U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2014

HEARING

BEFORE THE

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

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Thursday, April 11, 2013

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

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

Present: Representatives Miller, Bilirakis, Roe, Runyan, Benishek, Huelskamp, Wenstrup, Cook, Walorski, Michaud, Brown, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, Walz.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. This hearing will come to order and I want to welcome everybody to the VA Committee room to talk about the 2014 budget request for the Department of Veterans Affairs.

As everybody already knows, this budget is a couple of months late. It comes after the House and Senate have both passed their respective budget resolutions.

Unfortunately, it is a little late to influence the House and the Senate budgets that have already been passed, but I am sure that we have appropriations and authorization work that is ahead of us. And so our oversight on this request is still very, very important.

Mr. Secretary, thank you for being here. Welcome. As you know, Committee Members, and this is not on you, but Committee Members have had less than 24 hours to review some of the details associated with the budget request in advance of this hearing.

It is likely, therefore, that we will have follow-up questions after we have had a chance to look a little bit closer at the details.

I appreciate your attendance today and ask for your cooperation in getting timely answers to the Committee so that we can move forward.

My initial reaction to the budget is mixed. On the one hand, we see a proposed 4.3 percent increase in discretionary spending amidst what most would say is a stagnant or declining budget request for other agencies, most of which have, unlike VA, had to absorb sequester cuts. And that demonstrates that VA funding is clearly a priority in a very tight fiscal climate.

On the other hand, I am concerned that we are not really seeing the results for the money that Congress has provided to VA over the years. For example, the budget proposes a 7.2 percent increase for expanding mental health services.

I am still waiting, Mr. Secretary, for information from VA showing that veterans with mental illnesses are, in fact, getting healthier with the resources that we provided. After all, I know

that that is an outcome that you and this entire Committee are both after.

Dr. Petzel, I asked that question of you at our mental health hearing two months ago and we are still awaiting a response, so would ask if you would help us in getting an answer to some questions.

Then we get into the funding request for the Veterans Benefits Administration which is a 13.4 percent increase over the current year, but I am at a loss because we are seeing performance that does not match the dollars that have been put forward.

Despite already high record investments in technology, record numbers of employees available to process claims the situation is worse today than it ever has been before.

When last year's budget was released, VA issued a press release saying that with the funding provided, and I quote, "By 2013, no more than 40 percent of compensation and pension claims will be more than 125 days old."

Here we are today and we have 70 percent of claims out there that are older than 125 days. And the same is true for prior budget requests: lofty promises, excitement about new initiatives in technology, but lackluster at best results, and we do not have what this Committee would contend is a positive trend.

VA has missed its own performance goals every single year and I think most Committee Members here are really very tired of the excuses that we keep hearing from those that come before us to testify.

Look, I understand that more claims are being filed and that those claims are complex, but that has been true for decades. We all know that.

The workload created because of good decisions that you made for Agent Orange veterans, Mr. Secretary, Congress provided resources for an IT solution that you requested to help with that effort. And by establishing presumptions for combat post-traumatic stress and Gulf War illness, those claims, most of which would have been filed anyway, should have been easier to process, not cited as a contributing cause of the perennial failure.

As for technology improvements, I know many are pinning their hopes on the VBMS system on which we have already spent close to half a billion dollars. We have already had reports of VBMS problems from VA's inspector general. We also have reports of the system crashing just this week because all raters were caused at that point to temporarily transition back to their old computer system.

But what is worse, I have looked at the backlog numbers for the regional officers where VBMS went live at the end of last year, 2012, and 14 of the 18 offices have a higher percentage of backlogged cases now than when VBMS came online.

The other four have seen marginal improvement, but it is nowhere close to what it needs to be if we are going to meet the goal of 2015 that you have established.

I have been outspoken, as you know, in my efforts to protect VA funding and we have worked for over a year to ensure that VA was, in fact, exempt from sequester. I have introduced a bill along with the Ranking Member to advance fund all of VA's budget to

protect it from the effects of continuing resolutions or threatened government shutdowns.

I am proud of the efforts that this Committee has made to protect the resources that are important to VA, but the point of those efforts is to ensure improved benefits and services to the veterans of this country. And right now I am not seeing the improvement that I think most of us want to see in many key areas. I am seeing the opposite.

And, Mr. Secretary, I continue to say we have got to see results and I am sure you want the same thing. We need to see the outcomes the Administration has promised with the resources that Congress has provided. No more excuses.

I have supported you and your leadership up to this point. I believe that this Committee and the Congress has provided you with everything that you have asked for and it is time to deliver.

So with that, Mr. Secretary, I will yield to the Ranking Member, Mr. Michaud, for his opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAEL MICHAUD

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

And, Mr. Secretary, I would like to thank you and your staff for being here today. I look forward to your testimony on the funding needs of the VA.

I would also like to thank the VSO representatives who are also going to be testifying in the second panel. The Committee has relied on the veterans' community and the VSOs are testifying next to provide additional insight into the needs of VA.

You help us understand the pressing issues facing our veterans and their families, but you also help us find solutions to the current problems that we currently have. I especially appreciate the *Independent Budget* that you prepare as well.

Mr. Secretary, I applaud the Administration for providing a concrete example of the priority that our Nation gives to our veterans. As you heard the Chairman mention, in a time of austerity, a $2.5 billion increase over fiscal year 2013 levels represent the Nation's ongoing commitment to those who have served and sacrificed.

The key question today is, does this budget give you the resources that you need to complete your transformational efforts? The *Independent Budget* has recommended nearly $2 billion more than your fiscal year 2014 request.

Many of your transformational initiatives will come to fruition in the next year and a half. This includes your goal of eliminating the VA claims backlog by 2015. So again, does this budget give you the resources that you need to complete your transformational efforts, specifically achieving elimination of the backlog in 2015?

If the answer is yes, I will definitely work closely with you and my colleagues on this Committee and in Congress to get the resources that you need.

I can remember sitting on this Committee when I first got elected to Congress and we asked former Secretary Tony Principi whether or not he had the resources to provide the help that he

needs for our veterans. He hesitated and his answer was he requested an additional billion dollars, but he will live with what he receives. So that is why it is important that we know whether or not you got what you asked for.

When you look at it in a time of forced budget cuts and sacrifices within other agencies, you do have an increase with these funds, in these specific times come an increase in responsibility to show that tangible return on investment that we are investing in the VA.

It is imperative that over the next year we have an open dialogue about the accomplishments and achievements that this funding will give you and your agency. There must be a robust discussion of the programs you are moving forward and particularly the transformation system.

We need hard data and information if we are to share your confidence that the backlog will be addressed.

This year, you are asking for an additional $157.5 million in medical service funding. To me, this indicates the need for better, and more detailed planning in programming. The process of putting a budget together and making informed policy and program decisions is a fundamental management tool.

And as we begin the discussion of providing advanced appropriations for all of VA discretionary accounts, we need to also discuss whether the VA has the management processes and infrastructure in place to make strategic decisions that can inform budget estimates far into the future.

I believe we would all like to see a planning, program and budgeting process that is driven by the long-term strategic needs of the VA. All too often VA has been working on a crisis-by-crisis mode. There is not that long-term vision. And I think we need that.

It should be one that also would assist VA leadership at the very highest level as well to make the tough and smart decisions to improve on how we provide benefits and services to veterans and to evaluate the successes or failures of efforts over the long haul.

You have requested a large increase in Informational Technology as well. I understand the critical nature of IT spending. This is especially important within the context of your transformational efforts. But I want to be assured that we are wisely spending IT resources.

For example, as part of your proposed increase, you have requested $251 million to "fund the required development activities within the IEHR Interagency Program Office (IPD)." In light of the recent decision by DoD and VA regarding the integrated electronic health record, is this funding still required? Would these resources be better spent to support your claims backlog initiative?

I would also like to mention, actually in the Administration proposal that actually I oppose to, is the Administration budget's includes a proposal to utilize what is called a "chained CPI" in place of the current method of calculating inflation.

The Administration believes that the $44 million in savings over five years and $230 million over ten years. I line up with our different veterans' groups and the Senate share of the Veterans' Affairs Committee and our seniors to oppose this CPI change.

I am not convinced that it is a sounder manner in which to calculate inflation. Until I am convinced of that, I will be opposing it. I believe it would be a real damaging effort among many of our vulnerable citizens including veterans and their families.

So, once again, Mr. Secretary, I want to thank you and the staff for your leadership. I know these have been very tough, difficult times as you go into the transformation and look forward to working with you as we move forward over the next two years.

Once again, thank you very much, Mr. Chairman. I yield back.

[THE PREPARED STATEMENT OF HON. MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to the Ranking Member.

Our first panel this morning, we have got the Honorable Eric Shinseki, Secretary of the U.S. Department of Veterans Affairs.

Mr. Secretary, your complete statement will be made a part of the record, and I will forego introducing those you have with you at the table. And should you choose to introduce them, I would welcome that. You are recognized now, sir, and the clock is not running on you today.

STATEMENT OF ERIC K. SHINSEKI, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT A. PETZEL, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ALLISON HICKEY, UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEVE L. MURO, UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETERY ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; W. TODD GRAMS, EXECUTIVE IN CHARGE, OFFICE OF MANAGEMENT, CHIEF FINANCIAL OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS; STEPHEN W. WARREN, ACTING ASSISTANT SECRETARY, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary SHINSEKI. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Michaud, distinguished Members of the Committee, thank you for this opportunity to present the President's 2014 budget and 2015 advanced appropriations requests for VA.

We value your partnership, always have, and that will continue, your partnership and support in providing the resources needed to assure quality care and services for veterans.

Let me also acknowledge other partners here today, our veteran services organization whose insights and support make us much better at our mission of caring for veterans, their families, and our survivors.

Let me take the time, Mr. Chairman, to introduce members of the panel sitting with me. To my far left, your right, Mr. Stephen Warren, our Acting Assistant Secretary for Information and Technology. Next to him is Todd Grams, our Chief Financial Officer. To my right is Dr. Andy Petzel, our Under Secretary for Health and to his right Allison Hickey, our Under Secretary for Benefits, and

then to the far right, Mr. Steve Muro, our Under Secretary for Memorial Affairs.

Mr. Chairman, thank you for accepting my written statement for the record.

Let me just say very quickly the 2014 budget and 2015 advanced appropriations requests demonstrates the President's unwavering commitment to our Nation's veterans.

I thank the Members for your own commitment to veterans as well and seek your support of these requests.

The latest generation of veterans is enrolling in VA at a higher rate than previous ones. Sixty-two percent of those who deployed on Operations Enduring Freedom and Iraqi Freedom, Afghanistan and Iraq have used some benefit or service from VA.

VA's requirements are expected to continue growing for years to come and our plan must be robust enough to accommodate that. We must be ready to care for them.

The President's 2014 budget for VA requests $152.7 billion. As the Chairman indicated, $66.5 billion of that is in discretionary funding and $86.1 billion in mandatory funds. The increase of $2.7 billion in discretionary funds is 4.3 percent, as the Ranking Member indicated, above the 2013 level.

This is a strong budget which enables us to continue building momentum for delivering three long-term goals we set for ourselves roughly four years ago, increase veterans' access to our benefits and services, eliminate the claims backlog in 2015, and end veterans' homelessness in 2015.

These were bold and ambitious goals then. They remain bold and ambitious goals today. But our veterans deserve a VA that advocates for them and then puts muscle into the words.

Access. Of the roughly 22 million veterans, more than 11 million now receive at least one benefit or service from VA, an increase of a million veterans in four years. That has been achieved by opening new facilities, renovating others, increasing investments in telehealth and telemedicine, sending mobile clinics and vet centers to remote areas where veterans live, using every means available including social media to connect more veterans to VA. Increasing access is a success story for us.

The backlog. Too many veterans wait too long to receive benefits they deserve. We know this is unacceptable and no one wants to turn this situation around more than the workers at our Veterans Benefits Administration. Fifty-two percent of them are veterans themselves. We are resolved to eliminate the claims backlog in 2015 when claims will be processed in 125 days or less at a 98 percent accuracy level.

Our efforts mandate investments in VBA's people, processes, and technology.

People. More than 2,100 claims processors have completed training to improve the quality and productivity of claims decisions. More are being trained and VBA's new employees now complete more claims per day than their predecessors.

Processes. Use of disability benefits questionnaires, what we call the DBQs, online forms for submitting medical evidence has dropped average processing times in medical exams and improved accuracy.

There are now three lanes for processing claims, an express lane, about 30 percent of our claims go through that, for those that will predictably take less time; a special lane, special operations lane, if you will, for about ten percent of the claims for unusual cases or those requiring special handling; and then the core lane where roughly 60 percent of the processing is done.

Technology is critical to ending the backlog. Our paperless processing system, VBMS, Veterans Benefits Management System, will be faster, improve access, drive automation, reduce variance. Thirty regional offices now use VBMS. All 56 will be on VBMS by the end of this year.

Homelessness. The last of our three priority goals is to end homelessness in 2015. Since 2009, we have reduced the estimated number of homeless veterans by more than 17 percent. The January 2012 estimate is the latest available figure and that has the number at 62,600.

There is more work to be done here, but we have mobilized a national program that reaches into communities all across the Nation and partnered with the experts in those communities on dealing with homelessness.

Prevention of veterans' homelessness is a major effort and that will be the follow-on major effort to the rescue mission which we have given ourselves until 2015.

Mr. Chairman, we are committed to the responsible use of the resources you and this Committee provide.

Again, thank you for the opportunity to appear here today and for your support of veterans. We look forward to your questions.

[THE PREPARED STATEMENT OF ERIC K. SHINSEKI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Secretary, for your testimony.

I am going to start with a question that does not have anything to do with the backlog, but we will get there.

There is a witness on the second panel from the VFW who in testimony observes that major construction project backlog is upwards of $25 billion and at the current rate, it would take some 40 years to fully fund.

This budget proposes $342 million for major construction, putting us on a course, I believe, for completion of all the projects in 70 years.

So what I want to know from you, Mr. Secretary, what is the plan going forward in light of the severe funding restraints in this particular area and do you think we need a strategic reassessment of VA's Capital Asset Program going forward?

Secretary SHINSEKI. Mr. Chairman, let me just say the budget request that we submitted for construction is $2.39 billion for major and minor construction, NRM, nonrecurring maintenance, and medical lease programs.

These programs remain stable with an emphasis on providing safe, secure, sustainable, and accessible facilities for our veterans.

Our minor construction request is for $715 million. It is an increase of 17 percent compared to 2013. The reason minor construc-

tion receives attention from us is it is the program that impacts more VA facilities and delivers services to veterans more quickly.

Medical lease requests, $626.7 million, an increase of 12 percent compared to 2013, allows VA to provide services closer to where veterans live.

Major construction request is $342 million, as you indicated. With those funds, we intend to purchase three new national cemeteries in central east Florida, Brevard County Omaha, Nebraska, and Tallahassee, Florida. It also funds the completion of a mental health building in Seattle to replace the one that is seismically unsafe.

In terms of nonrecurring maintenance requests, $709.8 million, remains stable compared to 2013. The request funds projects with safety facility condition deficiencies and other high priority needs. And this is another one of those categories in which hospital directors can make quickest use of that kind of——

The CHAIRMAN. Mr. Secretary, I apologize, but my time is short and I appreciate it. But I was talking specifically about major construction.

Secretary SHINSEKI. Major? Okay.

The CHAIRMAN. Do we need to look at the capital assets plan again?

And, you know, we discussed the issues on some leasing problems with CBOCs. I see there are 13 in the budget this year. We have already got 12 plus three backlogged because of CBO and what they are requiring us to do in regards to an offset.

But, again, do we need a strategic reassessment of VA's Capital Asset Program going forward?

Secretary SHINSEKI. Mr. Chairman, we have a process by which we review all of our construction projects. As I think you know, we created a construction review council that did not exist before. We also have a process by which we strategically look at our capital infrastructure plan and those reviews are ongoing.

I would say that we do look at these closely and I am happy to share with you the results of those studies.

The CHAIRMAN. Okay. Thank you.

Let me real quick. VA submitted a strategic plan to eliminate the compensation claims backlog. That plan was submitted in January of this year in which it forecast expected numbers of claims it will decide in the years 2013, 2014, and 2015. And now three months later, the budget assumes a lower number of claims will be decided.

For example, the strategic plan assumed 1.6 million claims would be completed in 2014, but now the budget as it has been submitted assumes only 1.32 million will be completed.

So I think this is consistent with my opening statement where I said we talk about bold predictions about performance year after year, but the results are not backing up.

And, you know, my question is, it happens all the time. The goal posts keep shifting. And I would like just as brief an answer as possible because we will go to a second round of questioning and we will talk about the backlog further.

But why does the goal post keep moving on one of the most important issues that are out there within the veteran community today and that is the backlog?

Secretary SHINSEKI. Fair enough, Mr. Chairman. I am going to call on Secretary Hickey to provide some detail.

But I would say any time you write a long-term, large plan that describes solving a complex problem, they are assumptions based and we rely on those assumptions being fulfilled, one of which is there are no additional complicators that get added to the workload.

And another assumption is that we are going to be funded for the things we say we need. If either of those things change, it is going to change the work flow.

I believe the plan that you are referring to, the common operating plan delivered in January did not include VOW VEI as part of that discussion. The current estimate does. And so there is an additional requirement that we have accommodated.

I think, you know, we can explain the difference in those two numbers. We have a resource plan now with submission of this budget and I believe our latest estimates are accurate.

Let me just see if Secretary Hickey has anything to add.

Ms. HICKEY. So, Chairman, we do create a plan and then we look at our actuals. And I know that most of you all have individuals that are checking our weekly reports that we send to you through the Monday morning workload report or through ASPIRE.

And I will tell you that we try to adjust for what we see in real life. And you will see right now there is a slight decrease in applications being made for claims compensation, not a ton, but there is a little bit of a decrease.

These are objectives we look at. These are estimates for the future in terms of past veteran behavior. We have to base, you know, what we are looking at in the future in terms of, you know, what we are seeing and adjust for that year over year.

So we will be making those adjustments on a regular basis and as we start to see changes, we will certainly keep this Committee and you up to speed on where we are.

Secretary SHINSEKI. Mr. Chairman, I would just add as closeout here, I believe I am correct that the COP you saw in January did not have VOW VEI in it. This latest set of estimates does and that is why you see an adjustment.

The CHAIRMAN. And, Mr. Secretary, I have got a follow-up to that, but I will do it in the second round.

Mr. Michaud.

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

And, once again, I want to thank you, Mr. Secretary, and your team for being here today and for what you are doing for our veterans.

One of the issues, as you know, I have been a little skeptical of the 2015 backlog issue and primarily, because when you look at your plan that you put forward, I believe part of that plan also requires the Department of Defense to move forward, in a different mode as far as that seamless transition between DoD and the VA. And that is the concern that I have. I know we have a new secretary of DoD.

My question to you is, have you had any recent discussions with the new secretary of Department of Defense and are they willing

to move forward with that seamless transition, i.e. are they willing to accept the VistA system that VA currently has?

It is my understanding VistA VA owns, VA operates. The DoD system is actually, I believe that they purchased the L–3, I believe. I am not sure. You will have to correct me on that if I am wrong.

So is DoD willing to accept the VistA system and, if so, how soon?

Secretary SHINSEKI. Thank you, Congressman Michaud.

I would tell you that VA has decided that VistA is our core system and we are moving forward on the IEHR and still focused on an initial operating capability 2014.

And as you might expect, this has been a topic of discussion with the new secretary of Defense, Secretary Hagel. He is getting into the discussion. It is a complex one. And he wants to be sure he is structured correctly.

He and I have discussed this as recently as yesterday. I believe we are on the same path here and that is to look to develop a single common, joint, integrated electronic health record that is open in architecture and nonproprietary in design. And all of those terms are code word to get us to where we believe a seamless transition demands that we make the right decisions and the investments.

Secretary Hagel is working this hard personally. I know that. And I look forward to our next discussion.

Mr. MICHAUD. If they are not willing to accept it, what will that do towards the 2015 backlog issue that you are committed to breaking the backlog by 2015 if DoD does not do it?

Secretary SHINSEKI. Well, as a separate discussion, as we were building VBMS, the automation tool for benefits processing, we have also had a parallel discussion with other agencies, but primarily with DoD because, as I have said before, very little of what we work on in VA originates here. Most of what we work on originates over in DoD.

