated by VBA's 13 nationwide Resource Centers along with some employees at the St. Paul Regional Office.

Nehmer adjudication claims are those claims for the three new Agent Orange presumptive conditions that were received after Secretary Shinseki's announcement on October 13, 2009, and the date VA published the final regulation establishing a presumption of service-connection for the foregoing diseases on August 31, 2010. While these cases were not previously denied by VBA, because they were received prior to the publication of the final regulation, they qualify for adjudication under *Nehmer* provisions, as they were pending before VA issued the final rule adding the three new conditions. Approximately 50,000 cases were received during this time period. These *Nehmer* claims are being processed by the local regional office of jurisdiction. Special teams were established to process these claims expeditiously and as of March 22, 2011, less than 7,000 *Nehmer* adjudication claims remain pending.

Non-*Nehmer* or new claims are those claims for the three new Agent Orange presumptive conditions that have been received after the publication of the final regulation on August 31, 2010. All "Non-*Nehmer*" claims for the three new Agent Orange presumptive conditions are being processed by the local regional office of jurisdiction with a portion of those claims processed through the new Fast Track Claims Processing System. The Fast Track Claims Processing System has been operational since October 29, 2010, and accepts claims for the three Agent Orange presumptive conditions. Veterans may file claims for these conditions electronically into the system through the web-based portal, or traditionally by mail or fax to the Regional Office or the intake facility in Rocket Center, WV. Through the use of Disability Benefits Questionnaires, the system automatically generates recommended rating decisions to assist VA decision makers.

Although disability Benefits Questionnaires have been utilized in the Fast Track program for new claims for benefits, they were neither available nor prudent to use for the *Nehmer* readjudication and *Nehmer* adjudication claims. Therefore, many of those claims required VA medical examinations which were requested through the traditional examination process.

Question 4: Mr. Secretary, please discuss VA's current efforts to standardize the private medical questionnaires for disability benefits claims and how these forms will have an impact on the backlog? What is the timeline for the rollout of these questionnaires?

Response: VA is developing Disability Benefits Questionnaires (DBQs) to streamline the process by which veterans submit relevant medical evidence to VA. The targeted questions in the DBQs will improve the quality and timeliness of medical evidence necessary to support a veteran's claim for disability benefits, which will enable VA to adjudicate claims faster. Use of the streamlined medical questionnaires by private physicians, at the request of veterans, as well as by VA contractors and VHA physicians, will create an aggregate timeliness advantage for claims processing and thus help alleviate the claims backlog. It also offers the long-term potential for VBA to electronically pull the data directly into its systems to aid in the claims process.

VA developed the first three DBQs related to the new Agent Orange presumptive service-connected conditions of ischemic heart disease, Parkinson's disease, and hairy cell and B-cell leukemias. They were released to the public on October 6, 2010. VA is working on an additional 81 DBQs, in four stages of development. Fourteen DBQs were published in the Federal Register on February 15, 2011, for the initial 60-day public comment period. We estimate that they will be available for public use in September 2011. The remaining DBQs are in the process of development, review by Veterans Service Organization representatives and physicians, amendment, and formal public comment, with the plan for final publication of all DBQs by June 2012.

VA is putting feedback mechanisms in place to make future improvements to the DBQs. This iterative process will assist veterans and physicians in providing evidence that meets the requirements of the VA Schedule for Rating Disabilities, helping VA to increase consistency and timeliness of disability decisions.

Questions for the Record
The Honorable Bill Flores

Mr. Secretary, in the recent budget that you submitted for fiscal year 2012 I noticed that you are spending $124 million on "Greening the VA".

$27 million for solar photovoltaic projects
$51 million in energy infrastructure projects
$21 million in renewably fueled cogeneration using biomass
$1 million in sustainable building
$14 million for wind projects
$10 million for alternative fueling projects and expansion of environmental management system
TOTAL = $124 million

Question 1: Has the Veterans Administration done a cost-benefit analysis of "Greening the VA"? If the VA has not I would request one should be done immediately.

Response: VA performs cost-benefit and other analyses on all proposed projects. When assessing any energy or environmental project, VA's primary concern is whether the project will enhance the Department's ability to care for veterans. Criteria evaluated when assessing the feasibility of a project include the amount of savings to be realized from reduced maintenance and repair, utility bill savings, and simplified operations and maintenance. Other factors include the degree to which a project contributes to energy security and how it affects VA's ability to continue operations under a variety of adverse scenarios via on-site generation of electricity. In addition, VA also considers factors that are very important to veterans, but that are not easily quantified. These factors include indoor air quality, infection control, and improvements to patient comfort. Prospective projects are compared to other proposed projects and then ranked in order of how well they score in terms of getting the most benefit with the least investment.

The process of identifying, evaluating and selecting projects involves pre-screening, energy audits, feasibility studies, environmental assessments, and the calculation of return on investment and the use of other key statistics. This process enables VA to meet multiple goals, such as security and cost-control as well as to meet Congressional mandates.

Question 2: Also, I would like to know how long this initiative has been going on within your Department and how much funding it has received to date.

Response: VA has been striving to achieve compliance with environmental, energy, and transportation laws, regulations, and executive orders (EO) since 1970, when Congress enacted the National Environmental Policy Act. Additional environmental statutes, including the Resource Conservation and Recovery Act of 1976, the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and the Superfund Amendments and Reauthorization Act of 1986, have added to the base level of resources necessary for VA to operate our hospitals, cemeteries and other facilities in an environmentally responsible manner.

In recent years, VA has worked diligently to comply with energy legislation including the Energy Policy Acts of 1992 and 2005, and the Energy Independence and Security Act (EISA) of 2007. Revisions to EISA codified President George W. Bush's Executive Order 13423, Strengthening Federal Environmental, Energy, and Transportation Management (signed January 2007).

The following table summarizes VA's Green Management Program budget requests for FY 2006 through FY 2012.

Fiscal Year	Budget Request
2006	$25,000,000
2007	$25,000,000
2008	$24,587,000
2009	$27,600,000
2010	$151,683,000
2011	$272,396,000
2012	$144,564,000

The steep increase in FY 2010 resulted from integrating the previously separate budget for energy infrastructure improvement projects into the Greening VA program budget request for enhanced tracking of VA investment in energy efficiency and renewable energy.