And so this partnership between not just our two secretaries but our two departments, entirely important if we are going to have this seamless transition where all of our energies are focused on—the focal point being the young individual serving in uniform and that individual coming to us as a veteran. That should be seamless. They should not have to do anything about it. We should adjust.

And so while we are talking about the integrated electronic health record, that is one piece of this larger discussion of a digital hookup with DoD.

As we were developing VBMS, we have consulted with DoD and indicated to them that in 2014 when we are VBMS'd, we are looking for digits from them and they are committed to working to make that happen.

Mr. MICHAUD. Good. My last question actually deals with how you calculate claims. When you look at VBMS, you can have a claim that might have four medical conditions. Actually, I have seen some that actually has about a hundred medical conditions. I think that is probably outside the norm.

But normally if you have a claim that has 20 medical conditions, my concern is how do you really calculate it? How do you determine productivity among the employees by dealing with just a

claim versus breaking it down to the medical conditions which you could have several in one claim?

Secretary SHINSEKI. Let me call on Secretary Hickey here to just give us a short synopsis of the issue versus claims discussion and I will look to close out.

Ms. HICKEY. Thank you, Congressman Michaud.

You well noted that there has been a change in terms of what the content of a claim is. In the past, we might have found one or two medical issues inside of a claim. Our current veterans coming back from Iraq and Afghanistan are claiming at much higher levels, 12 to 15 medical issues per claim.

What we have done here of late is we have taken the claim, our employees, and we are now capable of going down inside the claim and assessing how they do at the individual medical issue level, giving different points for claims that have more medical issues in it, so that the different complexity and workload associated with that claim, you know, has an expectation for our employees of additional workload acknowledgment.

I will tell you as I look at the claim level quality versus the medical issue quality which really is what a veteran cares about today, that veteran cares that we are doing his knee or his hearing well at that issue level, we are actually across the board, across the Nation at 95 percent on our quality when I look at the medical issue level of how we do a claim.

Secretary SHINSEKI. Just to close out, Mr. Michaud, you bring up a good point. You know, if you are dealing with a claim with ten issues and you solve nine of them and you are taking care of that veteran, but the one issue remains open, that claim is still unresolved and, yet, 90 percent of it has been decided in favor of the veteran.

So there is this distinction between getting 90 percent of your work done or just counting the claim and it is a one or zero result.

We need to be better at this and how we explain it, but we will do that with the help and insights and, you know, support of the VSOs who have great experience here.

The CHAIRMAN. Mr. Bilirakis, you are recognized for five minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Appreciate it very much.

Thank you, General, for testifying today. Thank you for your service to our country and thank you for your commitment to our veterans.

I would like to elaborate on the process that the VA uses to reevaluate its projects that had already been funded, that have been appropriated.

As you know, James A. Haley Medical Center in Tampa, the most highly trafficked VA polytrauma center in the Nation, not only serves my constituents, but also severely injured veterans across the Nation.

Years ago, officials at Haley developed a proposal that would allow them to build a brand new hospital in lieu of renovating their existing facility using major construction funding already appropriated to the location.

If started now, the new hospital will save $500 million over 30 years, very significant, without interrupting current hospital operations, while better serving the future needs of our veterans, yet the VA has not allocated funding for this cost-saving project.

In fact, I notice that the budget request that this proposal was a priority 78 with no funding requested.

Why has the VA been reluctant to prioritize such projects and I question if there are other similarly meritorious projects on the horizon when the timing is optimal to build a facility that will not only better serve our Nation's veterans but also will save hundreds of millions of dollars over time? What obstacles must the VA overcome to consider such projects and ensure taxpayers' dollars are used wisely?

Secretary SHINSEKI. Thank you for that question.

Let me call on Dr. Petzel to provide some details here.

Dr. PETZEL. Congressman Bilirakis, let me give you the latest update on the Tampa project. As you know, originally the proposal was to renovate the bed tower. There is much other construction that was going to be new.

We reassessed the situation at Tampa and I believe that both the network and the facility have come to the conclusion that they really do need to build a new tower.

A proposal to re-scope that project is working its way now through central office and when it is approved, we will then begin the process of evaluating that project.

I believe there is enough money left so that we are not going to have to ask for additional money. It is a matter of just re-scoping it and that is in process.

Mr. BILIRAKIS. There is enough money left and then some.

Dr. PETZEL. Right.

Mr. BILIRAKIS. I appreciate that. Can I follow-up with you on this?

Dr. PETZEL. Certainly.

Mr. BILIRAKIS. Please. Thank you very much. I appreciate it.

I yield back, Mr. Chairman.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman and Ranking Member.

Secretary, first of all, let me thank you for your service to the country and to the Department of Veterans Affairs.

As I look out in the audience in the room, my first thought is whether we are doing all we can for the veterans. Since we enacted the advanced appropriation policy three years ago, veterans' health care has not been the subject of the whims of the Congress and for that I am very grateful.

I want to thank Dr. Petzel for coming to Jacksonville to open the clinic. As the Secretary said, the clinic is probably one of the best clinics in the entire country and we will be able to do 90 percent of the procedures right there in this clinic. And I know that is the future of how we want to do outpatient clinics.

I do most of my health care at Bethesda and it would be good for every Member to have an opportunity to go out there and visit because the veterans that are there, their injuries are so different from what they were 20 years ago or 10 years ago. It is a lot more serious. When you say one issue, they have a multiplicity of issues.

And what are we doing as a department to work with the local agencies to help deal with the problem that we have?

I really do not feel that the veterans can do it by themselves. It is like the partnership we have down in Florida where we are working with the University of Florida.

What are we doing to forge those relationships? Do you understand my question?

Secretary SHINSEKI. Let me try to answer it.

Ms. BROWN. Yes, sir.

Secretary SHINSEKI. I am going to ask Dr. Petzel to describe what we are doing, have done and are doing in establishing a polytrauma system of care——

Ms. BROWN. Yes.

Secretary SHINSEKI. —so that you see this end as military members who are severely injured. And, by the way, today I think we have six quadruple amputees and just very, very difficult situations.

What we have created in VA are five polytrauma centers that ring the country, Tampa, Richmond, Minneapolis, Palo Alto, and San Antonio. But this is where these patients are initially handed off from the military to us.

Polytrauma, the word we created to describe serious injuries where it is not just one thing but multiple injuries.

And then as part of that tiering, is as they come through that first phase of stabilization, so they are not there forever, there has to be a second tier that moves them closer to home, third tier, and finally get them as close to home as we can.

Let me ask Dr. Petzel to describe the effort here and then the numbers of facilities and people we have dedicated to this.

Dr. PETZEL. Thank you, Mr. Secretary.

Congresswoman Brown, as the secretary described, it is a tiered system, begins with the very intensive five polytrauma centers. We have done 23 polytrauma network sites around the country which would be the next level of care as a person moves closer to their community.

And then we have 86 polytrauma support teams so that when you put this together, most all of our medical centers have a polytrauma program that is relatively close to the individual's home.

The goal here is always to de-institutionalize people and to get them into their home. The 86 polytrauma support teams and then the other 39 polytrauma points of contact are really the connection that that patient and his family has with the VA system and the VA medical care.

We will do whatever we need to in order to support someone at home. It may be buying care in the community. It may be providing that care ourselves. But the goal here, again, is to return people into their community and into their homes.

Secretary SHINSEKI. Congresswoman, just take a second here. Our effort here in connecting VA's electronic health record system takes these five polytrauma centers as a priority and it is the next coming step and connect it to Bethesda. So we have that electronic hookup between the premier military hospital in the country and

there may be a couple others, but certainly our five polytrauma centers.

Ms. BROWN. Thank you.

Orlando, Florida Medical Center status report?

Secretary SHINSEKI. Let me call on Dr. Petzel.

Dr. PETZEL. Congresswoman Brown, work is proceeding at pace at Orlando. There are now over 900 people on the site working and we are in discussions with Brasfield & Gorrie, the contractor, about completion dates and continuing the project. We are optimistic that this is going to get done. And as I said, it is proceeding at pace.

Ms. BROWN. Thank you very much.

I was just there less than a month ago reviewing the project. You know, I wanted it completed yesterday, but thank you as we move forward together.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Dr. Benishek, you are recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

And thank you, Secretary Shinseki, for being here this morning along with your team.

I guess my concern is to tell you the truth, Mr. Secretary, is, I know how difficult it must be managing a bureaucracy the size of the Veterans Administration and I guess my concern is about the management of these projects that are going on here.

We are constantly being told that we are just not making it, you know, we did not get the IT thing done, we did not get this thing done, but we are working on it and it is going to be better.

I am just wondering is there any system in the management plan which rewards or disincentivizes people for not meeting these goals?

I just get a little bit frustrated when I see that, well, we had a goal for an integrated IT thing and now it all broke down and now we are kind of working on it again. It seems to me that, you know, if I have got somebody in charge of a project and all of a sudden the project is a mess and I have to explain it like you have had to do, I would make sure that that person was no longer in charge of that project or there is some incentive. If they are going to say they are going to do a project that they get it done like they say.

And you end up being an apologist for what your staff and, you know, the administration of, you know, the whole projects under you because you cannot be doing it yourself.

So I am wondering what exactly is in place in your management team to incentivize or disincentivize those people that are in charge of all these little projects that we are talking about here because I see it as a difficulty in management.

Could you kind of go through that with me a little bit?

Secretary SHINSEKI. Sure. Congressman, thanks for recognizing it is a large and complex operation.

And if you want to do everything well, you have got to go at the whole organization and think about change.

You know, when I arrived, I took a good look at the level of training we provided our people. It was not what I thought it needed to be. And in the four years, that has been validated.

So you will see in our effort tremendous expenditure of resources and commitment to get our people trained. It is difficult to hold someone accountable for a standard if you have not trained them to it. All you do is you keep changing out the players.

So for us as an organization, we are after building a competent organization not just at the top but all the way throughout the organization. And to do that, we must train people on the jobs we expect them to do. Get them to that standard and then we can hold them accountable by measuring performance against that standard.

And usually in a training discussion, that gap between the standard and an individual's performance is what is called the training gap. That is what you have to train on.

If we have trained them to the standard and they do not perform, then we have some actions we can take.

Mr. BENISHEK. Isn't there some point where, you know, training is over? You are on the job. You have not performed. I mean, I am a surgeon. I am sort of responsible for the stuff that I do.

Secretary SHINSEKI. Sure.

Mr. BENISHEK. You know, I had a training period. But after a while, your training is over and you get better as you go on. But to me, the answer of more training does not ring true.

Secretary SHINSEKI. Well, there is sufficient turnover in an organization that, you know, training is an ongoing process. The ones we have trained definitely we can hold them accountable. And then we provide them the tools to do their job.

And earlier there was some discussion about VBMS having crashed this week. The term crash is not an appropriate description when you field a large IT program. We started with VBMS 1.0. We are now up to 4.2. And in the 4.2 program, there was one of those patches that did not take.

And so as we fielded 4.2 two weekends ago, we noticed that that patch was not working and we pulled the patch offline to work it, but the rest of 4.2 went in and continued to function. VBMS was available.

We have now fixed that patch which is usually what happens and we have put it in place and VBMS is functioning. It is a powerful tool in the hands of trained people.

Mr. BENISHEK. You know, I know the person on the ground dealing with, you know, a program or something, that is an employee. But I am talking about the management, you know, the management of these individual sectors.

You know, it just seems to me that if you keep missing your goals, does anybody change? I mean, does management change? Are you changing somebody out? Are the people held responsible for not meeting their goals or the answer is that, well, we just could not meet the goals and that was an unrealistic goal and we are going to have to reassess it? But that is the answer we get all the time. Is there never a situation that arises where somebody is incompetent?

Secretary SHINSEKI. I will just say in 2009, this department rated executives above 53 percent. All of them were rated outstanding. Today those ratings are around 25 percent.

Mr. BENISHEK. I think there needs to be some sort of an incentive program for producing a goal that you get or a disincentive program that if you do not make it—you understand what I am saying because to me, it does not seem as if there is any consequences for not getting these things done?

So I think my time is up.

Secretary SHINSEKI. Fair enough. I am happy to have discussion with you, Congressman, on that. I am open to suggestions. We have to train our leaders as well as our workforce and that has been an ongoing process as well.

Mr. BENISHEK. Thank you, sir.

The CHAIRMAN. Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Mr. Secretary, I would also like to thank you for your service and what you describe as a very ambitious set of goals and agenda that is matched with the muscle necessary to implement it.

And I know that part of what we are considering today is the addition to the muscle of resources that you can allocate towards achieving these goals.

And I also want to thank you personally and your under secretaries for their responsiveness on issues that we brought to their attention. And case in point for us is the 19.5 full-time mental health positions that have gone unfilled for far too long in El Paso.

Since bringing that to your attention, we are down to 11 which is progress and we would like to see it get down to zero, of course. And we would appreciate your help with that.

Another issue that we brought to your attention is the poor performance of the regional office in Waco serving benefit claims throughout Texas including the 80,000 veterans who live in El Paso. And as you know, I think the average wait time is 439 days. Eighty percent of those claims are over 125 days.

So from the new resources being requested in the President's budget, how will you use those in regional offices like Waco to improve performance?

Secretary SHINSEKI. I am going to call on Secretary Hickey here to talk about Waco.

I would just say, Congressman, if you will recall, back in 2010, we made a decision to provide Agent Orange service-connection for Vietnam veterans 40 years ago who are experiencing three new diseases. That increased our workload.

Waco was one of those sites where a large number of those claims were brokered. And as a result, they had an increased workload unlike others. And so it took them two years to work through that and it slows other claims processing. Unfortunate. No veteran should wait. But, again, the decision made in 2010 was also the right decision to take care of Vietnam veterans. That is sort of the background on Waco.

Let me ask Secretary Hickey to address your details about how it looks going forward.

Ms. HICKEY. Congressman, so Waco is actually in the process of going through several of the transformation initiatives. To start with, we are running all of the individuals who are new to their positions through the new challenge training which allows people

to be—new employees coming into the system with that new challenge training to do 150 percent more claims and a 30 percent increase in quality than their predecessors could, effectively making them a much more helpful rater or claims evidence gatherer earlier in their career.

Second thing I will tell you is we have put quality review teams inside of Waco as we have done in every one of our other regional offices reducing the amount of cycle time we have for errors that we catch downstream.

I can tell you nationally, we have reduced the number of errors we have found on our exams by 12 percent and I can tell you nationally, we have reduced the number of errors we found on our letters by 23 percent. Those are both things that take time and create some of those long wait periods for our veterans that we want to get rid of so we do it right the first time by them.

The other thing I will tell you is we have put Waco into our new organizational model as we have done for now all of our regional offices nine months ahead of schedule. They now have that express lane, that core lane, that special operations lane.

They had a number of claims that could have been done in that express lane. Once we sort of broke them into the lanes, we could see that lift that work that is faster and easier to do because it has just one or two medical issues. They are pushing right now on that express lane really hard and they have staffed that lane to make sure it happens.

The last thing I will say is my appreciation to the State of Texas, the Texas Veterans Commission for the partnership that they are providing us in bringing us in more fully developed claims. That is where they help us go find all that evidence we need to make that decision. They have been particularly helpful in finding private medical records and my appreciation to the State for what they are contributing and helping us.

Mr. O'ROURKE. Thank you for your answer and your attention to this.

And as I have said before in previous hearings, we look forward to working with you collaboratively to make sure that we can do a better job out of Waco.

And I know I have very limited time, Mr. Secretary, but I am interested in hearing your response to how we can protect low and moderate income veterans from the negative consequences of chained CPI and how we make sure that we still take care of them and do not introduce an undue hardship to them and their families.

Secretary SHINSEKI. Congressman, I would just say, and here again, it is consistent with what the President has done elsewhere, and that is the desire to protect the vulnerable populations.

The proposal excludes veterans' pensions which are provided to low income wartime veterans who are age 65 or older or who are under age 65 but remain totally and permanently disabled as a result of conditions unrelated to their military service.

The budget proposal also excludes certain veterans' education benefit programs, for example, Post-9/11 GI Bill, Montgomery GI Bill active duty because inflationary adjustments for these programs are decided by the National Center for Educational Statistics.

Mr. O'ROURKE. Okay.

The CHAIRMAN. Dr. Roe.

Mr. ROE. I thank the Chairman.

And thank you all, General Shinseki, for being here and all the veterans that are here today. And, again, to echo, thank you all for your service all in the room.

You mentioned and as I read your testimony last night that you wanted to increase access to veterans' benefits and services and, of course, eliminate the claims backlog and homelessness.

I would add another and that is to reduce the alarming rate of suicide among our active duty military and veterans.

You and I when we spoke, I guess six weeks or so ago, looked at the budget, the VA budget and just from a 40-year look as I have had since I was in the military and looking at the last ten years, we have gone from $100 billion now to this budget request $152 billion. And you told me you thought you had the resources to do what you needed to do.

And I believe I have never seen the VA provide more services than it has right now at this point in time. It never has. So I think that is a good thing and certainly this Committee, I think, will continue to do that.

There are lots of problems in a bureaucracy this big. And as I have listened, one of the things that Dr. Benishek brought up and was brought up is that if you hear Mr. Bilirakis had an issue and Ms. Brown had an issue. It seems like it is the squeaky wheel that gets some noise. If we bring it to you, it gets looked at.

But I think that Dr. Benishek made a great point is that if there are 19 places unfilled, why in the world did that happen?

An issue I brought to you six weeks ago was when a veteran dies, and there is no discussion about that, you have a death certificate, this veteran dies, their spouse sometimes takes months or maybe as much as year to get their benefit. That is absolutely unacceptable.

When you have got a veteran out there, a spouse, man or woman, especially the older veterans that are out there that are living on a very meager income and then to have them wait and, as we talked about, they have a house payment, they have food to buy, they should not miss a check.

I mean, that should not even be questioned and why we cannot do that—I had Veterans Benefit people come in and talk to me about this and they had one that was a year long. And this person was in dire straits. So, anyway, I will listen for that.

I guess another question I have was brought up is that you mentioned the significant percentage of OIF/OEF members who are using veteran services, but that is only about ten percent of all veteran patients.

And as you all look forward, do you have the resources going forward to take care of those veterans that you expect to come in? I mean, I know you know they are going to. Are the resources there?

Secretary SHINSEKI. Congressman, just let me touch on the spouse issue you mention and go forward. I do have it from you and we are working it.

I am equally, you know, concerned and frustrated as you are by having to do this. I think we are required to do this. We are look-

ing for a way not to have to revalidate the spouse on, you know, the death of a veteran. But we will work with you on that.

Mr. ROE. Thank you.

Secretary SHINSEKI. Regarding our resourcing for Iraq and Afghanistan veterans as they return, what we have is the understanding that over the next five years, up to a million veterans will be leaving the military and becoming veterans. And based on that, we have at least described what we think that flow rate will be as best we understand it and then provided a resource request for the 2014, 2015 piece of that.

We are in the process of developing a five-year look at our budgeting process, this is VA internally, so that we look at a planning phase out there that is beyond the two-year budgets that we are fortunate to have because of the Congress, but then a programming and then a budgeting execution phase. So that gives us a way of describing what our requirements are going to be when we come to budget.

Based on what we know today, the two-year look we are providing here accommodates what we expect will be the flow.

Mr. ROE. Another question I have is the integration between DoD and VA on the electronic health records and the benefits. Should we have a joint meeting between DoD—and I realize that Defense Secretary Hagel has a lot on his plate with North Korea and the Middle East right now, but this is one of my concerns when we changed was the fact that this will get a back burner again.

And are we going to be sitting here, and you and I have spoken about this and that was a private conversation, it will remain that way, but are we going to be sitting here a year from now or two years or three years because it is not a resource—there is plenty of money—to be able to integrate these systems?

I mean, it has really become very frustrating to me to sit here year after year. Now, unless the voters have a different idea, I plan to be here in 2015, and to see if we complete these things that we are saying we are going to do. Is it there?

Secretary SHINSEKI. Yeah. I would say, again, Congressman, Secretary Hagel and I have discussed this on at least two, maybe three occasions. He is, again, putting in place a system to assure the way ahead for him to make this decision and be the partner that we need here. He is committed to an integrated electronic health record between the two departments.

VA has made its decision on the core and we are prepared to move forward.

Mr. ROE. Somebody has to blink and that would be one of you. I mean, obviously we cannot integrate them, so it is going to have to be one system or the other. And I think what I heard you say was you have decided the VA is going to stay with what it has. That means that he is going to have to blink.

Secretary SHINSEKI. I would say the VA system is government owned, government operated. We have put VistA into the open architecture trade space so anyone who wants to use it can use it. It is used in other countries. I believe it is a powerful system and I am just awaiting a discussion with Secretary Hagel.

Mr. ROE. I thank the Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. Secretary, for your words on VistA. I think the Committee is in full agreement.

I would remind he probably does not know, my colleague, yet that we are working on another joint meeting with both secretaries specifically on this issue because I am encouraged by some of the words that I have received regarding Secretary Hagel and his willingness to move forward. He has been involved in it for a long time and I think it may move in the right direction finally.

Mr. Walz, you are recognized for five minutes.

Mr. WALZ. Well, thank you, Mr. Chairman.

And, Mr. Secretary, and your team, thank you for being here. I am grateful for that. Always grateful for the work we are doing. But as we all know, until every veteran is served at the highest level we can, we have work to do. And I know this team understands that clearly.

I am hopeful now that the public understands the need to care for our veterans. I think the silver lining in the backlog is it has come to the attention of the American public and then that is a good thing.

Even some of our colleagues I have noticed outside of this Committee, have been using terms like seamless transition. That is good.

I think it is important for this Committee, though, to maybe gently remind them they are not the first people to think of it. There are complexities to this that have been thought about. And the Committee process works, at least in this place, where Members are trying to find it and looking through this.

So I am grateful for that, but I also know, General, you sense the frustration that grows. You have it yourself and I have seen you express that. And I have said it. I am convinced we have got the right people there, but we have got to bust this thing.

So it is an opportunity. It is an opportunity to talk to the American public. It is an opportunity for us to talk about what we do right, but it is an opportunity for us to work on getting things better.

And not to miss the opportunity for my wheel to squeak, Dr. Roe, since we are here, I did have this maybe parochial, but I think it is bigger than that, General. I just have a question.

Looking at the budget, there is no mention in here, and, Dr. Petzel, this may be for you, I see no mention of long-term TBI rehab provisions that came out of the Lejeune Act.

You know, when Congressman Boozeman was over here and now Senator Boozeman, we worked on this. It was the ambiguities in the law on TBI treatment to move beyond the holistic approach, to move beyond physical, move to get these folks back, mental needs as well as quality of life, long-term recovery, and process.

I see no hint that this provision is being implemented in the budget proposal. Indeed, the select medical program projects a reduction in TBI care for OEF and OIF veterans for 2014 and 2015.

Other than the non-reoccurring maintenance the Chairman spoke about, no other program is going to see a reduction. So we passed this bill, passed the House, passed the Senate. President signed it in there. It was crafted with the VSOs. It was crafted with the caregivers. It was to make sure that our warriors are

brought back to the highest level possible as the research catches up and takes them forward.

And looking at the budget, it is hard for me to see how we are going to implement that. So, yes, parochial, but I think an issue we all in this room deeply care about is returning care of those warriors, especially TBI.

Secretary SHINSEKI. Let me call on Dr. Petzel and then I will add something to close out.

Dr. PETZEL. Congressman Walz, thank you very much. It is an acute observation about the TBI budget.

We are anticipating that the acute TBI cases that we have seen as a result of the war are going to be decreasing, that we will not see as many people coming for the acute care.

But we do have in the process of being developed a plan for the holistic long-term care that you described before and there will be as a result of the fewer acute patients we are caring for, there will be money available to develop that program.

Mr. WALZ. Dr. Petzel, what we were asking for was, as the VA often does, is almost unprecedented. We were not seeing it in the civilian sector. We were asking for an approach to care that was at that cutting edge as it was going.

How are you seeing that implemented? What are some of the things that we do on that care to move them beyond just getting them back to a physical baseline? How are we not just maintaining that? How are we moving further on all those aspects of their life?

Dr. PETZEL. Well, first of all, it starts at the acute rehabilitation phase, Congressman, where you do not just have physical therapists doing physical therapy. You have behavioral scientists. You have recreational therapists. You have people who are even at that point in time working to reintegrate these people into their community and working with their families to do that.

And each one of our polytrauma centers now has a transition unit, if you will, an apartment that is suited to teach people how to survive and live by themselves or with minimal help. And as that is being done, all these other more holistic things in a person's life are being integrated into what that individual does.

And then as I mentioned earlier when we were talking about polytrauma, we progressively are moving people towards their community and towards their home.

I am very pleased that the huge majority of the people that we see in polytrauma are now back in their homes being cared for by home-based primary care, home-based care, et cetera.

Mr. WALZ. Dr. Petzel, do you feel like what this act did has been incorporated into the cultural treatment of how we see now what our responsibility is at VA?

Dr. PETZEL. Yes, I believe it is being incorporated. Absolutely.

Mr. WALZ. Very good. I appreciate that.

Secretary SHINSEKI. I just had just one small point here. Congressman, I think you are aware of this. At our polytrauma centers, we have an awakening awareness program and here is where our most severely injured, brain injured veterans go. And most of them are deeply comatose when they arrive there.

Through great work, cutting-edge work at these polytrauma centers, I believe we are about 69 percent of those deeply comatose

and in some cases declared vegetative patients are being brought back to consciousness and then worked back into the capability to communicate and go on living, you know, a life that has more independence with it.

Mr. WALZ. I am appreciative of that.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Mr. Runyan.

Mr. RUNYAN. I have nothing right now, Chairman. Yield back.

The CHAIRMAN. Let's see. Ms. Kuster. Hi. How are you?

Ms. KUSTER. Thank you very much, Mr. Chairman, and thank you, Ranking Member Michaud, for holding this hearing.

General Shinseki, great to see you again and thank you.

I want to cover two topics and I know our time is short. The first is a cultural shift similar to one we were just discussing. I am a new Member of Congress and I am extremely concerned about the treatment of women in the military when we have one out of every three women and a fair number of men experiencing sexual assault and the trauma that comes with that.

And so I would like to hear from you about your mental health treatment and how you intend to incorporate the very sensitive and cutting-edge treatment models for victims of sexual assault, particularly in the circumstance where they may or may not have had the opportunity to properly adjudicate those claims and they may have been re-victimized in the process, separated from service, separated from their unit. So I would like to hear from you and particularly whether those services are available throughout the veteran system.

Secretary SHINSEKI. Congresswoman, I am going to call on Secretary Hickey to talk a little bit about the claims that go along with this because I think her insights will be helpful.

I would just say I think the use of the term as you did, sexual assault, is an appropriate description of what we are dealing with. Somehow other terms make it sound like it is a condition. This is a crime and we ought to look at it that way. And then, you know, leaders ought to take charge here.

I would just point out that in this year's budget, if we were to look back to 2009 and come forward through our budgets, women veterans' programs have been increased by 134 percent. And so much of your concern about are we paying attention here and doing the right things, I think we are. It is reflected in the budget. But we are always open to insights on what we should be doing better.

With regard to disability claims, we are going back to take a look at decisions that may have been rendered earlier and just checking ourselves.

Let me ask Secretary Hickey to take that one on.

Ms. KUSTER. Thank you.

Ms. HICKEY. Thank you, Congresswoman.

Let me tell you when I arrived here in June of 2011, one of the first things I did within the first two weeks was to ask to have a comparison of our grant-denial rates between PTSD associated with sexual assault and PTSD associated with all the three other major conditions: combat, fear, and terrorism.

And I did note in June, 2011, this was an action I took of my own accord, that we had a disparity between the ways in which we granted and denied those. We put in some very fast action; it was together, both a VHA and a VBA action. We identified very specific people to deal with the situation from the VBA perspective. We heard from our veterans who were dealing with this issue; they wanted to talk to women. So, there is now a dedicated person in every regional office who handles these claims. We have trained together both those on the health side who are working with our victims here and put into play some new processes.

I can tell you every quarter I ask for an update. By June the next year, we were clearly at par with the way we grant and deny other PTSD environments. We have remained that way. I continue to pull them and adjust to assess it to make sure it happens. And Dr. Petzel, also in VHA, provides the health care, the ongoing health care, for these victims to ensure that they are cared for in that perspective as well.

Ms. KUSTER. So, thank you very much.

I am going to go on to my next question—my time is very short—but I would love to work with you, and I know there are others on this Committee and throughout the Congress that would like to work with you on that subject.

This is a much more parochial subject, but I think it probably impacts other areas. I have a very rural part in the north country of New Hampshire. We recently, with the New Hampshire delegation, sent a letter to you about both a telehealth and a clinic in Colebrook, New Hampshire, but more broadly, I would be interested in a conversation about expanding telehealth facilities, one-day-a-week facilities, and any information you might have to share with us about the new patient center community care program in New Hampshire and I would love to work with you and your team going forward to increase accesses to service for veterans living in a rural community.

Thank you.

Secretary SHINSEKI. I would just say—let me call on Dr. Petzel to try to provide as much detail—I think the letter is recent enough. I don't have a comprehensive plan to come back with, but let me see what Dr. Petzel can provide.

Dr. PETZEL. Thank you, Mr. Secretary, Congresswoman Kuster.

We are very empathetic with the ruralness of northern New Hampshire. Telemedicine is a burgeoning part of the way we deliver care and we would very much like to sit down with you and talk about how we can increase availability of those kinds of services.

We have places where we do this in the Veterans' Service Club where the telemedicine is there and it is connected to either a hospital or a large-scale clinic. There are many, many ways that we can provide this service in rural areas, and we would like to talk to you.

Secretary SHINSEKI. I would just add that this budget has $460 million in it for telehealth to address those kinds of things that you are talking about.

In addition, in those areas where we don't link well or we don't have a presence, we do have non-VA fee-care as an available option

so we can go on the local economy and veterans can be served. We have over $5 billion into paying fee-based, fee-care costs.

Ms. KUSTER. Thank you very much and thank you.

Mr. ROE. [Presiding] Thank you.

After yielding, Mr. Huelskamp is recognized for five minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the opportunity. I apologize for slipping in here, and I want to follow-up on that last comment about the issue about non-VA fee-basis care.

Can you describe—you gave us the numbers, Mr. Secretary, nationwide—can you describe the response of how often is it used and what services in general it can be used on and then I would like to follow-up on your response.

Secretary SHINSEKI. I just gave you the rough numbers nationwide. It is about $5.9 billion. Decisions on the use of fee-care is done locally by, you know, the attending physician to decide whether to and how much.

Let me call on Dr. Petzel to provide more detail.

Dr. PETZEL. Thank you, Mr. Secretary and Congressman Huelskamp.

It is a widely used program. It is used particularly in rural areas, but not exclusively. And as the secretary said, the decision is made on the part of the physician. They are prescribing or asking for some care that is not available in the community-based outpatient clinic or in the medical center or it may not be conveniently located to the individual's home, and that is when a fee-care authorization is asked for.

In Kansas, specifically, the Wichita VA Medical Center spends about $15 million a year on fee-care program, and as you know, we have in Kansas, Project ARCH, which is a pilot project using fee-care more extensively in a community to bring care into rural communities. We think it is a very important tool, if you will, to provide better access, along with telemedicine, community-based outpatient clinics and those other things we have.

Mr. HUELSKAMP. And, Doctor, a follow-up on the Project ARCH. I presume that is in reference to the pilot project in Pratt, Kansas?

Dr. PETZEL. That is correct.

Mr. HUELSKAMP. What is the local response to that?

A few months ago, it didn't seem very positive, that it wasn't working very well is what I was hearing from that community. Since it has been redistricted out of my congressional district, I don't have as much contact. Do you have more information on that?

Dr. PETZEL. The information I have, there are 223—as of January—223 patients that were using Project ARCH and the feedback that I have gotten was that they were satisfied. There may not be—there may be people who are not involved in the project that want to get involved, and I will find out about that.

Mr. HUELSKAMP. Uh-huh. You said how many were—how many patients?

Dr. PETZEL. Two hundred and twenty-three.

Mr. HUELSKAMP. Well, that has changed considerably from the last information that I had.

But back on the issue, the non-VA fee basis, I was at a hospital in La Harpe, Kansas—by the way, my congressional district is so

big that two days ago, the difference in temperature across the district was 75 degrees from end to end. It was minus 2 degrees on the western edge and 73 on the other end, so it is a big area and I will note that Pratt being fairly close to Wichita is not what we consider rural in terms of access; it is the 200 or 300-mile, but I was in La Harpe, Kansas and they said for every hour of patient care, they were filling out 30 minutes—spending 30 minutes filling out paperwork for every patient and the response was is that we can't do that. We just can't do that.

And so, I would like some more information on that. Is that what we are hearing as well? So, I mean, I know we spend—you are talking about the dollars we spend but there is incredible potential and need out there and not just for the veterans themselves, it is for the spouses that get to drive and drive and drive and the volunteers that drive from—by the way, thanks for finding a physician in Liberal, Kansas, and filling that this summer; I really appreciate that. We are talking 250-mile drives for volunteers and patients and spouses.

So, I would like to follow-up a little bit more, a little more information about the success of this non-VA fee basis, because it seems like it is underutilized particularly because of the heavy paperwork requirements.

Dr. PETZEL. We will particularly, Congressman, follow up with you about the paperwork requirements that you were talking about. I want to just add that in addition to a fee basis, telehealth in Kansas, as well as other parts of the country, is really very popular and rapidly growing way of delivering specialty care, particularly.

Mr. HUELSKAMP. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. ROE. I thank the gentleman for yielding.

Congresswoman Negrete McLeod?

Mrs. NEGRETE MCLEOD. Thank you.

Mr. Secretary, thank you for being here.

Homelessness among veterans is a serious problem in any district, and I am sure it is in other districts.

How many housing vouchers through the HUD VASH program do you anticipate will be funded by your requested amount of the $278 million?

Secretary SHINSEKI. Dr. Petzel?

Dr. PETZEL. Thank you, Mr. Secretary, Congresswoman McLeod.

We are expecting in the 2014 budget another 10,000 additional HUD VASH vouchers and that will bring, I believe, the number of vouchers we have to over 46,000.

Mrs. NEGRETE MCLEOD. Okay. My second question—thank you—as you mentioned in your testimony, the number of women veterans enrolled in the VA health care has increased by 22 percent since 2009.

What is the VA's timeline for increasing the number of facilities that have comprehensive women's clinics beyond the current 50 percent?

Dr. PETZEL. Another good question, Congresswoman McLeod.

The VA has three ways that we try to meet the special needs of women veterans. The first is, as you mentioned, a comprehensive

women's clinic that we find in places that have over a thousand women patients and that is bringing together all the services that might be needed into one clinical setting, so, mental health, OB/GYN, primary care, whatever might be needed is fixed in that area, and we have about 86 of those clinics, if I remember correctly, around the country.

The next level is having a primary care clinic that is designated specifically for women, in which the primary care providers are specially trained to be able to recognize and manage issues that might be specific to women veterans. In virtually all of our medical centers and most of our large outpatient clinics, we have that circumstance.

And then the last area, in very small places where we have one or two providers, we have trained about 2,500 physicians and nurse practitioners in the special needs that women may have and that is the way we manage it.

So, we have the three levels and we will—whenever we can see a large enough number of women who need it, we will set up, and do set up, a comprehensive women's clinic. I want to point out that the budget devoted specifically to women's needs has grown since 2009 by 134 percent.

Mrs. NEGRETE MCLEOD. Because of the number of women who are joining the forces and are coming home?

Dr. PETZEL. That's correct. We have well over 300,000 now enrolled in veterans' health care.

Mrs. NEGRETE MCLEOD. Thank you.

The CHAIRMAN. [Presiding] Thank you very much.

Dr. Wenstrup?

Mr. WENSTRUP. Thank you, Mr. Chairman.

Secretary Shinseki, we met a while ago, maybe three or four weeks ago, and I was wondering if you could update us. We talked about putting in place a way to increase the efficiency of the clinics and the ORs in our VA hospitals, from the standpoint, especially, of physicians having too much administrative duties that virtually anyone could do and it takes them away from patient care, and if we could do that, we could allow health care providers to see more patients in a day, do more surgeries in a day, things like that. I was just wondering if you could give me an update on that.

Secretary SHINSEKI. I am going to call on Dr. Petzel to provide some detail here, but this leads to our discussion of the Patient Aligned Care Team where the physician is sort of the focal point, but surrounded by other members of the care team that allow the physician to concentrate on what he or she does best, and that is see patients, take care of their needs, and then the administration, the tracking of pharmacy requirements is done by others, all part of that team. It is called PACT, Patient Aligned Care Team. That is our initiative and we are implementing that across VA as we resource it.

Dr. Petzel?

Dr. PETZEL. Thank you, Mr. Secretary.

Congressman, we absolutely agree with you that getting the most of the people that we have and operating our crowded facilities sometimes, like operating rooms, et cetera, in the most efficient manner, I think, is very, very important. And as the secretary de-

scribed, we are involved in trying to set up a circumstance where people, first of all, work in teams, and, secondly, where each individual works at the top of their license, so that physicians are only doing those things that physicians have to do; nurses are only doing those things that you have to have a nurse do; and then the administrative personnel, pharmacists, whatever, are doing only the things that they have to do.

The place where we have begun doing this first is in our primary care clinics, and as the secretary mentioned, they are called Patient Aligned Care Teams. We are moving this now into specialty areas, so that we are doing this in orthopedic—some orthopedic, ophthalmology, and other subspecialty clinics and cardiology. It is the way that we have to operate and it is the way that things need to be done in the operating room, as well as any of the other procedure rooms. So, we absolutely agree with you and we are embarked on trying to do that.

Mr. WENSTRUP. Thank you.

And, as I did that day, I, again, offer you my time to participate in that process as a physician and surgeon who has had private practice, as well as serving with DoD, and it might help to build a bridge between us and you.

Dr. PETZEL. That would be great. We would welcome that.

Secretary SHINSEKI. Congressman, I would just add, and so, the value of the physician's time in terms of being able to see patients, if you think about the network of health care we provide in very rural areas, the last thing we need to do is put that physician on a road trying to get someplace to see a patient. And that is why our investments in telehealth and telemedicine, about $460 million in this budget, is intended to allow patients to come to the nearest VA facility. If the specialist is not there, then this system hooks them up to the specialist they need to see, at least get that initial consult going, and then we can decide from there what needs to happen next.

Mr. WENSTRUP. Thank you. I yield back my time.

The CHAIRMAN. Ms. Kirkpatrick?

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Thank you, Secretary Shinseki, for your appearance today before the Committee, and for your transformational vision for the VA.

My question is: Does this 2014 budget reflect all of the resources you need to continue and achieve that transformation within the VA?

Secretary SHINSEKI. Congresswoman, thanks for that question.

We have described, as I said earlier, a very bold and ambitious plan. It is a plan that has been resourced and it is one that will give us the 2014 objectives that we need to deliver on leading to 2015 and on out, but it does give us the resources we need.

Mrs. KIRKPATRICK. Do you have any concerns or expectations that you are going to need additional funding to meet those goals, especially your goal to reduce the backlog by 2015?

Secretary SHINSEKI. I will say as I said earlier, the plan that we laid out is an assumption-based plan, that we know the variables out there. If there is a change, a sudden surge in the arrival of patients, we will have to adjust.

What we do know, you know, from the Department of Defense, is over the next five years, up to a million servicemembers will be leaving the military, and so we have been given an understanding that there will be a flow here, as opposed to a spike on day one or spike on day last, and so we have accommodated that flow. If that changes, then we will have to readjust the plan, and if needed, we will come back.

Mrs. KIRKPATRICK. That is my concern. That is a lot of veterans to process in a system that already has backlogs, and so I really have a concern about that, but we will be watching that process, but obviously, you have factored that into your budget and you are making those planning changes.

Secretary SHINSEKI. And all the more reason that we have to automate now. We are in paper; we have been in paper too long; we still receive paper. And all of this effort is not just to automate our systems, but to get others to provide us digits so that we have a seamless handoff of our veterans.

Mrs. KIRKPATRICK. Thank you.

Thank you, Secretary, and I yield back.

The CHAIRMAN. Ms. Walorski?

Mrs. WALORSKI. Thank you, Mr. Chairman.

Mr. Secretary, good to see you again.

And I understand your testimony, you had spoken about since 2009, the VA has opened an additional 57 community-based outpatient clinic, CBOCs, and as you are aware, a new CBOC is planning to open in my district in 2015. Since I saw you last, my understanding is that that project is behind.

Is there any kind of a status report that you guys can provide to the veterans in my district as to what the status is of that CBOC?

Secretary SHINSEKI. I would like to give you the best answer I can. I am going to call on Dr. Petzel here, to give you exactly the status of that CBOC.