Energy infrastructure improvements represent 35 percent of the FY 2012 Greening VA budget request, 40 percent of the FY 2011 budget, and 48 percent of the FY 2010 budget. Examples of projects thus funded include HVAC system upgrades at the Waco VA Medical Center (VAMC); steam and chilled water distribution system improvements at Big Spring VAMC; HVAC system upgrades at the Houston and San Antonio VAMCs; and boiler system improvements at the Kerrville VAMC.

As part of the Green Management Program, VA invested $115 million in fiscal years 2009 and 2010 for advanced metering and utility bill auditing, covering facilities nationwide. These systems help VA identify both problems (e.g., water leaks) and opportunities (e.g., qualifying for more favorable utility rates), resulting in better management of energy and water systems and utility cost savings. With metering and billing data and analysis at their fingertips, managers are able to target investments more precisely and gain maximum control of consumption and costs.

Question 3: At its current $124 million funding level, where does "Greening the VA" rank in the Department of Veterans Affairs funding priorities? Specifically, in respect to reducing the backlog of claims and providing more care for veterans.

Response: When developing its budget request, VA assesses all of its programs and allocates funds to a multiplicity of programs to address veterans' needs fully. While "Greening the VA" is important to the Department, the requested level of funding in FY 2011 is far below what VA has dedicated to improving compensation and pensions claims processing or increasing access to health care for veterans.

To reduce the claims backlog, VA requested an increase to its investment in the administration of Compensation and Pensions benefits by $369 million, or nearly 23 percent compared to FY 2010, to just under $2 billion in obligations. This increase, sustained in each Continuing Resolution enacted for FY 2011 to date, provides a 5 percent increase in the Compensation and Pensions workforce. Part of the increase supports an approximately $75 million contract for external claims processing support. $43 million for Veterans Benefits Management System (VBMS) business process re-engineering and training will also contribute to the near term reduction of the backlog. These VBA investments are matched with Information Technology account allocations of $148 million to be invested in the Veterans Benefits Manage-

ment System and another $70 million to be invested in the Virtual Lifetime Electronic Record initiative.

VA is also making improvements to health care access through an investment of $939 million to reduce veteran homelessness, up 15 percent from FY 2010. Inpatient, outpatient, and residential mental health programs are receiving an investment of $6.2 billion, up $459 million, over 7 percent over FY 2010. Another $6.9 billion will be invested in long term care improvements, up $597 million or nearly 9 percent from FY 2010, of which $146 million will be invested in telehome health care to facilitate near instant access to care. Women veterans programs will receive $270 million, an increase of 10 percent.

Conversely the $144 million for Greening VA projects is less than 0.1 percent of the Department's total FY 2012 budget request. Greening VA is a "supporting initiative" cited in the Department's FY 2011–2015 Strategic Plan. It supports Integrated Initiative 3—"Build our internal capacity to serve veterans, their families, and other stakeholders efficiently and effectively."

Funding Greening VA directly impacts the quality of care provided to veterans by improving the infrastructure of facilities where services are provided. Providing veterans with optimum services requires regular maintenance and periodic upgrades of our infrastructure to ensure efficient and effective operations of basic amenities such as the provision of hot water and air-conditioning. Ensuring sterile environments where needed and preventing infection requires reliable, secure electricity, clean water, and indoor air quality that meets or exceeds health care standards.

Investments designed to improve energy and water efficiency have an impact on operating costs immediately upon project completion. These investments make a long-term, ongoing, and compounding contribution toward reducing and managing utility services costs. These efforts make VA a more sustainable Department, thereby helping us to reduce and better manage operating costs and protect the resources that enable VA to better serve veterans.

Question 4: Could the $124 million dollars for "Greening the VA" help with the current back log problem the VA currently faces or help veterans gain more access to care?

The job of the Veterans Administration is to serve veterans who have sacrificed their lives for our freedom.

I believe the proposed budget is growing bureaucracy and picking and choosing initiatives that do not may not have giving veterans more access to their health care as their primary purpose as well as solving problems that the VA currently faces.

"Greening" initiatives and growing the bureaucracy at the Veterans Administration should not come at the cost of those who were called upon to serve in the interest of protecting the country we love and the freedom we cherish.

Response: While additional resources for either reducing the claims back log or improving access to health care could always be applied with some benefit, our currently proposed investments in FY 2012 already optimize the return on investment in both those areas. The marginal improvement we might see in either area is more than offset by the valued added by the "Greening the VA" investment of $124 million—less than one tenth of 1 percent of total proposed VA obligations in 2012.

Committee on Veterans' Affairs
Washington, DC.
March 7, 2011

The Honorable Eric K. Shinseki
The Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled "U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012," that took place on February 17, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 11, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore,

it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

DMT:ds

Questions for the Record
The Honorable Bob Filner
House Committee on Veterans' Affairs
"U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012"
February 17, 2011

Contingency Fund

Your Enrollee Health Care Projection estimated the need for an additional $953 million to address potential demand increases due to economic conditions. The VA budget submission states that the "fund will only become available for obligation if the Administration determines the anticipated changes in economic conditions, as estimated by the Model, materialize in 2012."

Question 1: Specifically, what economic changes would have to occur to trigger a determination to obligate these funds?

Response: Section 226 of the Administrative Provisions state that ". . . such funds shall only be available upon a determination by the Secretary of Veterans Affairs, with the concurrence of the Director of the Office of Management and Budget, that:

a. The most recent data available for:

1. National unemployment rates,
2. Enrollees' utilization rates, and
3. Obligations for Medical Services,

validates the economic conditions projected in the Enrollee Health Care Projection Model, and

b. Additional funding is required to offset the impact of such factors."

Question 2: What economic data was placed in the Model and how exactly does the Model come to a decision?

Response: Estimates of unemployment rates and how they are expected to influence Veterans reliance on VA for care were included in the Model.

Question 3: How confident are you that your Model can accurately engage in economic forecasting?

Response: The Model does not engage in economic forecasting. The Model uses Government estimated unemployment rates to estimate the impact they will have on Veterans reliance on VA for health care.

Question 4: If the Administration determines that the "economic conditions" do not take place what will the VA do with this funding?

Response: In this case, the funds would expire and be returned to the Treasury.

Your budget estimates a FY 2012 current services level for medical care of $54.5 billion. This current services level is funded by total budget authority of $53.9 billion, and the addition of $570 million in savings. The contingency fund is included as part of the total budgetary resources available for 2012.