Mrs. WALORSKI. Okay. Thank you.

Dr. PETZEL. I have information about the South Bend CBOC——

Mrs. WALORSKI. Correct.

Dr. PETZEL. —and that is, as I understand it—thank you—that, as I understand it, did have a delay, but as I am told, it is back on pace. I can't give you a date when it is opened, but we will get back to you and see if we could do that.

Mrs. WALORSKI. I appreciate that. Thank you very much.

And in that getting back to us, is there some kind of timeline where we can expect to know the status report?

Dr. PETZEL. Oh, immediately.

I will have someone get back to you within the next week at the latest.

Mrs. WALORSKI. Great. Thank you very much.

Thank you, Mr. Chairman. I yield back my time.

The CHAIRMAN. Thank you very much.

Mr. Ruiz?

Mr. RUIZ. Thank you, Mr. Chairman.

Thank you, Secretary Shinseki, for all the work that you are doing. It is great to see you again.

I just want to, initially, before I ask my question, follow-up with Dr. Wenstrup's comment to ensure that the paperwork that physicians have to do, in general, is not only a problem in the VA, but in the private sector, and I think that looking at the private sector would be a good way of looking at how we can cut down on the amount a physician spends on the paperwork.

One of the things we have done in the emergency department—for example, as you know, I am an emergency medicine physician—is to use scribes and we utilize oftentimes pre-med students in the VA system. It could be medics who can deal with the paperwork, the forms, that have been trained. That will allow physicians more time to spend with the patients as the goal should be. Now, so I am hoping that the scribe model would possibly be under the PACT team that will specifically address the paperwork and the forms that the physicians have to fill.

In terms of my question, I want to talk about the claims backlog, and I know that this is a very complicated system and I know that in order to address this and address the efficiency, we break it down into different parts of what a veteran has to go through from initially understanding what their benefits are to what they want to claim, and then to the end result.

In that systemic process, what, in your opinion, is the top one or two bottlenecks in the system that takes a long time?

Ms. HICKEY. Thank you, Congressman Ruiz.

The biggest bottleneck is collecting the evidence, finding the evidence. Whether that is—basically three big pieces we need: we need the DoD medical records while they were in service; we need the DoD personnel records for the character of their service, awards, declarations, DD–214 kinds of forms that let us know dates and times and how they served and whether that qualifies; and we need private medical records. We also need VHA medical records, but that is the easiest thing for us to do. We literally have access directly in VBA right into the medical record. We can look at it, bring that data forward, use that instantaneously. It is those other three parts are the parts that make it very difficult to do.

Mr. RUIZ. Thank you.

Secretary SHINSEKI. And that is why there is very significant effort to connect, digitally connect, VA to DoD for personnel records, for medical health records. Right now we rely on veterans to provide so much of this information and they shouldn't have to carry that burden. We ought to be able to do this as a department and that is what we are working on.

Mr. RUIZ. That is a very good point.

I have spoken to some veterans in the district that I am from, the 36th in California by Palm Springs, Coachella Valley, and some of them—most of them are seniors and they have very difficult time getting to their hearings for their claims in front of the VA Board due to many reasons, financial, transportation, et cetera.

Let me ask you: Is video conferencing an efficient way of decreasing that burden on our seniors?

Secretary SHINSEKI. I am going to ask Secretary Hickey to add some detail here, but the virtual hearings are a way that we are able to cut down on travel and also increase efficiency and decision-making. And when we review the face-to-face hearings and what

happens on the virtual hearings, the results are comparable; there is no disadvantage. And so, this would be our preference to resolve the issue you described, but the veterans have a choice and I know that some would prefer to be face-to-face and we accommodate when that request is made.

Ms. HICKEY. Congressman, the only thing I will add is that our partners, as in the entire claims process, are critical to our ability to assist, especially, our elderly patients—I mean our elderly veterans and their survivors and family members. So, we do work very closely with our VSOs and our state county service officers to facilitate those VTC exams and we are seeing a very large increase in willingness to take that process and so we are seeing that as a good thing.

The other thing that I would just share with you is that about 40 percent, right now, of our Board's efforts to do the teleconferencing are done via—I mean to do the face-to-face with the appeals process are done, via the teleconference—tele—VTC environment.

Mr. RUIZ. Thank you very much.

I appreciate all the work that you do, and I yield back my time.

The CHAIRMAN. Thank you very much.

Mr. Secretary, I know I promised we would have a second round of questions, but we are running out of time and I know that you have been here for an hour and a half and when I say running out of time, I mean legislative time. We have all the time in the world to help you in solving the problems that exist out there today, but a lot of the Members have expressed a desire to send additional questions. We will try and bring them all together into one document, if we can, to make it a little bit easier for you and your staff to be able to respond. We appreciate you being here this morning.

Secretary SHINSEKI. We will do that.

Thanks, again, Mr. Chairman, for this opportunity to be here to present our budget. We appreciate the past support and we look forward to your support on this one as well.

Thank you very much.

The CHAIRMAN. Thank you very much, and you are now excused.

And as the first panel is excused, I want to invite the second panel to start making their way forward, if you will, and we will wait for introductions until folks are seated at the table.

Thank you very much.

We will welcome the second panelists to the table.

With us this morning, Jeffrey Hall, Assistant National Legislative Director for the Disabled American Veterans; Carl Blake, National Legislative Director of the Paralyzed Veterans of America; Diane Zumatto, National Legislative Director of AMVETS; Ray Kelley, Legislative Director for the Veterans of Foreign Wars of the United States; and Mr. Louis Celli, Legislative Director of the American Legion.

Your complete written statements will be made a part of the hearing this morning.

Mr. Celli, I would say we didn't receive the Legion's testimony until less than an hour before this hearing. That has never happened that I am aware of, and so hopefully we won't have to—it is very difficult when we get the President's budget late and then we get comments from organizations late. It makes it very difficult

for Members to be able to absorb the testimony that you are giving here today.

So, again, your complete written statements will be made part of the hearing record.

And, Mr. Hall, you are recognized for five minutes.

STATEMENTS OF JEFFREY HALL, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CARL BLAKE, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; DIANE M. ZUMATTO, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; RAY KELLEY, LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WAR; LOUIS CELLI, LEGISLATIVE DIRECTOR, THE AMERICAN LEGION

STATEMENT OF JEFFREY HALL

Mr. HALL. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, on behalf of DAV, I am pleased to be here today to present recommendations of the *Independent Budget* for fiscal year 2014 related to veterans' benefits and the Veterans Benefits Administration.

This year's *IB* contains numerous recommendations to improve benefits programs and the claims processing system; however, I will be highlighting only a few of the more critical ones.

Mr. Chairman, with VBA committed to processing all disability claims in less than 125 days with a 98 percent accuracy by 2015, they have their work cut out for them. VBA is currently rolling out new organizational models and practices and continuing to develop and deploy new technologies almost daily. In the midst of the massive transformation it can be hard to get or keep the proper perspective to measure whether they will achieve their ambitious goals.

So, the question is: Will transformation be completely successful?

The simple answer is: We still think it is too early to tell, but we do believe that VBA is on the right path and has made sufficient progress to warrant continued support of the current transformation efforts.

Mr. Chairman, now is not the time to stop or change direction and Congress must continue to perform aggressive oversight particularly of the new IT programs, but must also continue to provide sufficient funding to complete the transition away from paper.

Additionally, in the middle of the comprehensive transformation, including the new IT system, which changes the roles and responsibilities of VBA's employees, it is difficult to determine whether or not staffing levels are or will be adequate to handle the workload once these changes are fully implemented. For that reason, the *IB* is not recommending a specific staffing increase for claims processing in fiscal year 2014; however, we are recommending modest staffing increases for the Board of Veterans' Appeals, as well as the Vocational Rehabilitation and Employment Service.

Although the board has been authorized to have up to 544 full-time employees in fiscal year 2011, its appropriated budget fell short and could only support 532 full-time employees that year. In

fiscal year 2012, that number was further reduced to 510. And at present, the board's fiscal year 2013 budget may be able to support as many as 518 full-time employees; however, based on an expected workload increase for fiscal year 2014 through conversations with the board, even while adjusting for the projected productivity gains, the *Independent Budget* VSOs recommend that the board be provided funding for at least 544 full-time employees for fiscal year 2014 in order to reduce its backlog and reduce the wait times.

Also in fiscal year 2012, VA's Vocational Rehabilitation & Employment Program, also known as VetSuccess Program had 121,000 participants, a 12 percent—12.3 percent more than in fiscal year 2011 and VRE anticipates a 10 percent workload increase for both fiscal year 2013 and 2014.

To meet this need, we are recommending that the VRE be provided funding for approximately 230 additional counselors in fiscal year 2014 in order to meet the rising workload demand and reduce their counselor-to-client ratio down to their stated goal of one counselor for every 125 veterans.

Mr. Chairman, in the past year, there has been much discussion about replacing the current CPI formula used for calculating the annual Social Security COLA with a new formula commonly called the chained CPI in an attempt to lower the Federal deficit by reducing the rates paid to Social Security recipients. Since the Social Security COLA is also applied annually to the rates of VA disability compensation and DNC, this would also mean a reduction in veterans' benefits. The *IB* VSO has urged Congress to reject any proposal to use the chained CPI or any other scheme that would attempt to reduce the Federal deficit on the back of America's wounded heroes.

And finally, Mr. Chairman, the *IB* VSOs call on Congress to correct some longstanding injustices in how certain disabled veterans and their surviving spouses are treated under current law. Congress must finally repeal the inequitable requirement that the veteran's military longevity retired pay be offset by the amount equal to disability compensation awarded to disabled veterans rated less than 50 percent; the same that exists for those rated 50 percent or greater.

And finally, Congress must finally repeal the inequitable offset between DIC and SBP. There is no duplication between these two benefits; they are separate and distinct.

And lastly, Congress should enact a legislation to enable survivors to retain their DIC on remarriage at the age of 55 for all eligible surviving spouses.

This concludes my statement. I will be happy to answer any questions.

[THE PREPARED STATEMENT OF JEFFREY HALL APPEARS IN THE APPENDIX]

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

Mr. Blake?

STATEMENT OF CARL BLAKE

Mr. BLAKE. Thank you, Mr. Chairman.

On behalf of the co-authors of the *Independent Budget*, I would like to thank you for the opportunity to be here today to testify.

I will say up front that we certainly believe that the Administration is committed to delivering timely, quality health care benefits to veterans. That being said, an increase in funding does not automatically lead to the assumption that sufficient funding is being provided.

I will note that the *Independent Budget* released our recommendations back in February and for the first time we included advanced appropriation recommendations for fiscal year 2015 for health care. I am going to limit my comments to the health care funding, in particular, to the 2015 advanced appropriations.

Just based on a quick analysis of the Administration's numbers released yesterday, you will see that they provide for approximately $1.1 billion in total medical care dollars from what was just recently enacted for 2014 to 2015. Certainly, that is not a small amount of money, but I would offer that we don't believe that $1.1 billion is sufficient to meet even current services increases.

Medical care inflation in general trends about three percent right now. One point one billion dollars is about 1.9 percent, so I would question whether the increase that they projected would even meet current services. That is without even considering the fact that they, once again, reduced spending or planned to reduce spending in medical facilities, particularly at the expense of non-reoccurring maintenance. And I won't talk about construction issues. I know my colleague from the VFW will get into that.

We reviewed their utilization and I think there is some sound reasoning in all of the utilization. I would point to one concern that we have, and we have raised this concern in the past about OIF, OEF, and OND utilization. I would note that they project for 2014 and 2015 the same exact number for both years.

My immediate concern would be that we are all aware of the status of the military funding as it has projected a plan to not only start withdrawing from Afghanistan in 2014, but also to start to draw down the military, which is actually going on right now, and we believe, certainly, that will have some sort of an impact on utilization in the VA.

A couple of particular concerns that we have, first with collections. We have voiced this concern many times in the past as well. Ultimately, the VA continues to over-project and underperform. I will use fiscal year 2013 as an example.

Last year they projected $2.9 billion, approximately, in collections. You now see from their budget request release yesterday, they are projecting about $2.8 billion, about $125 million. I know that is small change in the context of a multibillion dollar budget, but our concern would be that what is going to fill the gap now left by the $125 million in collections that they don't achieve?

Ultimately, that is dollars that need to be found somewhere, because that $2.9 billion was the basis for the assumption of providing care in the coming fiscal year.

We would draw your attention to the fact that their projections for this year and next year are around $3.1, $3.2 billion. It will be interesting to see if they can even come close to achieving those

projections. I would suggest that their track record on collections would suggest that they cannot.

Another concern that we have raised over and over again is with proposed savings and management improvements. In fact, it specifically says in the appendix for the VA budget this year, that due to projected management improvements that they would achieve in 2013, 2014, and 2015, that they will be able to reduce the need for appropriations in 2014 and 2015. It is not clear how much they have reduced their projection for needed appropriations.

I will suggest that in their budget they show $482 million in proposed savings for 2014 and 2015 and $1.3 billion in 2014 and 2015 for operational improvements. I don't know what portion of those two dollars—two dollar figures are factored into that reduction in appropriations, but those two together equal a large sum of money.

I will draw your attention, also, to some questions we have about the Affordable Care Act. The VA does mention that in 2014 they project a new cost associated with implementation of the ACA, about $85 million, which suggests that their assumptions are that between the number of veterans leaving the system and coming in is probably a net, not a large effect. Interestingly, though, for 2015, they project no new dollars needed for the implementation of the ACA. I would be curious to know what the basis for that is exactly.

We have concerns about funding for research. For the fourth year in a row, research funding is essentially being kept flat. I know it is like a three or four million dollar increase over last year. That is not substantial; that is essentially flat.

Lastly, Mr. Chairman and Mr. Michaud, we would like to thank you for the introduction of H.R. 813. The four co-authors of the *Independent Budget* all support your legislation. We hope the Committee will move that legislation pretty quickly.

I would also support the legislation introduced by Ms. Brownley, H.R. 806, that would extend the GAO requirement for reporting on advanced appropriations.

And with that, Mr. Chairman, I would like to thank you and I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Blake, also for your information.

In two weeks, the Full Committee is going to have a hearing on the impact of the ACA on VA, so we would welcome you to participate and be here to hear the testimony during that hearing.

Ms. Zumatto, you are recognized for five minutes.

STATEMENT OF DIANE ZUMATTO

Ms. ZUMATTO. Thank you, Mr. Chairman.

I appreciate the opportunity to be here today to share the recommendations from the *Independent Budget* for fiscal year 2014.

In light of the ongoing fiscal challenges facing our Nation and the growing demands for VA services, the *IB* VSOs call on Congress and the Administration to make it their priority to ensure that the VA continually receives sufficient, timely, and predictable funding. It is unfortunate that the Administration's funding rec-

ommendations for the VA in fiscal year 2014, as well as the advanced appropriation recommendations for 2015, have been delayed by almost two months and the *IB* VSOs are greatly concerned about how VA program funding may be impacted going forward.

Additionally, the ongoing breakdown in the appropriations process is a major concern to the *IB* VSOs and will most certainly have a negative effect on all VA operations.

In fiscal year 2014, *IB* covers a myriad of veteran-related issues and makes numerous recommendations to improve veterans' benefit programs and the claims processing system; however, I will focus my remarks today on employment.

Some of the reasons for the persistently high unemployment rate for veterans can be found in a June 2012 study done by the Center for a New American Security on employing America's veterans, and it examined the effect of military service on former servicemembers as it relates to their employment opportunities.

And while there are many positive reasons listed in the report for hiring veterans, it also noted that there were several challenges facing veterans when they are out seeking employment, and the focus of that was they have difficulty in skill translation; there is a problem of negative stereotype; there is the skill mismatch; there is the fear of employers, that if they hire national guard or reserve troops that they are going to be deployed; there is difficulty in acclimation and many employers say they just can't find veterans.

In considering the many challenges that are facing the transitioning veterans, it appears that the toughest barrier for them right now is employment and it seems abundantly clear that transitioning veterans seeking employment, especially those with health issues, face some unique obstacles, including the process of securing the licenses and credentials required by some professions. The issue of veteran licensing and credentialing continues to be of concern to those within the military and veterans' communities and is made especially difficult for veterans due to its highly parochial nature; the complexities within the civilian credentialing system itself; the fact that each of the military services has its own unique training and credentialing programs; the need to overcome real or perceived gaps in military training, experience and education; the ambiguity about which of the roughly 4,000 different credentials are most important to civilian employers; and perhaps most significantly, many military occupations, unlike their civilian equivalents, have no credentialing requirements.

Military service and training are provided at both the state level for members of the national guard or the Federal level for active duty and reserve personnel. In light of this, a massive collaboration between DoD, VA and DoL, as well as the Department of Education, and the individual states, will be required.

The *IB* VSOs applaud the fact that the Administration has offered its support to ensure that servicemembers leave the military career-ready by proposing the following: increased veteran and service-disabled veteran tax credits, challenge the private sectors to commit to hiring or training veterans, and the career-ready military, which calls for DoD and VA to leave—to lead a joint task force with the White House economic and domestic policy teams and other agencies to develop proposals to maximize the career-

readiness of all servicemembers, including a reverse boot camp and an initiative to deliver enhanced job search services to transitioning veterans through American job centers, including improved TAP workshops.

That concludes my testimony this morning and I will be happy to answer any questions.

[THE PREPARED STATEMENT OF DIANE ZUMATTO APPEARS IN THE APPENDIX]

Mr. BENISHEK. [Presiding] Mr. Kelley, you are now recognized for five minutes.

STATEMENT OF RAY KELLEY

Mr. KELLEY. Mr. Chairman, Mr. Michaud, Members of the Committee, thank you for the opportunity on behalf of the two million members of the Veterans of Foreign Wars and our auxiliary to be here today.

As a partner of the *Independent Budget*, the VFW is in charge of the construction portion, so I will limit my testimony to that. For the past few years, I have testified on how transparent the VA's Strategic Capital Investment Plan, or SCIP, has been in identifying gaps in safety, utilization, and access and how this plan outlined to accomplish—to close those gaps within a decade. I still believe that SCIP is an exceptional tool and is based on industry models and best practices.

At the same time that we praise SCIP, the *IB* called for funding levels that would keep pace with VA's own model to close these existing gaps within ten years. This model has not been met. In three years, the level of funding for major construction projects has fallen from $1.2 billion in fiscal year 2010 to $532 million in fiscal year 2013, and now the Administration is requesting only $342 million for fiscal year 2014.

The *Independent Budget* is requesting $1.1 billion to fund major construction projects in fiscal year 2014. This is nowhere enough to put VA back on track, to close all major construction gaps within ten years, but it is an amount that can be responsibly invested within one fiscal year. This funding request does address the *IB*'s greatest infrastructure concern, which is safety, specifically, seismic deficiencies.

There are currently six projects on VA's fiscal year 2014 top 20 major medical facility projects list that are seismic safety projects. All of these projects have been initially funded, one as early as fiscal year 2009, but none have been funded in this year's budget proposal. Only one project in the 2014 top 20 list is receiving any funding at all, and the VA's—to the VA's credit, this project will replace seismic deficient buildings with a new facility.

More must be done. The President has requested in his larger budget proposal that $50 billion be spent on capital infrastructure. The *IB* suggests that a discussion take place to use some portion of this $50 billion to close the seismic safety gaps within VA.

What is more important, repairing potholes and building bike paths or ensuring that our veterans and VA staff are protected from the horrors that took place 42 years ago in Sylmar, California,

when a 6.6 magnitude earthquake collapsed a VA hospital killing 49 and costing $2.8 billion in today's dollars to fix those damages?

The *IB* is also concerned about the current state of capital leasing. Prior to 2012, the Congressional Budget Office treated major capital leasing and short-term leases for already-existing facilities or renewal of leases. In evaluating the cost of VA major construction authorization at the end of 2012, CBO changed their perception of these leases. Under the new rules, VA will have to fund all major leasing projects like CBOCs, treatment centers, and research facilities in the first year of that lease.

Under current VA budgeting practices, this is impossible. The *IB* understands that this Committee and VA are exploring every way for VA to continue the pre-2012 leasing practice while staying within the current budget rules; however, if a solution cannot be found, the *IB* partners recommend that Congress should forego its own rules to ensure these leases can move forward and without further delay while a long-term solution is found.

In closing, the *IB* would like to thank VA for requesting funding for activation costs associated with new medical facilities. This will take undue pressure off of VA to find the money necessary to make new facilities operational once they have been completed.

Mr. Chairman, this concludes my remarks and I look forward to any questions you or the Committee may have.

[THE PREPARED STATEMENT OF RAY KELLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Kelley.

Mr. Celli, you are now recognized for five minutes.

STATEMENT OF LOUIS CELLI, JR.

Mr. CELLI. The American Legion has spent thousands of hours intimately working with the Department of Veterans Affairs. We appreciate their willingness to be transparent while reviewing their portion of the budget just last night and we applaud the President's support and commitment to increasing VA funding in areas that will help eliminate the growing backlog, as well as care for our wounded veterans.

Chairman Miller, Ranking Member Michaud, Members of this Committee, on behalf of Commander Koutz and the two and a half million members of the American Legion, we welcome this opportunity to comment on the Federal budget and specific funding programs for the Department of Veterans Affairs.

In October of last year, national commander, Jimmy Koutz, provided the Committee the American Legion's guidance for a robust Department of Veterans Affairs' budget that adequately provides for the health care and benefits for veterans of all wars during this period of difficult financial times.

As thousands of troops return from deployments from Afghanistan and elsewhere in the world, the United States shifts its policies in Iraq and Afghanistan, thus producing a new national security focus. The American Legion reminds the Committee that the national security change does not change the fact that the veterans of these wars, as well as prior conflicts, must be taken care in the

aftermath of these wars and this care will extend for these veterans and their caregivers for the next 60 years.

While grateful for prior VA funding, the American Legion remains vigilant to ensure the VA is not going to be shortchanged of the funding that it truly needs. The lack of appropriate funding will endanger veterans' care and benefits.

The American Legion has for years been testifying before the Congress of these United States reminding them that the cost of war, especially prolonged war, is expensive and that the true costs are only realized decades after the war is over. Last month, the Harvard Kennedy School issued a report that projected the total costs of these current conflicts to cost between four and six trillion dollars.

The American Legion is encouraged with the proposed increases in the areas of claims processing, electronics records development, and medical care, and believe this is a step in the right direction.

Lastly, as this Committee just pointed out earlier and my colleagues have highlighted, VA receives sufficient appropriations to continue to fund and operate, at least, facilities in 2012, but in 2013, the appropriations for these same facilities was eliminated due to a scoring change initiated by the Congressional Budget Office.

As a result of the Congressional Budget Office's adjustment in scoring review, Congress refused to introduce a fiscal year 2013 appropriations required to keep these community-based centers opened. As these leases now become due, there are 15 major medical facilities that will be forced to close unless Congress acts quickly to provide the appropriate funding to these centers.

The American Legion urges Congress to fund these centers immediately and continue to provide the medical support to these veterans in these remote areas. Based on the very short time that we have had to review this budget proposal, we prepared our preliminary review, which is reflected in our written testimony, and we look forward to answering any questions that the Committee may have.

Thank you.

[THE PREPARED STATEMENT OF LOUIS CELLI, JR. APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Celli.

We will now begin the first round of questions. I guess I will start.

Mr. Hall, on behalf of the *Independent Budget* co-authors, you testified that we believe that there has been sufficient progress to merit continued support of the current transformation effort.

Can you demonstrate some of these evidence of projects' progress? I mean, I am frustrated, as you can probably listen to my questions, you know, I have been frustrated by changing goals. Tell me what you see as a positive.

Mr. HALL. Well, there are several things—thank you for the question—there are several things that, I guess, but it is not certainly inclusive of others that I could mention, but simple things like the DBQ process, okay, which didn't exist, which is helpful to the discovery of evidence in a claim; QRTs, quality review teams,

that has been a positive step in the right direction towards accuracy; the e-benefits; the stakeholder enterprise portal.

These are all really good things that are going to matter to the system. All of them are in motion and still being worked out at the present time, so we certainly understand the frustration, but these are things, what we feel, are positives in the right direction. As well as the Veterans Claims Intake Processing, the VCIP, for the scanning, those are all things that—when I say sufficient progress.

Mr. BENISHEK. Well, thanks.

I want to get a little input from you all about my question to Mr. Shinseki about, you know, what incentives are there for the administrators of the program to fulfill these goals.

Do any of you have any input how this can be better managed so we don't have a moving goal post all the time so that, you know, the projects that the VA starts, you know, get finished on time or that people are responsible for the failure of getting things done on time? Does any one of you have an idea as to how to better manage that?

I mean, you have been involved with this probably longer than I have on an individual basis in dealing with that frustration, so just take a minute to see if you could each give me a comment as to how I can change the way the VA works to try to make it better.

Mr. HALL. Well, I will start and just simply say that, yes, VSOs enjoy an open, collaborative effort with VA at different levels. Given the different types of programs that I highlighted in my previous comment, service organizations or stakeholders were able to provide that input, number one. So, do they listen to it?

Well, they certainly listen to a lot of the recommendations; more so, it seems to me after 20 years of working in this business, that this Administration is more open towards receiving recommendations and not only receiving them, but actually implementing them.

Now, when it comes to, I guess, your question of accountability if there is a problem, they don't normally ask us——

Mr. BENISHEK. I know they are not going to ask you, but I am asking you.

Mr. HALL. Well, if we provide them feedback and say, You have to hold these folks accountable, that is something that is a little bit elusive at this particular time, Mr. Benishek.

Mr. BENISHEK. Yeah, I know that.

Mr. Blake, do you have any comments?

Mr. BLAKE. Mr. Benishek, the first thing I want to say is, I want to echo the comments of Mr. Hall. We were fortunate to have the opportunity to participate in VBMS as they are working out the bugs in that, too, and I think having met with the head of our benefits department on a number of occasions, he feels comfortable that they are really heading in the right direction with VBMS in particular.

To your actual question, when you asked the question earlier, I leaned in and I told my colleague, I said it sounds like the question ought to be: Can you fire a Federal employee?

And I am not sure that is a—as hard as it is to hire a Federal employee, it is probably equally as hard to fire a Federal employee—and I am not suggesting that that is what needs to hap-

pen—but it certainly points to the difficulty of accountability through sort of a hard-knocks approach.

I am not suggesting that, you know—I don't envy any of the senior leadership of VA, because I think—I can't imagine the tasks that they are responsible for and particularly for General Hickey. I mean, that might be the toughest job in Washington from my opinion given the responsibilities placed on her and what the expectation and outcome is supposed to be.

It is certainly not an easy answer. I mean, I am not suggesting that anybody should be punished any particular way. There certainly should be incentives and disincentives in some fashion.

Mr. BENISHEK. Well, that is what I am thinking. It just seems to me that there should be better accountability and better reward—for the managers, I am not talking about the employee out, you know, delivering the service—but the managers, the way the system is run should be more, you know, accountable, because I see Mr. Shinseki's job as very tough.

Does anybody else have a comment while I still have a minute?

Mr. KELLEY. I will echo what they said as well. The VFW would be very open to furthering the discussion of how to do that accountability. We think it is very important to have leaders held accountable to——

Mr. BENISHEK. Well, I will look forward to some conversations in the office. Thank you.

Mr. CELLI. And I just wanted to say that, you know, with the multitude of programs that the Department of Veterans Affairs has, there is a lot of work to be done. The fully developed claims project that the American Legion is involved with, with the Department of Veteran Affairs is a result of the collaboration that the VA has had with the VSOs. We think that that transparency needs to continue. We feel comfortable that, at this time, the Department of Veterans Affairs has opened and welcomed us in to try to work with us on some of their problems.

With regard to oversight, that is clearly your area.

Mr. BENISHEK. Thank you.

My time is up.

Mr. Michaud?

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

And, once again, I would like to thank the panel.

When you look at accountability and part of that is to make sure that the employees know what the clear standards are, the metrics that they are going to be held accountable to and for, so I want to follow-up on what Dr. Roe had mentioned during the first panel when he looks at the survivors' benefits and the widow's claim and he is absolutely right. The backlog has increased tremendously, which you wouldn't think it would, particularly with those particular types of claims.

And my big concern is, actually, as you know, Togus is a high-performing RO. We used to do the pension claims at Togus, however, VA decided to centralize that in Pennsylvania and, unfortunately, since it went to Pennsylvania, all we are getting are complaints now from our veterans in Maine and that is concerning. And I think it gets back to training, making sure that employees are trained properly. It comes back to the turnover rates, whether

or not you have an RO that really has a high turnover rate in those particular facilities.

So, my question for each of you is: What do you think the VA should do as far as metrics in dealing with the backlog? As you noticed my first question with the secretary is, you know, you have a claim that could have several medical conditions, another claim that actually might have 20 or so, compared to one that might have five. Do you think that we ought to be looking differently at how we calculate the performance of an employee and whether that is a better standard to hold them accountable for it?

I guess I would ask each one of you if you could do a quick yes or no. Should we do it the way it is done now or should we focus on medical conditions?

Mr. HALL. There should be some changes in the way they do that, and to answer your question a little bit more, if you are counting a claim that has a claim, but that contains eight contentions in that, you know, in the past it was or currently an error in one of those issues is an error for the claim.

If you are going to change that and make that metric, you know, each contention, now, is worth, you know, where the error is counted in each one of those contentions, but the overall claim isn't, those are things that they need to be looking at, and I know that the VA is looking at different ways. But, in doing so, the employee has to know exactly what it is that, you know, that they are responsible for or the complexity of it.

What I am getting at is if you are going to score an employee and you have a senior rater that is getting inherently the more difficult or more complex claims, you know, the special-ops claims type issues, I can't see how VA is going to be able to credit their employees or give them credit for their daily workload without changing how they score that.

Mr. BLAKE. I am certainly not the expert on the benefits side and I would like to take your question and spend a little bit of time talking to the head of our benefits department about that, but it is my understanding that the VA is looking at—and I think Mr. Hall referenced this—is looking at the way that they view a claim.

We complained in the years past about the numbers game associated with claims processing and finishing a claim is getting a one for that and so it puts an emphasis on just moving claims quickly, which leads to getting a lot of the easy stuff done quickly and the harder stuff being left behind, and it is my understanding that they are either looking at or maybe even moving towards an idea where if a claim has ten issues in it, each issue is scored individually for a credit as either a positive or a negative.

And we think that is probably the right way to go. We have always, I think, sort of argued that that made more sense because you have created a sort of disincentive to do the hard work if you are only going to get one credit for a ten-issue claim versus one credit for a four-issue claim.

Mr. KELLEY. Yes, there needs to be changes. Carl and Jeff pretty much summed it up, so I will return your time.

Mr. CELLI. Okay. We agree, and yes, the American Legion has actually submitted a comprehensive proposal to the Department of Veterans Affairs just last week, which works similarly to a check-

book system to where the claims are rated based on the difficulty and actually negative points are given when the claim is adjudicated improperly.

Mr. MICHAUD. Could you also provide that to the Committee as well?

Mr. CELLI. We would be happy to.

Mr. MICHAUD. Thank you.

Thank you, Mr. Chairman.

Mr. BENISHEK. Thanks, Mr. Ranking Member.

Mr. Walz?

Mr. WALZ. Thank you, Mr. Chairman.

I appreciate it.

Thank you all for being here, as always, your services and most importantly, thank you for being there every minute of the day for decades to make sure we get this right and bring this expertise to it. I am grateful in looking at the *IB*, some of those things.

And I know, Mr. Hall, it is sometimes hard to find the positives in things that are very frustrating, especially in the backlog of claims, but I think it is important that we understand that it is the outcome that matters, effectiveness is what matters, and we have got to look at this.

We all want it fixed, and there is a lot—as I have said I am glad they are there. Now they have recognized this as an issue and now they want to get it fixed, but we have to do it in a manner that works, so I am very appreciative of you doing that.

And I think Mr. Benishek is right, this issue of accountability, I think we all want it. When we figure this out, let us know so we can apply it to this Congress, then we will get things going.

But I have a specific issue—again, this comes out of your critical issues report—and I am not sure which one of you wants to take this. It is just an issue—it was on channel—or, excuse me, on page 27 where it talks about in there the DoD and VA should act on the recommendations provided in the Institute of Medicine's report to determine and address the long-term health effects resulting from airborne hazards. I am just concerned we have got Nehmer claims here on the horizon, if you will, that are going to be addressed.

Do changes need to be made—do any of you—if you have an expertise on this—need to be made in the way that IOM partners with VA and if there is enough transparency there? This looks like a pretty solid study. It is one that we have been waiting on. It is one we have been looking at and we are starting to see some implications there. I think the implications are generational and we have never crossed that path and I think we may have to of what are the implications on the children of these exposures.

So, I don't know if any of you— are we getting this right? IOM laid out what I think is some solid evidence. Now what is going to happen with it?

Mr. BLAKE. No.

Mr. WALZ. Okay.

Mr. BLAKE. I think the issue is it is much like any other report. The IOM has done a number of great studies on issues under the umbrella of the VA over the years and whether those recommendations necessarily see the light of day, I am not sure.

You know, I don't know if that has to do with the connection between VA and IOM. I would be surprised if anybody could honestly tell you what that connection here actually is, but, to the specific report, certainly, there is some great ideas there that the VA needs to look at, but I think that same statement has been made about a number of things over the years, too, so——

Mr. WALZ. And I, of course, worded my question in a very good Minnesota passive-aggressive fashion. I agree with you, but I don't think it is being implemented. I don't know if it is going any further and I have deep concern on numerous ones, but this one, specifically, that I think there is some research on there. I think we are moving and the VA is taking a very aggressive approach to be addressing whether it was Agent Orange or other things.

This seems like one to me, that this opened the door for more collaboration, more transparency for us to look at, and then to do it. I mean, this is a door that we need to go through to see what are the implications, genetically, on generational impact of exposures to these.

So, with that, I appreciate, again, all of you being here, and I really think it is important that you are here and with the *Independent Budget* focusing on the whole spectrum of care to our veterans.

I think Dr. Roe summed it up right. I don't think any of us have seen the level of services being provided by the VA. Many of them are top quality, best practices, you know, verified and some of them are not.

And I think it is important for us to never lose the focus. If we spend too much energy in one area at the expense of others, then we all know that is detrimental to the veteran and I know that you get that and I appreciate you being here.

Mr. BENISHEK. Thank you, Mr. Walz.

We are just about out of questions, but Mr. Michaud expressed to ask another question while you are here.

Mr. BLAKE. Yes?

Mr. MICHAUD. Just one quick question.

I know you support the advanced appropriation of all of VA. Would you also support—my biggest concern with just giving budgets on a yearly basis or a two-year basis is the long-term planning—would you support requiring, if we are going to do advanced appropriation for the rest of VA that they have to provide, say, a five-year plan to the Committee, as well, because I think DoD does that, but I am wondering if you think that the VA should do the same thing, long-term planning?

Mr. BLAKE. No comment.

I think it is a reasonable idea, when they release the entire Federal budget, it is done on a long-term plan. I think a fear would be that we wouldn't want that to set down the benchmarks for the preceding years, you know, if the VA were to project next year and three or four years beyond that as dollar figures.

You know, what we have seen with advanced appropriations now that raises some concerns is the VA projects a number for advanced appropriations and very little change occurs in the next year when we are looking at it in that current year——

Mr. MICHAUD. No, that is not what I am asking for money. I am talking about a plan.

For instance, if you look at the aging population of veterans, Vietnam veterans, for instance, and you look at the budget, there is actually a decrease in State veterans' homes reimbursement rate. So the long-term plan, five, ten, twenty years down the road, is there is going to be more need for long-term health care. When you look at five, ten, twenty years down the road, more of the soldiers coming back from Iraq and Afghanistan that has traumatic brain injury or PTSD, prosthetic issues, probably will increase.

I am not talking about setting a budget to it beyond the two years. I am talking about a plan beyond the two years because that plan—the budget might say, well, we are going to do a transformational and here is what it is going to be for the next two years, but the third year out, they plan to have a huge increase in their budget because that is the implementation of it, so I am not talking about the budget. I am talking about a plan of where they plan on going.

Mr. KELLEY. I would say that VA already does that to some extent especially with their capital infrastructure, which does take into account where veterans are going to live, how many of them are going to be migrating from one area to another, what specialty needs they may need, and I think they do that.

Could it be expanded, should it be reported? I would be happy to discuss that.

Mr. CELLI. We are certainly proponents of prior planning, of course, we just wouldn't want to see a situation, as brought up by our colleague where the tail is wagging the dog, where in future years we need a service or we need some additional support that wasn't in the plan and then we are now afraid to introduce it because it wasn't pre-thought of.

Mr. BENISHEK. I would like to thank you all for being here today.

There is going to be further written questions from the Committee to you all and we will look forward to those answers and I personally look forward to you coming to me and bringing forth some of these questions you may not have wanted to testify too much about today.

But you are all now excused. I would like to reiterate my thanks to all of today's witnesses, especially Secretary Shinseki for being with us today, and I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material, and without objection, so ordered.

The hearing is now adjourned.

[THE STATEMENT OF HON. JACKIE WALORSKI APPEARS IN THE APPENDIX]

[Whereupon, at 12:24 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

This hearing will come to order. Good morning everyone. Welcome to our hearing on the President's Fiscal Year 2014 budget request for the Department of Veterans Affairs. As everyone knows, this budget is a couple of months late and comes after the House and Senate have both passed their respective budget resolutions. Unfortunately, this budget is too late to influence that process. However, we do have appropriations and authorization work coming up, so our oversight on this request is still very important.

Mr. Secretary, welcome. Committee Members have had less than 24 hours to review some of the details associated with the budget request in advance of this hearing. It is therefore likely that we'll have numerous follow-up questions after we have had the chance to take a closer look at those details. With that said, I appreciate your attendance today and ask for your cooperation in getting timely responses back to the many questions we will undoubtedly have.

My initial reaction to the budget request is mixed. On the one hand, a proposed 4.3 percent increase in discretionary spending amidst stagnant or declining budget requests for other agencies, most of which have, unlike VA, absorbed sequester cuts, demonstrates that VA funding is clearly a priority in a tight fiscal climate. On the other hand, I'm concerned that we're not seeing the results for all the money Congress has provided VA over the years.

For example, the budget proposes a 7.2 percent increase for expanding mental health services. I'm still waiting on information from VA showing that veterans with mental illness are getting healthier with the resources we've already provided. After all, that's the ultimate outcome we're after. Dr. Petzel, I asked that question of you at our mental health hearing two months ago and still we don't have a response.

Then we get into the funding request for the Veterans Benefits Administration – a staggering 13.4 percent increase over the current year – and I'm really at a loss, because the claims processing performance just isn't there. Despite already record high budgets, numerous investments in technology, record numbers of employees available to process claims, the situation is worse today than ever before.

Mr. Secretary, when last year's budget was released VA issued a press release saying that with the funding provided (quote) "By 2013 . . . no more than 40 percent of compensation and pension claims will be more than 125 days old . . . ." Well, here we are, and we're now at over 70 percent of claims being older than 125 days. The same is true for prior budget requests: lofty promises, excitement about new initiatives and technologies, but no results . . . we don't even have a positive trend. VA has missed its own performance goals every single year.

I am tired of the excuses. I understand more claims are being filed and that they're complex . . . but that's been true for decades. And the workload created because of good decisions you made for Agent Orange veterans, Mr. Secretary, Congress provided resources for an IT solution that you requested to help with that effort. And by establishing presumptions for combat Post Traumatic Stress and Gulf War Illness, those claims – most of which would have been filed anyway –should have been *easier* to process, not cited as a contributing cause of perennial failure.

As for the technology improvements, I know many are pinning their hopes on the VBMS system, which we've already spent close to a half-a-billion dollars. We've already had reports of VBMS problems from VA's Inspector General; we also have reports of the system crashing just this week causing all raters to temporarily transition back to the old computer system. But what's worse, I've looked at the backlog numbers for the Regional Offices where VBMS went live by the end of 2012, and 14 of the 18 offices have a higher percentage of backlogged cases now than when VBMS came online. The other four have seen marginal improvement, but it's nowhere close to where it needs to be.

I have been outspoken in my efforts to protect VA funding. We worked for over a year to ensure VA was exempt from sequestration. I've introduced a bill with the

Ranking Member to advance fund all of VA's budget to protect it from the effects of continuing resolutions or threatened government shutdowns. I'm proud of the efforts this Committee has made to protect VA's resources. But the point of those efforts is to ensure improved benefits and services to America's veterans. And, right now, I'm not seeing improvement in many key areas. I'm seeing the opposite.