Question 5: It looks like the "contingency fund" is already required to meet your current services estimate for 2012. Why didn't you just add this amount to your bottom line request for the Medical Services account?

Response: The contingency fund is included in the bottom line request for the Medical Services account. The $953 million contingency fund, estimated in VA's En-

rollee Health Care Projection Model, was created to address the potential demand increase for medical care services due to changes in economic conditions. The fund will only become available for obligation if the Administration determines the anticipated changes in economic conditions, as estimated by the Model, materialize in 2012. The current services level for medical care of $54.5 billion includes the contingency fund of $953 million.

Carryover Funding

Prior to the advent of advance appropriations for VA medical care, appropriations bills routinely provided authority for a small amount of the appropriation provided in one fiscal year to be expended in during the course of the next fiscal year. This authority was provided as a budgeting tool enabling the VA to better weather disruptions that might be caused by the necessity to rely upon temporary funding bills. The last time this authority was provided was for amounts appropriated for FY 2010, with the expectation that these amounts would be expended in FY 2010 and FY 2011. You state in your testimony that you require carry-over authority from FY 2011 in order to provide a sufficient budget for FY 2012 and FY 2013 and that the failure to provide this authority will necessitate an increase in appropriations for 2012 and 2013.

Question 1: Can you provide us with the specifics as to the amounts and the rationale behind projecting unobligated balances at the end of this fiscal year?

Response: At the end of FY 2010, we had an unobligated balance of $1.449B ($1.208B in Medical Services, $132M in Medical Support and Compliance, and $109M in Medical Facilities). These amounts were related to numerous factors such as: equipment purchases planned for FY 2010 but were executed in FY 2011, non-recurring maintenance projects planned for FY 2010 that had to be moved to FY 2011, contracts that were not awarded in FY 2010 as planned but were awarded in FY 2011, and full year hiring actions planned for FY 2010 that did not occur as planned. The estimated unobligated balances at the end of FY 2011 are $1.1B ($1.0B in Medical Services, and $100M in Medical Facilities). These estimated amounts reflect anticipation of similar factors described for FY 2010 and are consistent with the actual carry-over balances from prior years.

Question 2: Of the $1 billion in carryover authority provided in the Medical Services account in the FY 2010 appropriations act, how much has been obligated as of February 1, 2011?

Response: As of January 31, 2011, $719.6M had been obligated. As of February 28, 2011, $731.5M had been obligated.

Question 3: [If there is any remaining] Of the amount remaining do you anticipate obligating this amount by September 30, 2011?

Response: Yes.

Question 4: Do you still plan on having unobligated balances that could be carried over in FY 2013 in light of the reduction in your estimates as to collections of $473 million?

Response: The President's Budget estimates that $500M will be carried over at the end of FY 2012 into FY 2013 and that zero would be carried over at the end of FY 2013.

Collections

Your estimates as to collections have been substantially reduced, leaving a shortfall in expected revenues for 2011 and 2012. For FY 2011 you had estimated $3.4 billion but your current estimate is for $2.9 billion. For 2012, you had estimated $3.7 billion but now expect $3 billion.

Question 1: Can you explain to us what has caused this decrease in your collection levels and estimates and how are you going to fill the budgetary holes these lower amounts have created?

Response: There are a number of factors that have caused the decrease in collection levels for FY 2011 and estimates for FY 2012. These factors include, but are not limited to, the following:

Poor economic conditions—Growth in national unemployment (from 7.7 percent in the First Quarter of FY 2009 to 9.8 percent at the end of the First Quarter of FY 2011) will continue to impact both first party collections (Veteran out-of-pocket costs) and third party collections (unemployment and resultant loss of health insurance coverage).

Hardship waivers and exemptions from copayments are increasing—Veteran first party copayment economic hardship waivers and exemptions were at their highest levels in FY 2010 (the most recent completed year) than in any prior year, and this is expected to continue with the current economic conditions.

Third party "Collections to Billings" (CtB) ratios are down nationally—CtB ratios are expected to continue a downward trend, reducing third party collections. CtB decreased from 43.1 percent in January 2009 to 39.1 percent in January 2011, and was influenced by the continued shift by insurers of payment responsibility to the patient (i.e., higher deductibles, increased copayments, etc.). Section 1729 of title 38 prevents VA from billing the Veteran if the insurance company does not pay. Each 1 percent decrease in CtB represents a $55 million loss in revenue.

Priority Group migration from lower to higher status—National Priority Group migration over the past 2 years has shown a sharp decrease in collections for Veterans in Priority Group 8, which are the primary drivers of both first and third party collections.

Veterans aging to 65 years and older—FY 2012 begins to reflect the shift in workload for Vietnam Era Veterans aging to 65 years and older. Once a Veteran is Medicare-eligible, Medicare becomes the primary insurance coverage and VA can bill insurance companies only for the portions Medicare does not cover (typically their deductibles). This significantly reduces the amount VA can collect.

The decrease in the collections estimate for FY 2011 of $473 million is offset by a lower overall requirement (–$140 million) and increased utilization of carryover funds for FY 2010 (+$349 million). The lower overall requirement takes into consideration operational improvements in FY 2011. The decrease in the collections estimate for FY 2012 of $601 million is offset by increases in the Reimbursement and Prior Year Recoveries estimate (+$1 million) and utilization of carryover funds (+$600 million). The revised FY 2012 estimate includes an offset of $713 million for the pay freeze rescission.

Dollars in Thousands

Description	2011 Estimate			2012 Estimate*		
	2011 Pres. Subm.	2012 Pres. Subm.	Increase/ Decrease	2011 Pres. Subm.	2012 Pres. Subm.	Increase/ Decrease
Total Obligations	$51,865,000	$51,724,974	($140,026)	$54,631,985	$54,871,985	$240,000
Funding Sources:						
Appropriation (Including Transfers)	$48,183,000	$48,168,000	($15,000)	$50,610,985	$50,850,985	$240,000
Collections	$3,355,000	$2,882,000	($473,000)	$3,679,000	$3,078,000	($601,000)
Reimbursements & PY Recoveries	$327,000	$326,000	($1,000)	$342,000	$343,000	$1,000
Use of Carryover Funds	$0	$348,974	$348,974	$0	$600,000	$600,000
Total	$51,865,000	$51,724,974	($140,026)	$54,631,985	$54,871,985	$240,000

*In 2012, $953 million will be obligated if the Administration determines the requirements for the contingency fund are met.

Operational Improvements

Question 1: VA is proposing $1.5 billion in new initiatives for FY 2012 that will be partly paid for by $1.2 billion in operational improvements started in 2011. Some of these initiatives are very vague such as, "expanding health care access to veterans which aims at creating care alternatives, including implementation of Systems Redesign and using new technologies." Can you explain to the Committee what that means?

Response: Access to health care is vital to the Department's overall mission of providing exceptional health care to Veterans. VA is the largest integrated provider of health care in the country, with over 5.4 million Veterans each year receiving care at over 1,100 locations, including inpatient hospitals, health care centers, residential facilities, community based outpatient clinics (CBOCs), and in their homes. It is VA's commitment to provide clinically-appropriate, quality care for eligible Veterans when they want and need it. This will be accomplished through Systems Redesign which involves multiple strategies addressing transportation, use of advancements in medical technology, workforce challenges, and partnerships in rural communities. It is the intent to develop a culture nationally within VA which pursues continuous improvement so that staff is empowered to solve problems at the front line or at whatever point the Veteran accesses the health care system.

A few years ago, it was felt that the VA was using ever-increasing estimates of savings resulting from "management efficiencies" in order to, on paper, cover the increasing gulf between appropriated dollars and the actual fiscal requirements of providing health care to veterans.

Question 2: Can you provide real details regarding these "operational improvements"?

Response: To improve VA health care operations and improve the value of services provided to the Veterans and their families as well as recognizing the Federal deficit challenge this Nation faces, VA has proposed a number of management actions. Many of these proposals will improve VA's medical services delivery over the long-term.

Fee Care Payments Consistent with Medicare

- **(–$315 million in 2012)**
- **(–$362 million in 2013)**

Dialysis Regulation Savings and other care services are the estimated cost savings from purchasing dialysis treatments and other care from civilian providers at the Centers for Medicare and Medicaid Services rates instead of current community rates.

Fee Care Savings

- **(–$200 million in 2012)**
- **(–$200 million in 2013)**

Fee care savings will be generated through application of the following initiatives: use of electronic repricing tools, use of contract and blanket ordering agreements, decrease contract hospital average daily census, decrease duplicate payments, decrease interest penalty payments, and increase revenue generation through the use of automated tools.

Clinical Staff and Resource Realignment

- **(–$151 million in 2012)**
- **(–$151 million in 2013)**

Conversion of selected physicians to non-physician providers; conversion of selected registered nurses to licensed practical nurses; and to more appropriately align the required clinical skills with patient care needs.

Medical & Administrative Support Savings

- **(–$150 million in 2012)**
- **(–$150 million in 2013)**

These savings will be achieved by more efficiently employing resources to reduce administrative and support costs across VA's medical facilities. The intent is to invest these savings in direct patient care and thereby enable VA to provide health care services to Veterans more effectively and efficiently.

Acquisition Improvements

- **(–$355 million in 2012)**
- **(–$355 million in 2013)**

VA has eight ongoing initiatives. A brief description of each is as follows:

- Consolidated Contracting—This initiative consists of multi-facility, VISN, and Regional Contracts. It also involves contracts being administered at the VHA Health Administration Center (HAC). Contract savings result from combining requirements and obtaining lower unit pricing.
- Increasing Competition—This initiative relates to competing contracts that were formerly awarded on a sole source basis. The majority of the savings in this category come from competing requirements among Service-Disabled Veteran-Owned Small Business firms.
- Bring Back Contracting In House—Under this initiative, VHA is bringing contracting workload back into VHA contracting offices from the Army Corps of Engineers. By bringing the workload back, VHA avoids paying the Corps of Engineers administrative charges.
- Reverse Auction Utilities—Several VHA facilities are participating in a program administered by GSA, whereby utilities are procured using reverse auctions. This has produced savings in utility pricing.

- MED PDB/EZ Save—Through a consolidated effort with DoD, VHA has been able to obtain visibility of the most favorable government pricing overall. This has allowed VHA to procure needed supplies at the identified lower price.
- Reduce Contracts—This effort involves canceling/avoiding contracts by performing the required services in house.
- Property Re-utilization—This initiative brings back the practice of considering "excess as the first source of supply." VHA has been able to avoid procurement of new equipment by reutilizing excess equipment.
- Prime Vendor—VHA has been able to use the med/surg prime vendor to achieve additional price concessions. Additionally, the prime vendor provides improved inventory management thereby eliminating the procurement of unneeded supplies.

VA Real Property Cost Savings and Innovation Plan

- **(–$66 million in 2012)**
- **(–$66 million in 2013)**

VA Real Property Cost Savings and Innovation Plan includes the following initiatives for VHA: Repurpose Vacant and Underutilized Assets—VA has identified 17 vacant or underutilized buildings to repurpose for homeless housing and other enhanced-use lease (EUL) initiatives. Demolition and Mothballing—VA has identified 116 vacant or underutilized buildings to demolish or mothball which will reduce operating costs after the cost of demolition. Energy and Sustainability—VA will achieve these savings by regionally pooling energy commodity purchasing contracts, aggressively pursuing energy and water conservation, and investing in the co-generation of electric and thermal energy on-site. Procurement Savings—VA will achieve savings by engaging in the direct purchase of building supplies and equipment, and regionalizing certain building service contracts.

In your budget proposal, for example, you portray the operational improvement amounts as the same for both 2012 and 2013, for acquisition improvements. This is projected to save VA $355 million in 2012 and $355 million in 2013.

Question 3: Does this mean that over the course of 2 years that VA will save over $700 million in real dollars by implementing those improvements?

Response: Yes, as reflected in the budget, VA estimates acquisition improvements to save $355 million in FY 2012 and $355 million in FY 2013.

Question 4: Can you provide us with the estimated overall savings that each improvement is expected to save regardless of fiscal year?

Response: As reflected in the budget, VA estimates the operational improvements to provide overall savings of $746 million in FY 2011, $1.237 million in FY 2012, and $1.284 million in 2013.