Mr. Secretary, we need to see results. We need to see the outcomes the Administration promised with the resources Congress provided. The excuses must stop. I have supported you and your leadership up to this point. I believe the Committee and the Congress has provided you with everything you have asked. It's time to deliver.

I yield to the Ranking Member . . . .

Prepared Statement of Hon. Michael Michaud

Thank you, Mr. Chairman.

Secretary Shinseki, thank you for coming today.

I look forward to your testimony on the funding needs of the VA.

Welcome also to the VSO representatives on our second panel.

This Committee relies on the veterans' community to provide additional insight into the needs of the VA. You help us understand the pressing issues facing veterans and their families.

I especially appreciate the *Independent Budget* you prepare each year.

Mr. Secretary, I applaud the Administration for providing a concrete example of the priority that our Nation gives to veterans.

In a time of austerity, a $2.5 billion increase over FY2013 levels represents the Nation's ongoing commitment to those who have served and sacrificed.

The key question today is: Does this budget give you the resources you need to complete your transformational efforts?

The *Independent Budget* has recommended nearly

$2 billion more than your FY2014 request.

Many of your transformational initiatives will come to fruition in the next year and a half. This includes your goal of eliminating the VA claims backlog by 2015.

So again, does this budget give you the resources you need to complete your transformational efforts – specifically, to achieve eliminating the backlog in 2015?

If the answer is yes, I will work closely with my colleagues on this Committee, and in this Congress, to get you the resources you need.

To whom much is given much will be required.

In a time of forced budget cuts and scarce Federal resources, you have proposed an increase.

With these funds, in these times, comes an increased responsibility to show tangible return-on-investment.

It is imperative, that over the next year, we have open dialogue about the accomplishments and achievements this funding allows you.

There must be robust discussion of the progress you are making toward finalizing VA's transformation. We need hard data and information if we are to share your confidence of success.

Since the advent of advanced appropriations, you have consistently asked for additional funding beyond what was requested and provided.

This year, you are asking for an additional $157.5 million in medical services funding.

To me, this indicates the need for better, more detailed planning and programming.

The process of putting a budget together and making informed policy and program decisions is a fundamental management tool.

As we begin the discussion of providing advance appropriations for all of VA's discretionary accounts, we need to also discuss whether VA has the management processes and infrastructure in place to make strategic decisions that can inform budget estimates far into the future.

I believe we would all like to see a planning, programming and budgeting process that is driven by the long-term, strategic needs of the VA.

It should be one that assists VA leadership, at the very highest levels, to make tough and smart decisions to improve how we provide benefits and services to veterans, and to evaluate the success or failure of efforts over the long run.

You have requested a large increase for Information Technology.

I understand the critical nature of IT spending.

This is especially important within the context of your transformational efforts.

But I want to be assured that we are wisely spending our IT resources.

For example, as part of your proposed increase you have requested $251 million to "fund the required development activities within the iEHR Interagency Program Office (IPO)."

In light of the recent decision by DoD and VA regarding the integrated electronic health record, is this funding still required? Would these resources be better spent to support your claims backlog initiative?

I would like to mention an Administration proposal I oppose.

The Administration's budget includes a proposal to utilize what is called a "chained-CPI" in place of the current method of calculating inflation.

The Administration believes that this will result in a $44 million dollar in savings over 5 years and $230 million over ten years.

I line up with our veterans' groups and our seniors in opposing this proposal.

I am not convinced that it is a sounder manner in which to calculate inflation.

I believe it would have a real and damaging effect on many of our most vulnerable citizens – including veterans and their families.

This Nation is committed to its veterans.

This budget reflects that commitment.

I stand with you, as part of this Nation's government, committed to delivering on that commitment.

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

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman and Ranking Member, it's an honor to serve on this Committee.

I would like to thank you for holding this hearing, and I would also like to thank the Secretary and the veteran organizations appearing before the Committee today.

Yesterday, the President unveiled his Fiscal Year 2014 Budget. The Budget highlights issues this Committee has tirelessly advocated to improve.

This being said, Mr. Chairman, I agree that increased funding must produce greater access to quality care. The Department of Veterans Affairs has greatly improved the services it provides, but there is still much more work to be done.

We owe it to these men and women who have served and their families to ensure they are receiving treatment that thoroughly addresses their individual and unique needs.

I look forward to working with my colleagues and our panelists, today, to ensure the funding for the Department of Veterans Affairs will be used to increase access for care and improve services.

Thank you.

Prepared Statement of Hon. Eric K. Shinseki

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

Thank you for the opportunity to present the President's 2014 Budget and 2015 advance appropriations requests for the Department of Veterans Affairs (VA). This budget continues the President's historic initiatives and strong budgetary support and will have a positive impact on the lives of Veterans, their families, and survivors. We value the unwavering support of the Congress in providing the resources and legislative authorities needed to care for our Veterans and recognize the sacrifices they have made for our Nation.

The current generation of Veterans will help to grow our middle class and provide a return on the country's investments in them. The President believes in Veterans and their families, believes in providing them the care and benefits they've earned, and knows that by their service, they and their families add strength to our Nation.

Twenty-two million living Americans today have distinguished themselves by their service in uniform. After a decade of war, many Servicemembers are returning and making the transition to Veterans status. The President's 2014 Budget for VA requests $152.7 billion – comprised of $66.5 billion in discretionary funds, including medical care collections, and $86.1 billion in mandatory funds. The discretionary request reflects an increase of $2.7 billion, 4.3 percent above the 2013 level. Our 2014

budget will allow VA to operate the largest integrated healthcare system in the country, with more than 9.0 million Veterans enrolled to receive healthcare; the ninth largest life insurance provider, covering both active duty members as well as enrolled Veterans; an education assistance program serving over 1 million students; a home mortgage service that guarantees over 1.5 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter about 121,000 Veterans and family members in 2014.

Priority Goals

Over the next few years, more than one million Veterans will leave military service and transition to civilian life. VA must be ready to care for them and their families. Our data shows that the newest of our country's Veterans are relying on VA at unprecedented levels. Through January 31, 2012, of the approximately 1.58 million Veterans who returned from Operations Enduring Freedom, Iraqi Freedom, and New Dawn, at least 62 percent have used some VA benefit or service.

VA's top three priorities – increase access to VA benefits and services; eliminate the disability compensation claims backlog in in 2015; and end Veterans homelessness, also in 2015 – anticipate these changes and identify the performance levels required to meet emerging needs. These ambitious goals will take steady focus and determination to see them through. As we enter the critical funding year for VA's priority goals, this 2014 budget builds upon our multi-year effort to position the Department through effective, efficient, and accountable programming and budget execution for delivering claims and homeless priority goals.

Stewardship of Resources

Safeguarding the resources – people, money, time – entrusted to us by the Congress, managing them effectively, and deploying them judiciously, is a fundamental duty. Effective stewardship requires an unflagging commitment to use resources efficiently with clear accounting rules and procedures, to safeguard, train, motivate, and hold our workforce accountable, and to assure the effective use of time in serving Veterans on behalf of the American people. Striving for excellence in stewardship of resources is a daily priority. At VA, we are ever attentive to areas in which we need to improve our operations, and are committed to taking swift corrective action to eliminate any financial management practice that does not deliver value for Veterans.

VA's stewardship of resources begins at headquarters. Recognizing the very difficult fiscal constraints facing our country, the 2014 request includes a 5.0 percent reduction in the Departmental Administration budget from the 2013 enacted level. This reduction follows a headquarters freeze in the 2013 President's Budget—a two-year commitment.

Recent audits of the Department's financial statements have certified VA's success in remediating all three of our remaining material weaknesses in financial management, which had been carried forward for over a decade. In terms of internal controls and fiscal integrity, this was a major accomplishment. In the past four years, we have also dramatically reduced the number of significant financial deficiencies from 16 to 1.

At VA, we believe that part of being responsible stewards is shutting down information technology (IT) projects that are no longer performing. Developed by our Office of Information and Technology, the Project Management Accountability System (PMAS) requires IT projects to establish milestones to deliver new functionality to its customers every 6 months. Now entering its third year, PMAS continues to instill accountability and discipline in our IT organization. Through PMAS, the cumulative, on-time delivery of IT functionality since its inception is 82 percent, a rate unheard of in the industry where, by contrast, the average is 42 percent. By implementing PMAS, we have achieved at least $200 million in cost avoidance by shutting down or improving the management of 15 projects.

Through the effective management of our acquisition resources, VA has achieved savings of over $200 million by participating in Federal strategic sourcing programs and establishing innovative IT acquisition contracts. In 2012, VA led the civilian agencies in contracting with Service-Disabled Veteran-Owned Small Businesses, which, at $3.4 billion, accounted for 19.3 percent of all VA procurement awards. In addition, we have reduced interest penalties for late payments by 19 percent (from $47 to $38 per million) over the past four years.

Finally, VA's stewardship achieved savings in several other areas across the Department. The National Cemetery Administration (NCA) assumed responsibility in 2009 for processing First Notices of Death to terminate compensation benefits to de-

ceased Veterans. Since taking on this responsibility, NCA has advised families of the burial benefits available to them, assisted in averting overpayments of some $142 million in benefit payments and, thereby, helped survivors avoid possible collections. In addition, we implemented the use of Medicare pricing methodologies at the Veterans Health Administration (VHA) to pay for fee-basis services, resulting in savings of over $528 million since 2012 without negatively impacting Veteran care and with improved consistency in billing and payment.

Technology

To serve Veterans as well as they have served us, we are working on delivering a 21st century VA that provides medical care, benefits, and services through a digital infrastructure. Technology is integrated with everything we do for Veterans. Our hospitals use information technology to properly and accurately distribute and deliver prescriptions/medications to patients, track lab tests, process MRI and X-ray imaging, coordinate consults, and store medical records. VA IT systems supported over 1,300 VA points of healthcare in 2012: 152 medical centers, 107 domiciliary rehabilitation treatment programs, 821 community-based outpatient clinics, 300 Vet Centers, 6 independent outpatient clinics, 11 mobile outpatient clinics, and 70 mobile Vet Centers. Technology supports Veterans' education and disability claims processing, claims payments, home loans, insurance, and memorial services. Our IT infrastructure consists of telephone lines, data networks, servers, workstations, printers, cell phones, and mobile applications.

No Veteran should have to wait months or years for the benefits that they have earned. We will eliminate the disability claims backlog in 2015; technology is the critical component for achieving our goal. VA is deploying technology solutions to improve access, drive automation, reduce variance, and enable faster and more efficient operations. Building on the resources Congress has provided in recent years to expand our claims processing capacity, the 2014 budget requests $291 million for technology to eliminate the claims backlog? $155 million in Veterans Benefits management System (VBMS) for our new paperless processing system, and $136 million in the Veterans Benefits Administration (VBA) to support a Veterans Claims Intake Program, our new online application system that will allow for the conversion of paper to digital images for our new paperless processing system, the Veterans Benefits Management System (VBMS). Without these resources, VA will be unable to meet its goal to eliminate the disability claims backlog in 2015.

Information Technology

At VA, advances in technology—and the adoption of and reliance on IT in our daily commercial life—have been dramatic. Technology is integral to providing high quality healthcare and benefits. The 2014 budget requests $3.683 billion for IT, an increase of $359 million from the President's 2013 Budget, reflecting the critical role technology plays in VA's daily work in serving and caring for Veterans and their families. Of the total request, $2.2 billion will support the operation and maintenance of our digital infrastructure and $495 million is for IT development modernization and enhancement projects.

The 2014 budget includes $32.8 million for development of VBMS, our new paperless processing system that enables VA to move from its current paper-based process to a digital operating environment that improves access, drives automation, reduces variance, and enables faster, more efficient operations. As we increase claims examiners' use of VBMS version 4.2 to process rating disability claims, our major focus is on system performance, as we tune the system to be responsive and effective. VA will complete the rollout of VBMS in June 2013.

In addition, the 2014 budget includes $120 million for development of the Veterans Relationship Management (VRM) initiative, which enhances Veterans' access to comprehensive VA services and benefits, especially in the delivery of compensation and pension claims processing. The program gives Veterans secure, personalized access to benefits and information and allows a timely response to their inquiries. Recently, VRM released Veterans Online Application Direct Connect (VDC), which enables Veterans to apply for VBA benefits by answering guided interview questions through the security of the eBenefits portal. Claims filed through eBenefits use VDC to load information and data directly into VBMS.

The Virtual Lifetime Electronic Record (VLER) is an overarching program which aims to share health, benefits, and administrative information, including personnel records and military history records, among DoD, VA, SSA, private healthcare providers, and other Federal, State and local government partners. eBenefits is already reaching 2 million Veterans and Servicemembers and 1 million active users with BlueButton. The 2014 budget requests $15.4 million for VLER to develop and sup-

port these functions as well as the Warrior Support Veterans Tracking Application; the Disability Benefits Questionnaires; a VA/DoD joint health information sharing project known as Bidirectional Health Information Exchange; and a storage interface known as Clinical Data Repository/Health Data Repository. All of these efforts are designed to enable the sharing of health, military personnel and personal information among VA, other Federal agencies, Veteran Service Organizations and private health care providers to expedite the award and processing of disability claims and other services such as education, training and job placement.

Eliminating the Claims Backlog

Too many Veterans wait too long to receive benefits they have earned. This is unacceptable. Today's claims backlog is the result of several factors, including: increased demand; over a decade of war with many Veterans returning with more severe, complex injuries; decisions on Agent Orange, Gulf War, and combat PTSD presumptions; and, successful outreach to Veterans informing them of their benefits. These facts, in no way, diminish the urgency that we all feel at VA to fix this problem which has been decades in the making. VA remains focused on eliminating the disability claims backlog in 2015 and processing all claims within 125 days at a 98-percent accuracy level.

To deliver this goal, the Veterans Benefits Administration (VBA) is implementing a comprehensive transformation plan based on more than 40 targeted initiatives to boost productivity by over the next several years However, as VBA transforms its people, processes, and technologies, its claims demand is expected to exceed on million annually. From 2010 through 2012, for the first time in its history, VBA processed more than one million claims in three consecutive years. In 2013, VBA expects to receive another million claims and similar levels of demand are anticipated in 2014. This is driven by successful outreach, claims growth not previously captured in VBA's baseline, and new requirements. Included are mandatory Servicemember participation in VOW/VEI benefits briefings and an expected increase upon successful completion of a transition assistance program, revamped by the President as Transition: Goals, Plan, Success (GPS). As more than one million troops leave service over the next 5 years, we expect our claims workload to continue to rise. In addition, VBA is experiencing an unprecedented workload growth arising from the number and complexity of medical conditions in Veterans' compensation claims. The average number of claimed conditions for our recently separated Servicemembers is now in the 12 to 16 range – roughly 5 times the number of disabilities claimed by Veterans of earlier eras. While the increase in compensation applications presents challenges, it is also an indication that we are being successful in our efforts to expand access to VA benefits.

Investments in transformation of our people, processes, and technologies are already paying off in terms of improved performance. For example:

- **People:** More than 2,100 claims processors have completed Challenge Training, which improves the quality and productivity of VBA compensation claims decision makers. As a result of Challenge Training, VBA's new employees complete more claims per day than their predecessors – with a 30 percent increase in accuracy.

VBA's new standardized organizational model incorporates a case-management approach to claims processing that organizes its workforce into cross-functional teams that work together on one of three segmented lanes: express, special operations, or core. Claims that predictably can take less time will flow through an express lane (30 percent); those taking more time or requiring special handling will flow through a special operations lane (10 percent); and the rest of the claims flow through the core lane (60 percent). Initially planned for deployment throughout 2013, VBA accelerated the implementation of the new organizational model by nine months due to early indications of its positive impact on performance.

VBA instituted Quality Review Teams (QRTs) in 2012 to improve employee training and accuracy while decreasing rework time. QRTs focus on improving performance on the most common sources of error in the claims processing cycle. Today, for example, QRTs are focused on the process by which proper physical examinations are ordered; incorrect or insufficient exams previously accounted for 30 percent of VBA's error rate. As a result of this focus, VBA has seen a 23 percent improvement in this area.

- **Process:** Disability Benefits Questionnaires (DBQs) are online forms used by non-VA physicians to submit medical evidence. Use of DBQs has improved timeliness and accuracy of VHA-provided exams – average processing time improved by 6 days from June 2011 to October 2012 (from 32 to 26 days).

Fully developed claims (FDCs) are critical to reducing "wait time" and "rework." FDCs include all DoD service medical and personnel records, including entrance and exit exams, applicable DBQs, any private medical records, and a fully completed claim form. Today, VBA receives 4.5 percent of claims in fully developed form and completes them in 117 days, while a regular claim takes 262 days to process. Fulfilling the Veterans Claims Assistance Act, to search for potential evidence, is the greatest portion of the current 262-day process. The Veterans Benefit Act of 2003 allows Veterans up to 365 days, from the date of VA notice for additional information or evidence, to provide documentation. Of the 262 days to complete a regular claim, approximately145 days are spent waiting for potential evidence to qualify the application as a fully developed claim.

VBA built new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. Rules-based calculators provide suggested evaluations for certain conditions using objective data and rules-based functionality. The Evaluation Builder uses a series of check boxes that are associated with the Veteran's symptoms to help determine the proper diagnostic code of over 800 codes, as well as the appropriate level of compensation based on the Veteran's symptoms.

- **Technology:** The centerpiece of VBA's transformation plan is VBMS – a new paperless electronic claims processing system that employs rules-based technology to improve decision speed and accuracy. For our Veterans, VBMS will mean faster, higher-quality, and more consistent decisions on claims. Our strategy includes active stakeholder participation (Veterans Service Officers, State Departments of Veterans Affairs, County Veterans Service Officers, and Department of Defense) to provide digital electronic files and claims pre-scanned through online claims submission via the eBenefits Web portal.
- VBA recently established the Veterans Claims Intake Program (VCIP). This program will streamline processes for receiving records and data into VBMS and other VBA systems. Scanning operations and the transfer of Veteran data into VBMS are primary intake capabilities that are managed by VCIP. As VBMS is deployed to additional regional offices, document scanning becomes increasingly important as the main mechanism for transitioning from paper-based claim folders to the new electronic environment.

There are other ways that VA is working to eliminate the claims backlog. VHA has implemented multiple initiatives to expedite timely and efficient delivery of medical evidence needed to process a disability claim by VBA. As a result, timeliness improved by nearly one-third, from an average of 38 days in January 2011 to 26 days in October 2012. Recently, VA launched Acceptable Clinical Evidence (ACE), an initiative that allows clinicians to review existing medical evidence and determine whether they can use that evidence to complete a DBQ without requiring the Veteran to report for an in-person examination. This initiative was developed by both VHA and VBA in a joint effort to provide a Veteran-centric approach for disability examinations. Use of the ACE process opens the possibility of doing assessments without an in-person examination when there is sufficient information in the record.

Another way to eliminate the claims backlog is by working closely with the DoD. The Integrated Disability Evaluation System (IDES) is a collaborative system to make disability evaluations seamless, simple, fast and fair. If the Service member is found medically unfit for duty, the IDES gives them a proposed VA disability rating before they leave the service. These ratings are normally based on VA examinations that are conducted using required IDES examination templates. In FY 2012, IDES participants were notified of VA benefit entitlement in an average of 54 days after discharge. This reflects an improvement from 67 days in May 2012 to 49 days in September 2012.

The Benefits Delivery at Discharge (BDD) and Quick Start programs are two other collaborations for Servicemembers to file claims for service-connected disabilities. This can be done from 180 to 60 days prior to separation or retirement. BDD claims are accepted at every VA Regional Office and at intake sites on military installations in the U.S., and at two intake site locations overseas. In 2012, BDD received more than 30,300 claims and completed 24,944—a 14% increase over 2011's productivity (21,657). During this same period of time Quick Start decreased their rating inventory by over 44 percent.

Expanding Access to Benefits and Services

VA remains committed to ensuring that Veterans are not only aware of the benefits and services that they are entitled to, but that they are able to access them. We are improving access to VA services by opening new or improved facilities closer to where Veterans live. Since 2009, we have added 57 community-based outpatient clinics (CBOCs), for a total of 840 CBOCs through 2013, and increased the number of mobile outpatient clinics and mobile Vet Centers, serving rural Veterans, to 81. Last August, we opened a state-of-the-art medical center in Las Vegas, the first new VAMC in 17 years. The 2014 medical care budget request includes $799 million to open new and renovated healthcare facilities and includes the authorization request for 28 new and replacement medical leases to increase Veteran access to services.