Dollars in Millions

Description	2011 Current Estimate	2012 Estimate	2013 Estimate
Fee Care Payments Consistent with Medicare	($275)	($315)	($362)
Fee Care Savings	($150)	($200)	($200)
Clinical Staffing and Resources Alignment	($44)	($151)	($151)
Medical & Administrative Support	($100)	($150)	($150)
Acquisition Improvements	($177)	($355)	($355)
VA Real Property Cost Savings & Innovation Plan	$0	($66)	($66)
Total	($746)	($1,237)	($1,284)

Health Informatics

In transforming the VA into a 21st Century organization, your testimony states the "Our health informatics initiative is a foundational component for VA's transition from a medical model to a patient-centered model of care. The delivery of health care will be better tailored to the individual veteran."

Question 1: Can you explain in detail what health informatics initiatives you reference here?

Response: *VA Major Initiative: Transforming Health Care Delivery through Health Informatics.*

Transforming Health Care Delivery through Health Informatics (Health Informatics) is a new VA Major Initiative (Initiative) that was formally launched on October 1, 2010. The purpose of the Initiative is two-fold: To assist with VHA's transition from a medical model of care to a patient-centered model of care; and, to build a sustainable and effective collaboration between the Veterans Health Administration (VHA) and the VA Office of Information and Technology (OIT).

The Initiative is the vehicle for promoting and fostering open, transparent communication between health care providers and software development teams through shared responsibility and accountability. The Health Informatics Initiative is composed of three major projects:

A. **Adopt a Health/IT Collaborative** supporting rapid product development and delivery. This effort restructures the working relationship between VHA and OIT and provides an organizational foundation for reengineering existing processes and piloting VHA clinical software prototypes in a rapid, agile and iterative fashion.
B. **Build a Health Management Platform** to transform patient care. This effort integrates informatics and health information technology (IT) in the delivery of health care. It provides a succession plan to transition the Computerized Patient Record System (CPRS) to the next generation of browser-based Electronic Health Record (EHR).
C. **Create Health Informatics Capacities.** This effort develops the Health Informatics workforce and enhances organizational informatics literacy through competency, career and community development.

Capital Infrastructure

The VA has recently rolled out the Strategic Capital Investment Planning (SCIP) process to help strategically plan their infrastructure needs for the next 10 years. I understand that this process is one that encompasses all three administration's needs.

Question 1: Can you please explain the difference between SCIP and the Capital Asset Realignment for Enhanced Services (CARES) process?

Response:

- The CARES process was focused chiefly on the realignment of clinical services to provide for the delivery of health care.
- SCIP is not a replacement for CARES, rather it is an enhancement which builds off of the important lessons learned through the CARES process.
- CARES and SCIP both identify performance gaps (utilization, access, space, facility condition) and lead to the development of long term capital plans to meet the gaps.
- SCIP is more flexible in its approach as it places emphasis on looking at non-capital solutions (longer hours of operation) as well as infrastructure improvements to meet identified gaps.
- SCIP looked at disposing or repurposing of individual underutilized buildings (not entire campuses as in CARES).
- CARES did not produce a comprehensive, integrated list of capital investments that identified the highest priority medical and non-medical capital needs within VA.

SCIP ultimately resulted in a 10-year capital plan for all programs (Major, Minor, NRM, and leases) which includes specific investments necessary to close all "gaps" currently identified by VA Administrations, Regions and facilities.

Veterans Benefits

Question 1: With the very recent reorganization implementation of the Veterans Benefits Administration is there adequate allocation of Full Time Equivalent (FTEs) or are additional FTEs going to be needed? Please elaborate on what you believe the numbers might be.

Response: The reorganization is being accomplished within existing resource levels. The change in VBA Headquarters structure does not result in any change to the VBA field structure, nor is there any direct impact on VBA's FY 2012 budget request.

The Veterans Benefits Management System (VBMS) is the cornerstone of VA's plans to address disability claims processing in a paperless manner.

Question 2: Would you briefly tell us about this system and how has it impacted the claims process to date?

Response: The VBMS is a business transformation initiative designed to assist VA in eliminating the claims backlog. The centerpiece of VBMS is a paperless system, which will be complemented by improved business processes and workflows.

VBMS will dramatically reduce the amount of paper in the current claims process, and will employ rules-based claims development and decision recommendations where possible. Additionally, by using a services-oriented architecture (SOA) and commercial off-the-shelf (COTS) products, VA will be positioned to take advantage of future advances in technology developed in the marketplace to respond to the changing needs of Veterans over time.

The first iteration of the software is currently being tested at the Providence Regional Office (RO). Claims processors at the Providence RO are using the new software to validate and harden the business requirements, as well as to generate new business requirements for future software releases. They are utilizing a new graphical user interface, electronic claims repository, and scanning solution, which are integrated with existing core business applications (VETSNET) that support claims processing.

Additional development and testing will continue throughout calendar year 2011 and into 2012 at additional sites. Full national deployment is scheduled to begin in calendar year 2012.

In their written statement, the Disabled American Veterans (DAV) admits that a modern information technology system to process claims in a paperless environment is long overdue, but they have reservations about whether the Veterans Benefits Management System (VBMS), VA's answer to paperless claims processing, is being rushed to meet "self-imposed" deadlines in order to show progress toward the backlog.

Question 3: Can you address these reservations?

Response: The project schedule for the VBMS initiative, while aggressive, ensures a strategic approach to enhancing claims processing. The initiative has a deliberate schedule with specific goals along the timeline. For instance, the software is being developed, deployed, and tested in a phased approach that began with the Virtual Regional Office and continues today with testing of the first iteration of production software at the Providence Regional Office.

VA ensures an appropriate level of transparency and accountability for the VBMS initiative through the Operational Management Review (OMR) process. The OMR is a collaborative process where VA senior leaders come together on a regular basis in a structured forum to problem solve, achieve closure on any major initiative issues, and provide insights and transparency for all of the Department's major initiatives.

As part of the OMR process, the VBMS initiative leader and executive sponsor meet with the VA Deputy Secretary on a monthly basis to discuss performance, schedule, and cost. Key challenges and mitigations are discussed, as well as lessons learned and best practices that may be useful to other initiatives. Any challenges or refinements needed to the schedule are discussed and resolved through the OMR.

As you know, stakeholders are a very important part of a change process. DAV mentions in their testimony their frustration with the VBA's failure to fully integrate service organizations in reforming the claims process and the development of the draft regulations for the updated rating schedule.

Question 4: How do you respond to that?

Response: VA held four medical and scientific forums on updating the rating schedule in January and February of this year. The Veterans Service Organizations (VSOs) were given the opportunity to provide formal presentations in 2-hour sessions at each of the forums. In addition, the VSOs participated in the working group panel sessions and offered numerous and significant contributions during each body system review. Our plan is to follow this process in all future forums.

The Independent Budget veterans service organizations have expressed concern with the oversight by the Veterans Benefits Administration to ensure the required training is completed or to assess the adequacy and consistency of the training.

Question 5: Would you address the annual training requirement that has only been met by one VA Regional office and an additional nine VA regional offices that had less than half of their employees meet the 80 hours of training requirement?

Response: Improved monitoring procedures and emphasis on training by leadership increased the number of claims processors that completed the annual training requirement from 68 percent in FY 2009 to 81 percent in FY 2010. This 13 percent improvement is on top of absorbing nearly 1,900 new Compensation and Pensions employees in FY 2010, many of whom were not available for training for a full year.

Question 6: How many veterans have used the Fully Developed Claims initiative?

Response: Since the pilot started in June 2010, 5,193 claims have been completed through the Fully Developed Claims program as of March 9, 2011.

The expansion to the Integrated Disability Evaluation System (IDES) Program that will include a component on Vocational Rehabilitation and Employment (VR&E) services for those active duty Servicemembers transitioning through the IDES will require an additional 110 FTE to support. The budget has requested $16.2 million to cover this increase.

Question 7: Given the big plan to expand IDES to all Military Treatment Facilities (MTFs) by the end of FY 2011, do you believe the additional 110 FTE is enough to meet the demand?

Response: In collaboration with DoD, VA will assign the 110 Rehabilitation Counselors at some, but not all, of the IDES locations. During this expansion of the VR&E IDES initiative, VA will collect data regarding workload, services provided, and outcomes to be considered in future expansion efforts.

Office of Inspector General

The President's 2011 and 2012 Budget Requests reflected significant increases for VA offices in the General Administration (GOE) account. The increases ranged from 3 to 57 percent and averaged 17 and 13 percent, respectively. Additionally, all of these offices received substantial increases going from 2009 to 2010. The Administration places great emphasis on the need for increased accountability, transparency, internal controls, and minimizing improper payments.

Question 1: In view of the expansion of benefit programs and the expanded budget authority for most VA offices, could you tell us why the VA Office of Inspector General funding has not also increased in a similar fashion since 2010?

Response: The VA OIG has received a $20.6 million, or 23 percent, increase in 2012 compared to 2009. This is an average increase of 7.7 percent per year, which is comparable to the General Administration staff office 3-year average of 8.8 percent when excluding funding for the President's government-wide acquisitions initiative. In addition, the VA OIG FTE has increased by 103 over the 2009 level (20.2 percent).

Committee on Veterans' Affairs
Washington, DC.
March 7, 2011

Carl Blake
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Dear Members of the Independent Budget:

In reference to our Full Committee hearing entitled "U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012," that took place on February 17, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 11, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

DMT:ds

Independent Budget
Washington, DC.
April 7, 2011

Honorable Bob Filner
Ranking Minority Members
House Committee on Veterans' Affairs
338 Cannon House Office Building
Washington, D.C. 20515

Dear Ranking Member Filner:

On behalf of *The Independent Budget,* we would like to thank you for the opportunity to present our views on the FY 2012 budget for the Department of Veterans' Affairs (VA). We are pleased to see that the Committee has chosen to provide Views and Estimates in a bipartisan manner this year; however, we believe that much work remains to ensure that the VA receives a sufficient budget for FY 2012 and FY 2013. Only through cooperation between the veterans' service organizations and the Members of the Committee can we hope to attain a sufficient, timely, and predictable budget for the VA.

We have included with our letter a response to each of the questions that you presented following the hearing on February 17, 2011. Thank you very much.

Sincerely,

Christina M. Roof
National Deputy Legislative Director
AMVETS

Joseph A. Violante
National Legislative Director
Disabled American Veterans

Carl Blake
National Legislative Director
Paralyzed Veterans of America

Raymond C. Kelley
National Legislative Director
Veterans of Foreign Wars of the United States

VA is proposing $1.5 billion in new initiatives for FY 2012 that will be partly paid for by $1.2 billion in operational improvements started in 2011. Some of these initiatives are very vague and the "operational improvements" are not actual realized savings, yet. An example of very vague language in the operational improvements category is contained in the Medical and Administrative Support savings narrative, "indirect cost savings will be produced by more efficiently employing the resources in various medical care, administrative, and support activities at each medical center and in VISN and central office operations." VA says they will save $150 million dollars by implementing this. In light of the fact that many of VA's budgets in the past were based on failed "management efficiencies" savings:

Question 1: In your experience, what is the impact of "operational improvements" to the veteran trying to gain access or get an appointment at a local VA medical center?

Answer: Gauging the real impact of "operational improvements" can be particularly difficult. In theory, steps taken to make the delivery of health care more efficient would seemingly benefit veterans seeking care. However, the impact upon veterans is usually a secondary consequence of the inability of the VA to actually properly and effectively implement operational improvements.

Generally, the Administration recommends "operational improvements" in order to realize some savings in real dollars. Unfortunately, as has been the case with previous Administrations that have proposed similar gimmicks, the VA typically does not actually achieve those savings. As a result, the proposed VA budget would then be short of the funding needed to effectively deliver timely, quality health care. The immediate impact on veterans is then a rationing of care. Veterans will find it harder to make appointments in a timely manner and in some cases the VA will be forced to reduce the services it delivers. In a worst case scenario, the VA could be forced to take steps similar to those taken in 2003 when the VA chose to close enrollment into the health care system for Priority Group 8 veterans—steps that have still not been fully overturned.

Question 2: Would you care to comment on the feasibility of VA actually realizing $1.2 billion dollars in "operational improvements?"

Answer: In order to appropriately address the question, each of the individual "operational improvements" proposed by the VA must be looked at separately. These proposals include Fee Care Payments Consistent with Medicare ($315 million in 2012); Fee Care Savings ($200 million in 2012); Clinical Staff and Resource Realignment ($151 million in 2012); Medical and Administrative Support Savings ($150 million in 2012); and Acquisition Improvements ($355 million in 2012).