Today, access is much more than the ability to walk into a VA medical facility; it also includes technology, and programs, as well as, facilities. Expanding access includes taking the facility to the Veteran—be it virtually through telehealth, by sending Mobile Vet Centers to rural areas where services are scarce, or by using social media sites like Facebook, Twitter, and YouTube to connect Veterans to VA benefits and facilities. Telehealth is a major breakthrough in healthcare delivery in 21st century medicine, and is particularly important for Veterans who live in rural and remote areas. The 2014 budget requests $460 million for telehealth, an increase of $388 million, or 542 percent, since 2009.

As more Veterans access our healthcare services, we recognize their unique needs and the needs of their families—many have been affected by multiple, lengthy deployments. VA provides a comprehensive system of high-quality mental health treatment and services to Veterans. We are using many tools to recruit and retain our large mental healthcare workforce to better serve Veterans by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capabilities. In response to increased demand over the last four years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that Veterans can more readily access them. Since 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from over 927,000 to more than 1.3 million in 2012, partly due to proactive screening. Outpatient visits have increased from 14 million in 2009 to over 17 million in 2012. VA believes that mental healthcare must constantly evolve and improve as new knowledge becomes available through research.

The 2014 budget includes $168.5 million for the Veterans Relationship Management (VRM) initiative, which is fundamentally transforming Veterans' access to VA benefits and services by empowering VA clients with new self-service tools. VA has already made major strides under this initiative. Most recently, in November 2012, VRM added new features to eBenefits, a Web application that allows Veterans to access their VA benefits and submit some claims online. Veterans can now enroll in and manage their insurance policies, select reserve retirement benefits, and browse the Veterans Benefits Handbook from the eBenefits Website. With the help of Google mapping services, the update also enables Veterans to find VA representatives in their area and where they are located. Since its inception in 2009, eBenefits has added more than 45 features allowing Veterans easier, quicker, and more convenient access to their VA benefits and personal information.

VBA has aggressively promoted eBenefits and the ease of enrolling into the system. We currently have over 2.5 million registered eBenefits users. Users can check the status of claims or appeals, review VA payment history, obtain military documents, and perform numerous other benefit actions through eBenefits. The Stakeholder Enterprise Portal (SEP) is a secure Web-based access point for VA's business partners. This electronic portal provides the ability for VSOs and other external VA business partners to represent Veterans quickly and efficiently.

VA also continues to increase access to burial services for Veterans and their families through the largest expansion of its national cemetery system since the Civil War. At present, approximately 90 percent of the Veteran population—about 20 million Veterans—has access to a burial option in a national, state, or tribal Veterans cemetery within 75 miles of their homes. In 2004, only 75 percent of Veterans had such access. This dramatic increase is the result of a comprehensive strategic planning process that results in the most efficient use of resources to reach the greatest number of Veterans.

Ending Veteran Homelessness

The last of our three priority goals is to end homelessness among Veterans in 2015. Since 2009, we have reduced the estimated number of homeless Veterans by more than 17 percent. The January 2012 Point-In-Time estimate, the latest avail-

able, is 62,619. We have also created a National Homeless Veterans Registry to track our known homeless and at-risk populations closely to ensure resources end up where they are needed. In 2012, over 240,000 homeless or at-risk Veterans accessed benefits or services through VA and 96,681 homeless or at –risk Veterans were assessed by VHA's homeless programs. Over 31,000 homeless and at-risk Veterans and their families obtained permanent housing through VA specialized homeless programs.

In the 2014 budget, VA is requesting $1.393 billion for programs to assist homeless Veterans, through programs such as Department of Housing and Urban Development-VASupportive Housing (HUD–VASH), Grant and Per Diem, Homeless Registry, and Health Care for Homeless Veterans. This represents an increase of $41 million, or 3 percent over the 2013 enacted level. This budget will support our long-range plan to end Veteran homelessness by emphasizing rescue and prevention—rescue for those who are homeless today, and prevention for those at risk of homelessness.

Our prevention strategy includes close partnerships with some 150 community non-profits through the Supportive Services for Veteran Families (SSVF) program; SSVF grants promote housing stability among homeless and at-risk Veterans and their families. The grants can have an immediate impact, helping lift Veterans out of homelessness or providing aid in emergency situations that put Veterans and their families at risk of homelessness. In 2012, we awarded $100 million in Supportive Service grants to help Veterans and families avoid life on the streets. We are currently reviewing proposals for the $300 million in grants we will distribute later this year. In 2012, SSVF resources directly helped approximately 21,000 Veterans and over 35,000 household members, including nearly 9,000 children. This year's grants will help up to 70,000 Veterans and family members avoid homelessness. The 2014 budget includes $300 million for SSVF.

To increase homeless Veterans' access to benefits, care, and services, VA established the National Call Center for Homeless Veterans (NCCHV). The NCCHV provides homeless Veterans and Veterans at-risk for homelessness free, 24/7 access to trained counselors. The call center is intended to assist homeless Veterans and their families, VA medical centers, federal, state and local partners, community agencies, service providers, and others in the community. Family members and non-VA providers who call on behalf of homeless Veterans are provided with information on VA homeless programs and services. In 2012, the National Call Center for Homeless Veterans received 80,558 calls (123 percent increase) and the center made 50,608 referrals to VA medical centers (133 percent increase).

VA's Homeless Patient Aligned Care Teams (H–PACTs) program provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. The program integrates clinical care with delivery of social services and enhanced access and community coordination. Implementation of this model is expected to address health disparity and equity issues facing the homeless population. Expected program outcomes include reduced emergency department use and hospitalizations, improved chronic disease management, and improved "housing readiness" with fewer Veterans returning to homelessness once housed.

During 2012, 119,878 unique homeless Veterans were served by the Health Care for Homeless Veterans Program (HCHV), an increase of more than 21 percent from 2011. At more than 135 sites, HCHV offers outreach, exams, treatment, referrals, and case management to Veterans who are homeless and dealing with mental health issues, including substance use. Initially serving as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for myriad housing and other services that provide VA with a way to outreach and assist homeless Veterans by offering them entry to VA medical care.

VA's Homeless Veterans Apprenticeship Program was established in 2012—a 1-year paid employment training program for Veterans who are homeless or at risk of homelessness. This program created paid employment positions as Cemetery Caretakers at five of our 131 national cemeteries. The initial class of 21 homeless Veterans is simultaneously enrolled in VHA's Homeless Veterans Supported Employment program. Apprentices who successfully complete 12 months of competency-based training will be offered permanent full-time employment at a national cemetery. Successful participants will receive a Certificate of Competency which can also be used to support employment applications in the private sector.

Another avenue of assistance is through Veterans Treatment Courts, which were developed to avoid unnecessary incarceration of Veterans who have developed mental health problems. The goal of Veterans Treatment Courts is to divert those with mental health issues and homelessness from the traditional justice system and to give them treatment and tools for rehabilitation and readjustment. While each Vet-

erans Treatment Court is part of the local community's justice system, they form close working partnerships with VA and Veterans' organizations. As of early 2012 there are 88 Courts.

The Veterans Justice Outreach (VJO) program exists to connect these justice-involved Veterans with the treatment and other services that can help prevent homelessness and facilitate recovery, whether or not they live in a community that has a Veterans Treatment Court. Each VA Medical Center has at least one designated justice outreach specialist who functions as a link between VA, Veterans, and the local justice system. Although VA cannot treat Veterans while they are incarcerated, these specialists provide outreach, assessment and linkage to VA and community treatment, and other services to both incarcerated Veterans and justice-involved Veterans who have not been incarcerated.

Multi-Year Plan for Medical Care Budget

Under the Veterans Health Care Budget Reform and Transparency Act of 2009, which we are grateful to Congress for passing; VA submits its medical care budget that includes an advance appropriations request in each budget submission. The legislation requires VA to plan its medical care budget using a multi-year approach. This policy ensures that VA requirements are reviewed and updated based on the most recent data available and actual program experience.

The 2014 budget request for VA medical care appropriations is $54.6 billion, an increase of 3.7 percent over the 2013 enacted level of $52.7 billion. The request is an increase of $157.5 million above the enacted 2014 advance appropriations level. Based on updated 2014 estimates largely derived from the Enrollee Health Care Projection Model, the requested amount would allow VA to increase funding in programs to eliminate Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; fulfill multiple responsibilities under the Affordable Care Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. Our multi-year budget plan assumes that VHA will carry over negligible unobligated balances from 2013 into 2014 – consistent with the 2013 budget submitted to Congress.

The 2015 request for medical care advance appropriations is $55.6 billion, an increase of $1.1 billion, or 1.9 percent, over the 2014 budget request. Medical care funding levels for 2015, including funding for activations, non-recurring maintenance, and initiatives, will be revisited during the 2015 budget process, and could be revised to reflect updated information on known funding requirements and unobligated balances.

Medical Care Program

The 2014 budget of $57.7 billion, including collections, provides for healthcare services to treat over 6.5 million unique patients, an increase of 1.3 percent over the 2013 estimate. Of those unique patients, 4.5 million Veterans are in Priority Groups 1–6, an increase of more than 71,000 or 1.6 percent. Additionally, VA anticipates treating over 674,000 Veterans from the conflicts in Iraq and Afghanistan, an increase of over 67,000 patients, or 11.1 percent, over the 2013 level. VA also provides medical care to non-Veterans through programs such the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Spina Bifida Health Care Program; this population is expected to increase by over 17,000 patients, 2.6 percent, during the same time period.

The 2014 budget proposes to extend the Administration's current policy to freeze Veterans' pharmacy co-payments at the 2012 rates, until January 2015. Under this policy, which will be implemented in a future rulemaking, co-payments will continue at $8 for Veterans in Priority Groups 2 through 6 and at $9 for Priority Groups 7 through 8.

The 2014 budget requests $47 million to provide healthcare for Veterans who were potentially exposed to contaminated drinking water at Camp Lejeune as required by the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, enacted last August. Since VA began implementation of the law and in January 2013, 1,400 Veterans have contacted us concerning Camp Lejeune. Of these, roughly 1,100 were already enrolled in VA healthcare. Veterans who are eligible for care under the Camp Lejeune authority, regardless of current enrollment status with VA, will not be charged a co-payment for healthcare related to the 15 illnesses or conditions recognized, nor will a third-party insurance company be billed for these services. In 2015, VA expects to start treating family members as authorized under the law and has included $25 million for this purpose within the 2015 advance appropriations request. VA continues a robust outreach campaign to these

Veterans and family members while we press forward with implementing this complex new law.

Mental Healthcare and Suicide Prevention

At VA, we have the opportunity and the responsibility to anticipate the needs of returning Veterans. Mental healthcare at VA is a system of comprehensive treatments and services to meet the individual mental health needs of Veterans. VA is expanding mental health programs and is integrating mental health services with primary and specialty care to provide better coordinated care for our Veteran patients. Our 2014 budget provides nearly $7.0 billion for mental healthcare, an increase of $469 million, or 7.2 percent, over 2013. Since 2009, VA has increased funding for mental health services by 56.9 percent. VA provided mental health services to 1,391,523 patients in 2012, 58,000 more than in 2011.

To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and is increasing the number of staff in support of mental health services. Consistent with the President's August 31, 2012 Executive Order, VHA is on target to complete the goal of hiring 1,600 additional mental health clinical providers and 300 administrative support staff by June 30, 2013 to meet the growing demand for mental health services. In addition, as part of VA's efforts to implement the Caregivers and Veterans Omnibus Health Services Act of 2010, VA has hired over 100 Peer Specialists in recent months, and is hiring and training nearly 700 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams.

In addition to hiring more mental health workers, VA is developing electronic tools to help VA clinicians manage the mental health needs of their patients. Clinical Reminders give clinicians timely information about patient health maintenance schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, Clinical Reminders prompt the clinician to follow-up with the Veteran.

Since its inception in 2007, the Veterans Crisis Line in Canandaigua, New York, has answered over 725,000 calls and responded to more than 80,000 chats and 5,000 texts from Veterans in need. In the most serious calls, approximately 26,000 men and women have been rescued from a suicide in progress because of our intervention—the equivalent of two Army divisions.

We recently completed a 2012 VA suicide data report, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. We are working hard to understand this issue—and VA and DoD have jointly funded a $100 million suicide research project. We will be better informed about suicides, but while research is ongoing, we are taking immediate action and are not waiting 10 years for final study outcomes. These actions include Veterans Chat on the Veterans Crisis Line, local Suicide Prevention Coordinators' for counseling and services, and availability of VA/DoD Suicide Outreach resources.

The Affordable Care Act

The Affordable Care Act (ACA) expands access to coverage, reins in health care costs, and improves the Nation's health care delivery system. The Act has important implications for VA. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions to make coverage more affordable. The 2014 budget requests $85 million within the Medical Care request and $3.4 million within the Information Technology request to fulfill multiple responsibilities as a provider of Minimum Essential Coverage under the Affordable Care Act, including: (1) providing outreach and communication on ACA to Veterans related to VA health care; (2) reporting to Treasury on individuals who are enrolled in the VA healthcare system; and (3) providing a written statement to each enrolled Veteran about their coverage by January 2015.

Medical Care in Rural Areas

VA remains committed to the delivery of medical care in rural areas of our country. For that reason, in 2012, we obligated $248 million to support the efforts of the Office of Rural Health to improve access and quality of care for enrolled Veterans who live in rural areas. Some 3.4 million Veterans enrolled in the VA healthcare system live in rural or highly rural areas of the country; this represents about 41 percent of all enrolled Veterans. For that reason, VA will continue to emphasize

rural health in our budget planning, including addressing the needs of American Indian and Alaska Native (AI/AN) Veterans.

VA is committed to expanding access to the full range of VA programs to eligible AI/AN Veterans. Last year, VA signed a Memorandum of Agreement with the Indian Health Service (IHS), through which VA will reimburse IHS for direct care services provided to eligible American Indian and Alaska Native Veterans. While the national agreement applies only to VA and IHS, it will inform agreements negotiated between the VA and tribal health programs.

This follows the agreement already in place between VA and IHS whereby nearly 250,000 patients served by IHS have utilized a prescription program that allows IHS pharmacies to use VA's Consolidated Mail Outpatient Pharmacy (CMOP) to process and mail prescription refills for IHS patients. By accessing the service, IHS patients can now have their prescriptions mailed to them, in many cases eliminating the need to pick them up at an IHS pharmacy.

Women Veterans Medical Care

Changing demographics are also driving change at VA. Today, we have over 2.2 million women Veterans in our country; they are the fastest growing segment of our Veterans' population. Since 2009, the number of women Veterans enrolled in VA healthcare increased by almost 22 percent, to 591,500. However, by 2022—less than a decade from now—their number is projected to spike to almost 2.5 million, and an estimated 900,000 will be enrolled in VA healthcare.

The 2014 budget requests $422 million, an increase of 134 percent since 2009, for gender-specific medical care for women Veterans. Since 2009, we have invested $25.5 million in improvements to women Veterans' clinics and opened 19 new ones. Today, nearly 50 percent of our facilities have comprehensive women's clinics, and every VA healthcare system has designated women's health primary care providers, and has a women Veteran's program manager on staff.

In 2012, VA awarded 32 grants totaling $2 million to VA facilities for projects that will improve emergency healthcare services for women Veterans, expand women's health education programs for VA staff, and offer telehealth programs to female Veterans in rural areas. These new projects will improve access and quality of critical healthcare services for women. This is the largest number of one-year grants VA has ever awarded for enhancing women's health services.

Medical Research

Medical Research is being supported with $586 million in direct appropriations in 2014, with an additional $1.3 billion in funding support from VA's medical care program and through Federal and non-Federal grants. VA Research and Development will support 2,224 projects during 2014.

Projects funded in 2014 will be focused on supporting development of New Models of Care, identifying or developing new treatments for Gulf War Veterans, improving social reintegration following traumatic brain injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of post-traumatic stress disorder and mild traumatic brain injury, and advancing genomic medicine.

The 2014 budget continues support for the Million Veteran Program (MVP), an unprecedented research program that advances the promises of genomic science. The MVP will establish a database, used only by authorized researchers in a secure manner, to conduct health and wellness studies to determine which genetic variations are associated with particular health issues – potentially helping the health of America's Veterans and the general public. MVP recently enrolled its 100,000th volunteer research participant, and by the end of 2013, the goal is to enroll at least 150,000 participants in the program.

Veterans Benefits Administration

The 2014 budget request of $2.455 billion for VBA, an increase of $294 million in discretionary funds from the 2013 enacted level, is vital to the transformation strategy that drives our performance improvements focused most squarely on the backlog.

Virtually all 860,000 claims in the VBA inventory, including the 600,000 claims that have been at VA for over 125 days and are considered backlogged, exist only in paper. Our transition to VBMS and electronic claims processing is a massive and crucial phase in VBA transformation. VA awarded two VCIP contracts in 2012 to provide document conversion services that will populate the electronic claims folder, or eFolder, in VBMS with images and data extracted from paper and other source material. Without VCIP, we cannot populate the eFolder on which the VBMS sys-

tem relies. The 2014 request for $136 million for our scanning services contracts will ensure that we remain on track to reach this key goal. In addition, the budget request includes $4.9 million for help desk support for Veterans using the Veterans On-Line Application/eBenefits system.

VBA projects a beneficiary caseload of 4.6 million in 2014, with more than $70 billion in compensation and pension benefits obligations. We expect to process 1.2 million compensation claims in 2014, and we are pursuing improvements that will enable us to meet the emerging needs of Veterans and their families.

Veterans Employment

Under the leadership of President Obama, VA, DoD, the Department of Labor, and the entire Federal government have made Veterans employment one of their highest priorities. In August 2011, the President announced his comprehensive plan to address this issue and to ensure that all of America's Veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce. He created a new DoD–VA Employment Initiative Task Force that would develop a new training and services delivery model to help strengthen the transition of our Veteran Servicemembers from military to civilian life. VA has worked closely with other partners in the Task Force to identify its responsibilities and ensure delivery of the President's vision. On November 21, 2012, the effective date of the VOW Act, VA began deployment of the enhanced VA benefits briefings under the revised Transition Assistance Program (TAP), called Transition GPS (Goals, Plans, Success). VA will also provide training for the optional Technical Training Track Curriculum and participate in the Capstone event, which will ensure that separating Servicemembers have the opportunity to verify that they have met Career Readiness Standards and are steered to the resources and benefits available to them as Veterans. Accordingly, the 2014 budget requests $104 million to support the implementation of Transition GPS and meet VA's responsibilities under the VOW Act and the President's Veterans Employment Initiative.

Veterans Job Corps

In his State of the Union address in 2012, President Obama called for a new Veterans Job Corps initiative to help our returning Veterans find pathways to civilian employment. The 2014 budget includes $1 billion in mandatory funding to develop a Veterans Job Corps conservation program that will put up to 20,000 Veterans back to work over the next five years protecting and rebuilding America. Jobs will include park maintenance projects, patrolling public lands, rehabilitating natural and recreational areas, and administrative, technical, and law enforcement-related activities. Additionally, Veterans will help make a significant dent in the deferred maintenance of our Federal, State, local, and tribal lands including jobs that will repair and rehabilitate trails, roads, levees, recreation facilities and other assets. The program will serve all Veterans, but will have a particular focus on post-9/11 Veterans.

Post 9–11 and other Education Programs

Since 2009, VA has provided over $25 billion in Post-9/11 GI Bill benefits to cover the education and training of more than 893,000 Servicemembers, Veterans, family members, and survivors. We are now working with Student Veterans of America to track graduation and training completion rates.

The Post-9/11 GI Bill continues to be a focus of VBA transformation as it implements the Long-Term Solution (LTS). At the end of February we had approximately 60,000 education claims pending, 70 percent lower than the total claims pending the same time last year. The average days to process Post-9/11 GI Bill supplemental claims has decreased by 17 days, from 23 days in September 2012 to 6 days in February 2013. The average time to process initial Post-9/11 GI Bill original education benefit claims in February was 24 days.

National Cemetery Administration

The 2014 budget includes $250 million in operations and maintenance funding for the National Cemetery Administration (NCA). As we move forward into the next fiscal year, NCA projects our workload numbers will continue to increase. For 2014, we anticipate conducting approximately 121,000 interments of Veterans or their family members, maintaining and providing perpetual care for approximately 3.4 million gravesites. NCA will also maintain 9,000 developed acres and process approximately 345,000 headstone and marker applications.