First, the VA proposes to realize cost savings by reimbursing contract providers of dialysis and other care services at the Medicare reimbursement rate. This proposal intends to replace current unpredictable and financially vulnerable fee-basis

reimbursement rates with Medicare reimbursement rates for ambulatory surgical center care, anesthesia, clinical laboratory, hospital outpatient perspective payment systems, and end stage renal disease. While this may be a fair assumption on the surface, the VA ignores the likelihood that this will not actually happen. The fact is that contract providers who would be affected by this change are adamantly opposed to this proposal, which could undermine the VA's ability to actually make this change. As a result, veterans will almost certainly be negatively impacted by this proposal as some providers will likely refuse to accept new veteran patients because they will not accept the Medicare reimbursement rate.

Additionally, while existing contracts will not be affected now, they will be up for review in the future and VA may opt out of renewing existing contracts and use Medicare reimbursement rates. Our concern with this proposal is that it will reduce veteran patients access to care in the community where providers are not accepting Medicare patients in greater numbers. Specifically, current non-VA providers may be subjected to significant rate reductions. To remain viable, these providers may need to make changes to their patient case mix which could be detrimental to veteran patients if the applicable reimbursement rates are non-competitive.

Questions have also been raised over VA's ability to administratively implement and adjust to Medicare's soon to be released "bundled payment system," which in and of itself is complex in application by the Centers for Medicare and Medicaid as well as to multiple providers across many settings. It is noteworthy however, that there are significant savings to CMS under this new payment system and there is incentive for community providers to coordinate care in a more cost-effective manner would serve to address the veteran communities long-standing concern over quality standards, care coordination and health information sharing in VA's fee-based care.

We also understand that VA has submitted requests through the Office of Information and Technology procurement process for a complete systems modernization to provide automation support for this critical business process. The Veterans Health Administration (VHA) is also in the process of deploying the Fee Basis Claims Systems as an interim technical support solution. Likewise, VHA is also developing a pilot program for one Veterans Integrated Service Network (VISN) to partner with the Financial Services Center (FSC) for processing of all non-VA Fee claims. Finally, VHA will continue to assess alternatives for improving administration of the Fee program to include opportunities for consolidation of the claims processing function.

The Independent Budget is aware that some temporary stand-alone information technology systems have been put in place, but they lack the functionality for centralized reporting, recording, and decision support systems. Clearly, what VA leadership expects of IT today to manage this program for decision-making, policy change, etc., is not being provided by the interim solution. In light of the need for significant changes to be made to the overall infrastructure, the short-term "band-aid" approach may be adequate, but it is not in the best interest of veteran patients or VA to provide timely access to quality health-care services.

VA currently has three pilot projects to select one automated claims system for its Fee Program. We are pleased that the VHA has initiated these efforts in moving toward fee claims automation but are concerned about the process being used to establish these pilots and how VA will determine the approach and software that will be implemented nationwide. There appears to be no coordinated effort with a single point of accountability or an approved plan for how to evaluate these pilots' performance in order to ensure VA makes the best decision on how to automate the fee claims. There is not a publicly available plan defining specific VHA objectives and the metrics that will be used to evaluate each pilot.

The IBVSOs would have preferred that before any pilot program or other project was initiated, a project plan with defined milestones and desired results, performance metrics, and evaluation methodology would have been established, analyzed, and approved—as is now required under VA's Performance Management and Accountability System (PMAS) to strengthen our IT oversight and performance. It appears that each pilot program is being implemented separately, without a single point of Office of Information Technology and program oversight or management of the objectives, costs, schedule, and performance, and without a consistent evaluation framework that holds each pilot accountable for achieving comparable results.

We also believe that savings from Clinical Staff and Resource Realignment could be problematic. As explained by the American Federation of Government Employees in testimony before the Senate Committee on Veterans' Affairs on March 2, 2011, it remains unclear "whether these proposed conversions to lower skilled positions will result in a more efficient use of scarce VA medical dollars, or a harmful de-skilling of the care provided to veterans." Unfortunately, similar efforts to achieve these types of savings in the past have merely led to reduced access and quality

of care. Likewise, as the VA transitions to the Patient Aligned Care Team (PACT) delivery model, we are concerned that this effort has already been hindered by short staffing and poor coordination, which leads us to question how the VA will realize cost savings from a proposed staff realignment in light of these difficulties.

Additionally, *The Independent Budget* believes that estimated savings from the Medical and Administrative Support Savings are dubious at best. In the FY 2012 Budget Request, the Administration proposes to save money by "more efficiently employing the resources in various administrative, medical, and support activities" at all levels. And yet, the VA outlines no real plan as to how it will "efficiently employ" these resources. Previous Administrations also proposed "management efficiencies" that would presumably save the VA money in much the same manner. However, the VA never seemed to achieve those so-called efficiencies, arguably leaving the VA budget short each year.

Question 3: VA's budget request contains a $1.1 billion carryover from the previous Fiscal Year. I would like to ask this panel if they have heard from the field, anecdotally, concerns with hiring freezes, programs that were not adequately funded, or any other type of services shortages that were attributed to a "funding shortfall" by the VA medical centers or VISNs.

Answer: First, we would like to express our serious concern with the fact that the VA has identified such a significant amount of money that it apparently has not spent from the previous fiscal year. Given the growing pressure of demand from new veterans entering the VA health care system as well as the continued emphasis by Congress and other stakeholders to improve mental health services, women veterans' services, and rural health care delivery, it is incomprehensible to *The Independent Budget* co-authors that the VA would have appropriated dollars still available.

We have in fact been hearing from staff in the field who report that VA medical facilities have placed freezes on hiring new staff. Similarly, we have received reports that facilities are instituting staffing caps when there is an obvious need for professional staff. For example, there continues to be a shortage of nurse staffing across the VA system, particularly in specialized services such as the spinal cord injury service. By establishing staffing caps, VA facilities are not filling staff positions that become open as a result of retirements and staff departures. We even received information from a particular facility where the medical center director outlined a plan that would replace two similar open positions with one full-time equivalent employee. For example, if two registered nurses (RN) working in a particular hospital unit leave the VA, that facility will only hire one new RN to handle the responsibilities of those two positions.

We have also been told by nurses in various medical centers that the VA is not fulfilling promises made during their recruitment and retention negotiations. Specifically, we have heard complaints about the VA offering education program reimbursements through the Education Debt Reduction Program (EDRP) and then not providing these recruitment and retention incentives to nurses once they have been locked into their positions.

Committee on Veterans' Affairs
Washington, DC.
March 7, 2011

Tim Tetz
Director, National Legislative Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Tim:

In reference to our Full Committee hearing entitled "U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012," that took place on February 17, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 11, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

DMT:ds

American Legion
Washington, DC.
April 11, 2011

Honorable Bob Filner, Ranking Member
U.S. House of Representatives
Veterans' Affairs Committee
333 Cannon Office Building
Washington, DC 20515

Ranking Member Filner:

This letter is in response to your post-hearing questions from the February 17th hearing that The American Legion testified at regarding U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012.

- ***In your experience, what is the impact of "operational improvements" to the veteran trying to gain access or get an appointment at a local VA medical center?***
  - Operational improvements can be difficult to properly define, so it is difficult to state definitively if such "operational improvements" bring direct benefit to the veteran, although often it would seem that this is contrary to the case. VA, to their credit, has made strides over the past few years in reducing wait times for appointments; however, greater problems have potentially appeared on the horizon. As discussed later, reports have surfaced noting that perhaps VA facilities are not able to fill their allotted number of beds, which could mean that veterans are not receiving full access to care as intended.

    It is important to recognize, however, that there is not a direct correlation between spending and service to the veteran. Despite record budget increases for veterans, massive hiring increases, and the throwing of every available Congressional resource at VBA for the purposes of reducing the backlog of veterans' claims, the backlog is paradoxically increasing. Secretary Shinseki has stated an ambitious goal of ensuring that no claim is pending over 125 days, while increasing VA's accuracy rate to 98 percent. Over the past year, VA failed in both of those categories, seeing even their own generous, internal accuracy numbers drop from 86 percent accuracy to below 84 percent while the number of claims pending over 125 days rose from under 180,00 to over 290,000.

    While VA maintains they are maneuvering into position to deal with the backlog via IT solutions and business model solutions, there is little hard evidence thus far to indicate that operational improvements have been made, and with over 40 pilot programs in operation last year, there has yet to be any kind of indication what lessons were learned towards improvement of operations through those pilot programs. For now, it would seem wise to adopt a "wait and see" mindset in determining whether or not VA is capable of providing operational improvements, be they towards the operation of medical centers or the claims offices of the VBA.

- ***Would you care to comment on the feasibility of VA actually realizing $1.2 billion dollars [sic] in "operational improvements"?***
  - As indicated by the skepticism expressed above, the ability of VA to make substantive operational improvements, much less improvements capable of delivering more than $1.2 billion in savings, is in question. The American Legion has concerns that "operational improvements" may consist more of consolidation of activity within the realm of VA Central Office, and not of actual

improvements distributed out to the individual regions of operation and the veterans therein.

Further question must be raised when VA claims $1.2 billion in "operational savings" yet requests to hold just under $1 billion in reserve as a "contingency fund" which would seem to indicate that VA's own planners doubt the ability to achieve real savings and must hold onto a reserve fund to compensate for overambitious estimates of achievable savings.

While The American Legion supports the bottom line of the budget, VA could better serve veterans by targeting that contingency money to real projects, such as fully funding a Major and Minor Construction budget slashed by over half from the previous 2010 levels.

- ***VA's budget request contains a $1.1 billion dollar [sic] carryover from the previous Fiscal Year. I would like to ask this panel if they have heard from the field, anecdotally, concerns with hiring freezes, programs that were not adequately funded, or any other type of services shortages that were attributed to a "funding shortfall" by the VA medical centers or VISNs.***

  - The American Legion has also heard concerning stories anecdotally of letters from VISN and Medical Center Directors expressing hiring freezes due to inadequate funding. While Indianapolis and Cleveland are certainly areas of concern, recent testimony delivered by American Federation of Government Employees (AFGE) representative Maryann D. Hooker, MD to the Senate Committee on Veterans' Affairs explicitly highlighted this exact problem, stating in part in her written testimony:

    - *As mentioned above, emergency care has suffered tremendously because of inadequate staffing. The goal is no longer to provide care to the veteran in the emergency department, but to refer the patient outside the VA system for care. At Wilmington, VA, we recently learned that the emergency department is slated to increase its maximum capacity from six to 14 patients, yet administration wants to provide zero increase in nursing or physician staff. Recently, five patients each spent over 48 hours in the emergency department, including one who received two blood transfusions while he lay on a stretcher for 2 days. Meanwhile a 25-bed ward has sat idle for the past 3 years because of too few floor nurses.*

  Such conditions raise serious concerns about the ability to provide quality care to veterans. When questioned about these shortfalls, Dr. Robert A. Petzel, the Undersecretary for Health, responded that "there may be gaps between what these Directors *want* and what they are getting, but not between what they *need* and what they are getting. There are no shortfalls in any of the VISN budgets." Clearly the reality as indicated by the testimony above would indicate otherwise. The American Legion urges Congress to initiate more oversight into this area.

  By no means, however, are the stories of shortfalls limited to those necessary for hiring positions to adequately staff existing facilities to fully implement their allotted bed spaces. The American Legion has received other reports of new facilities falling short of needed "activation monies" required to bring these new facilities online. The failure to fund needed startup costs of a facility is tantamount to the failure to build the facility to begin with, as this prevents veterans from accessing the resources that have been built to service their needs. The American Legion urges Congress to use their oversight powers to investigate how widespread this situation is and to encourage VA to rectify this situation. If these cuts in costs are a portion of VA's proposed slashing of construction costs by over half in the proposed FY 2012 budget, then The American Legion urges Congress to ensure that those funding numbers are increased to proper levels so that veterans aren't denied the long sought access to care provided by these new facilities.

  As this Committee is well aware, The American Legion regularly performs inspection visits of VA Medical Facilities for field research compiling our annual "System Worth Saving" reports on the state of VA Health Care delivery. The American Legion reminds the Committee we will gladly partner with any member of Congress or any staff of the Committee who wish to delve further into this area and determine whether or not the funding designated by Congress is truly reaching the veteran at ground level. Dedicated field research is essential to finding "ground truth" in matters such as this.

The American Legion thanks the Committee for the opportunity to provide answers to these questions and remains ready and willing to work with the Committee to determine further answers to these or any other questions.

For God and Country,

Tim Tetz
Director
National Legislative Commission

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