Review of National Cemeteries

For the first time in the 150-year history of national cemeteries, NCA has completed a self-initiated, comprehensive review of the entire inventory of 3.2 million headstones and markers within the 131 national cemeteries and 33 Soldiers' Lots it maintains. The information gained was invaluable in validating current operations and ensuring a sustainment plan is in place to enhance our management practices. The review was part of NCA's ongoing effort to ensure the full and accurate accounting of remains interred in VA national cemeteries. Families of those buried in our national shrines can be assured their loved ones will continue to be cared for into perpetuity.

Veterans Employment

NCA continues to maintain its commitment to hiring Veterans. Currently, Veterans comprise over 74 percent of its workforce. Since 2009, NCA has hired over 400 returning Iraq and Afghanistan Veterans. In addition, 82 percent of contracts in 2012 were awarded to Veteran-owned and service-disabled Veteran-owned small businesses. NCA's committed, Veteran-centric workforce is the main reason it is able to provide a world-class level of customer service. NCA received the highest score—94 out of 100 possible—in the 2010 American Customer Satisfaction Index (ACSI) sponsored by the University of Michigan. This was the fourth time NCA participated and the fourth time it received the top rating in the Nation.

Partnerships

NCA continues to leverage its partnerships to increase service for Veterans and their families. As a complement to the national cemetery system, NCA administers the Veterans Cemetery Grant Service (VCGS). There are currently 88 operational state and tribal cemeteries in 43 states, Guam, and Saipan, with 6 more under construction. Since 1978, VCGS has awarded grants totaling more than $500 million to establish, expand, or improve Veterans' cemeteries. In 2012, these cemeteries conducted over 31,000 burials for Veterans and family members.

NCA works closely with funeral directors and private cemeteries, two significant stakeholder groups, who assist with the coordination of committal services and interments. Funeral directors may also help families in applying for headstones, markers, and other memorial benefits. NCA partners with private cemeteries by furnishing headstones and markers for Veterans' gravesites in these private cemeteries. In January of this year, NCA announced the availability of a new online funeral directors resource kit that may be used by funeral directors nationwide when helping Veterans and their families make burial arrangements in VA national cemeteries.

Capital Infrastructure

A total of $1.1 billion is requested in 2014 for VA's major and minor construction programs. The capital asset budget reflects VA's commitment to provide safe, secure, sustainable, and accessible facilities for Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gap between our current status and the needs identified in our Strategic Capital Investment Planning (SCIP) process.

Major Construction

The major construction request in 2014 is $342 million for one medical facility project and three National Cemeteries. The request will fund the completion of a mental health building in Seattle, Washington, to replace the existing, seismically deficient building. It will also increase access to Veteran burial services by providing a National Cemetery in Central East Florida; Omaha, Nebraska; and Tallahassee, Florida.

The 2014 budget includes $5 million for NCA for advance planning activities. VA is in the process of establishing two additional national cemeteries in Western New York and Southern Colorado, according to the burial access policies included in the 2011 budget. These two new cemeteries, along with the three requested in 2014, will increase access to 550,000 Veterans. NCA has obligated approximately $16 million to acquire land in 2012 and 2013 for the planned new national cemeteries in Central East Florida; Tallahassee, Florida; and Omaha, Nebraska.

Minor Construction

In 2014, the minor construction request is $715 million, an increase of 17.8 percent from the 2013 enacted level. It would provide for constructing, renovating, expanding and improving VA facilities, including planning, assessment of needs, gravesite expansions, site acquisition, and disposition. VA is placing a funding pri-

ority on minor construction projects in 2014 for two reasons. First, our aging infrastructure requires a focus on maintenance and repair of existing facilities. Second, the minor construction program can be implemented more quickly than the long-term major construction program to enhance Veterans' services.

In light of the difficult fiscal outlook for our Nation, it's time to carefully consider VA's footprint and our real property portfolio. In 2012, VA spent approximately $23 million to maintain unneeded buildings. Achieving significant reduction in unneeded space is a priority for the Administration and VA. To support this priority, the President has proposed a Civilian Property Realignment Act (CPRA), which would allow agencies like VA to address the competing stakeholder interests, funding issues, and red tape that slows down or prevents the Federal Government from disposing of real estate. If enacted by Congress, this process would give VA more flexibility to dispose of property and improve the management of its inventory.

Legislation

Besides presenting VA's resource requirements to meet our commitment to the Nation's Veterans, the President's Budget also requests legislative action that we believe will benefit Veterans. There are many worthwhile proposals for your consideration, but let me highlight a few. For improvements to Veterans healthcare, our budget includes a measure to allow VA to provide Veterans with alternatives to long-stay nursing homes, and enhance VA's ability to provide transportation services to assist Veterans with accessing VA healthcare services. Our legislative proposasl also request that Congress make numerous improvements to VA's critical homelessness programs, including allowing an increased focus on homeless Veterans with special needs, including women, those with minor dependents, the chronically mentally ill, and the terminally ill.

We also are putting forward proposals aimed squarely at the disability claims backlog – such as establishing standard claims application forms—that are reasonable and thoughtful changes that go hand-in-hand with the ongoing transformation and modernization of our disability claims system. We are offering reforms to our Specially Adaptive Housing program that will remove rules that in some circumstances can arbitrarily limit the benefit. The budget's legislative proposals also include ideas for expanding and improving services in our national cemeteries.

Finally, this budget includes provisions that will benefit Veterans and taxpayers by allowing for efficiencies and cost savings in VA's operations – for example, we are forwarding a proposal that would require that private health plans treat VA as a 'participating provider' – preventing those plans from limiting payments or excluding coverage for Veterans' non-service-connected conditions. VA merits having this status, and the additional revenue will fund medical care for Veterans. We are also requesting spending flexibility so that we can more effectively partner with other federal agencies, including DoD, in pursuit of collaborations that will benefit Veterans and Servicemembers and deliver healthcare more efficiently.

Summary

Veterans stand ready to help rebuild the American middle class and return every dollar invested in them by strengthening our Nation. And we, at VA, will continue to implement the President's vision of a 21st century VA, worthy of those who, by their service and sacrifice, have kept our Nation free. Thanks to the President's leadership and the solid support of Congress, we have made huge strides in our journey to provide all generations of Veterans the best possible care and benefits through improved technology that they earned through their selfless service. We are committed to continue that journey, even as the numbers of Veterans using VA services increase in the coming years, through the responsible use of the resources provided in the 2014 budget and 2015 advance appropriations requests. Again, thank you for the opportunity to appear before you today and for your steadfast support of our Nation's Veterans.

Prepared Statement of Jeffrey C. Hall

Chairman Miller, Ranking Member Michaud and Members of the Committee:

On behalf of the DAV (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 recommendations of The *Independent Budget* (IB) for the fiscal year (FY) 2014 budget related to veterans benefits and the Veterans Benefits Administration (VBA). The IB is jointly produced each year by DAV, AMVETS, Paralyzed Veterans of America

and Veterans of Foreign Wars. This year's IB contains numerous recommendations to improve veterans benefit programs and the claims processing system; however, in today's testimony I will highlight just some of the most critical ones for this Committee to consider. Unfortunately, the Administration's budget proposal was still not available at the time this testimony was due, and therefore it does not offer comments about the sufficiency or adequacy of that budget proposal; however, we are aware that the Administration is proposing a 13.6 percent increase in funding in an effort to reduce the backlog of disability claims, although we do not know the details of how the increase will be allocated or the resources used.

Mr. Chairman, the timely delivery of earned benefits to the millions of men and women who have served in our Armed Forces is one of the most sacred obligations of the federal government. The award of a service-connected disability rating does more than provide compensation payments; it is the gateway to an array of benefits that support the recovery and transition of veterans, their families and survivors. However, when these benefits are delayed or unjustly denied, the consequences to veterans and their families can be devastating. For those wounded heroes who file claims for disability compensation, the wait to receive an accurate rating decision and award can take anywhere from a few months to several years; longer if they have to appeal incorrect decisions.

Today there are about 900,000 claims for compensation and pension awaiting decisions at VBA, more than double the number pending four years ago. Of those, fully 70 percent have been waiting more than 125 days, VBA's official target for measuring the backlog, which is double the number from just two years earlier. Moreover, the length of time it takes to process veterans' claims also continues to rise, with the average processing time now almost 280 days, far from VBA's target of 80 days. Looking at these numbers, it is clear that the challenges facing VBA are enormous, and in many ways they are the same core problems that have plagued VBA for decades. The solution will require new technologies and business processes, and most importantly, a cultural transformation built upon the foundations of quality, accuracy and accountability.

In early 2010, Secretary Shinseki laid out an extremely ambitious goal for VBA to achieve by 2015: process 100 percent of claims in less than 125 days, and do so with 98 percent accuracy. Since that time, VBA has worked to completely transform their IT systems, business processes and corporate culture, while simultaneously continuing to process more than a million claims each year. VBA is actively rolling out new organizational models and practices, and continuing to develop and deploy new technologies almost daily. In the midst of this massive transformation, it can be hard to get the proper perspective to measure whether their final systems will be successful, but we believe there has been sufficient progress to merit continued support of the current transformation efforts.

We urge this Committee and Congress to provide the support and resources necessary to complete this transformation as currently planned, while continuing to exercise strong oversight to ensure that VBA remains focused on the long term goal of creating a new claims processing system that decides each claim right the first time. It is absolutely essential that VBA complete transformation from an outdated, paper-based claims system to a modern, paperless, automated claims system. Now is not the time to stop or change direction.

One of the most important signs of positive change over the past four years has been VBA's unprecedented openness and partnership with VSOs. Our organizations possess significant knowledge and experience of the claims process and collectively we hold power of attorney (POA) for millions of veterans who are filing or have filed claims. VBA recognized that close collaboration with VSOs could not only reduce its workload but also increase the quality of its work. We make VBA's job easier by helping veterans prepare and submit better claims, thereby requiring less time and resources for VBA to develop and adjudicate them. The IBVSOs have also been increasingly consulted about initiatives proposed or underway at VBA, including Fully Developed Claims (FDC), Disability Benefit Questionnaires (DBQs), the Veterans Benefit Management System (VBMS), the Stakeholder Enterprise Portal (SEP), and the update of the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). Both Secretary Shinseki and Under Secretary Hickey have consistently reached out to consult and collaborate with VSOs and we are confident that this partnership will result in better service and outcomes for veterans.

Since 2009, VBA has made some significant changes in how claims are processed. The most important amongst these is the development of the new Veterans Benefits Management System (VBMS), its new IT system. VBMS has been rolled out to 20 Regional Offices and is scheduled to be fully deployed to all remaining Regional Offices (ROs) by mid-year. It is important to remember that VBMS is not yet a finished product; rather, it continues to be developed and perfected as it is deployed

so it is still premature to judge whether it will ultimately deliver all of the functionality and efficiency required to meet VBA's future claims processing needs.

Another very important milestone was VBA's decision and commitment to scan all paper claims files for every new or reopened claim requiring a rating-related action, and creating digital e-folders to serve as the cornerstone of the new VBMS system. E-folders facilitate instantaneous transmission and simultaneous reviewing of claims files. At present, there are an estimated 200,000 e-folders and that number will continue to grow as the remaining ROs convert to VBMS this year. In addition, the Appeals Management Center (AMC) is now working in VBMS and able to review e-folders. The Board of Veterans Appeals (BVA) will also begin receiving appeals in VBMS on a pilot basis.

VBA also continues to strengthen its e-Benefits and SEP systems, which allow veterans and their representatives to file claims, upload supporting evidence and check on the status of pending claims. VBA has rolled out a new transformation organizational model (TOM) to every Regional Office that has reorganized workflow by segmenting claims into different processing lanes depending upon the complexity of the issues to be decided for each claim. Other key process improvements that we strongly support include the FDC program, which expedites ready-to-rate claims, and DBQs, which standardize and encourage the collection of private medical evidence to aid in rating decisions. To improve the accuracy of their work, VBA also fulfilled one of our longstanding recommendations by creating local Quality Review Teams (QRTs), whose primary function is to monitor claims processing in real time to catch and correct errors before rating decisions are finalized.

CLAIMS PROCESSING RECOMMENDATIONS

Over the next year, Congress must continue to perform aggressive oversight of VBA's ongoing claims transformation efforts, particularly new IT programs, while actively supporting the completion and full implementation of these vital initiatives. In order for VBA's current transformation plans to have any reasonable chance of success, VBA must be allowed to complete and fully implement them. Congress must continue to fully fund the completion of VBMS, including providing sufficient funding for digital scanning and conversion of legacy paper files, as well as the development of new automation components for VBMS. At the same time, the IBVSOs recommend that Congress encourage an independent, expert review of VBMS while there is still time to make course corrections.

Congress must also encourage and support VBA's efforts to develop a new corporate culture based on quality, accuracy and accountability, as well as strengthen the transmission and adoption of these values and appropriate supportive policies throughout all VBA Regional Offices. The long-term success of all of VBA's transformation efforts will depend on the degree to which these changes are institutionalized and disseminated from the national level to the local level. In addition to strengthening training, testing and quality control, VBA must be encouraged to properly align measuring and reporting functions with desired goals and outcomes for both its leadership and employees. For example, as long as the most widely reported metric of VBA's success is the Monday Morning Workload Reports, particularly the weekly update on the size of the backlog, there will remain tremendous pressure throughout VBA to place production gains ahead of quality and accuracy. Similarly, if individual employee performance standards set unrealistic production goals, or fail to properly credit ancillary activity that contributes to quality but not production, those employees will be incentivized to focus on activities that maximize only production. VBA must develop more and better measures of work performance that focus on quality and accuracy, both for the agency as a whole and for individual employees. Furthermore, VBA must ensure that employee performance standards are based on accurate measures of the time it takes to properly perform their jobs.

Congress must also ensure that VBA does not change its reporting or metrics for the sole purpose of achieving statistical gains, commonly referred to as "gaming the system," in the absence of actual improvements to the system. For example, VBA recently announced that they will change how errors are scored for multi-issue claims. Previously, a claim would be considered to have an error if one mistake on at least one issue in the claim was detected during a STAR review. Under the new error policy, if there are 10 issues in the claim and a single error is found on one of the issues, that would now be scored as only 0.1 errors for that claim. While this may be a more valid way of measuring technical accuracy, it also has the effect of lowering the error rate without actually lowering the number of errors committed.

To make the system more efficient, Congress should enact and promote legislation and policies that maximize the use of private medical evidence to conserve VBA resources and enable quicker, more accurate rating decisions for veterans. The IBVSOs have long encouraged VBA to make greater use of private medical evidence

when making claims decisions, which would save veterans time and VBA the cost of unnecessary examinations. DBQs, many of which were developed in consultation with IBVSO experts, are designed to allow private physicians to submit medical evidence on behalf of veterans they treat in a format that aids rating specialists. However, we continue to receive credible reports from across the country that many Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) do not accept the adequacy of DBQs submitted by private physicians, resulting in redundant VA medical examinations being ordered and valid evidence supporting veterans' claims being rejected.

Although there are currently 81 approved DBQs, VBA has only released 71 of them to the public for use by private physicians. In particular, VBA should allow private treating physicians to complete DBQs for medical opinions about whether injuries and disabilities are service connected, as well as DBQs for PTSD, which current VBA rules do not allow; only VA physicians can make PTSD diagnoses for compensation claims. Congress should work with VBA to make both of these DBQs available to private physicians.

To further encourage the use of private medical evidence, Congress should amend title 38, United States Code, section 5103A(d)(1) to provide that, when a claimant submits private medical evidence, including a private medical opinion, that is competent, credible, probative, and otherwise adequate for rating purposes, the Secretary shall not request a VA medical examination. This legislative change would require VSRs and RVSRs to first document that private medical evidence was inadequate for rating purposes before ordering examinations, which are often unnecessary.

VBA STAFFING AND RESOURCE RECOMMENDATIONS

Over the past five years, the VBA has seen a significant staffing increase because Congress recognized that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel and thus provided additional resources each year to do so. More than 5,000 full time employee equivalents (FTEE) were added to VBA over the past five years, a 33 percent increase, with most of that increase going to the Compensation Service. In fiscal year (FY) 2013, VBA's budget supports an additional 450 FTEE above the FY 2012 authorized level.

Compensation Service Staffing

Since VBA is in the middle of a comprehensive transformation that makes changes in the roles and responsibilities of its employees, it is difficult to determine whether Compensation Service's staffing levels are sufficient now or will be in the near future. Without knowing the outcome of the transformation, it is difficult to estimate whether they will require additional or even fewer personnel to address the future workload they will need to process. For this reason, the IB does not recommend a specific staffing increase for FY 2014, although it is important that Congress and VBA be certain that staffing levels are regularly adjusted to remain aligned with changes in workload and productivity.

In this regard, it is imperative that VBA and Congress continue to closely monitor Compensation Service's actual and projected workload, measurable and documented increases in productivity resulting from the new organizational model and the VBMS, as well as personnel changes, such as attrition, in order to ensure that staffing is sufficient. Furthermore, VBA must develop a better, more consistent and data-driven method of determining future staffing requirements to more accurately inform future funding requirements.

Board of Veterans' Appeals Staffing

Based on historical trends, the number of new appeals to the Board averages approximately 5 percent of all claims received, so as the number of claims processed by the VBA is expected to rise significantly, so too will the Board's workload rise accordingly. Yet the budget provided to the Board has been declining, forcing it to reduce the number of employees. Although the Board had been authorized to have up to 544 FTEE in FY 2011, its appropriated budget could support only 532 FTEE that year. In FY 2012, that number was further reduced to 510. At present, due to cost-saving initiatives, the Board may be able to support as many as 518 FTEE with the FY 2013 budget; however, this does not correct the downward trend over the past several years, particularly as workload continues to rise. Based on the expected workload increase in FY 2014, and adjusting for projected productivity gains, the IBVSOs believe that the Board should have at least 544 FTEE in FY 2014 in order to reduce its backlog.

Vocational Rehabilitation and Employment Service Staffing

In FY 2012, VA's Vocational Rehabilitation and Employment (VR&E) program, also known as the VetSuccess program, had 121,000 participants in one or more of the five assistance tracks of VR&E's VetSuccess program, an increase of 12.3 percent above the FY 2011 participation level of 107,925 veterans. In FY 2012, VR&E had a total of 1,446 FTEE, and anticipates an increase of approximately 150 FTEE for FY 2013. Given the estimated 10 percent workload increases for both FY 2013 and FY 2014, the IB estimates that VR&E would need an additional 230 counselors in FY 2014 in order to reduce their counselor-to-client ratio down to their stated goal of 1:125.

An extension for the delivery of VR&E assistance at a key transition point for veterans is through the VetSuccess on Campus program. This program provides support to student veterans in completing college or university degrees. VetSuccess on Campus has developed into a program that places a full-time Vocational Rehabilitation Counselor and a part-time Vet Center Outreach Coordinator at an office on campus specifically for the student veterans attending that college. These VA officers are there to help the transition from military to civilian and student life. The VetSuccess on Campus program is designed to give needed support to all student veterans, whether or not they are entitled to one of VA's education benefit programs.

VA is expected to increase its VetSuccess on Campus program from 34 colleges in FY 2012 to 50 colleges in FY 2013. In FY 2014, the IBVSOs recommend that VR&E further expand this program to create a presence on a total of at least 70 college campuses, which would require approximately 20 additional FTEE.

RECOMMENDATIONS FOR IMPROVEMENTS TO VA BENEFITS

Automatic Annual Cost-of-Living Adjustment (COLA)

Congress has annually authorized increases in compensation and dependency and indemnity compensation (DIC) by the same percent as Social Security is increased. Under current law, the government monitors inflation throughout the year and, if inflation occurs, automatically increasing Social Security payments by the percent of increase for the following year, which the Congress then applies to veterans programs.

While Congress has always increased compensation and DIC based on inflation, there have been years when such increases were delayed, which puts unnecessary financial strain on veterans and their survivors. The IB veterans service organizations urge Congress to enact legislation indexing compensation and DIC to Social Security COLA increases.

End Rounding Down of Veterans' and Survivors' Benefits Payments

In 1990, Congress, in an omnibus reconciliation act, mandated that veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress eventually made it permanent. The cumulative effect of this provision of the law effectively levies a tax on totally disabled veterans and their survivors. Congress should repeal the current policy of rounding down veterans' and survivors' benefits payments.

Reject Any Proposal to Use the "Chained CPI"

In the past year, there has been much discussion about replacing the current CPI formula used for calculating the annual Social Security COLA with the Bureau of Labor Statistics (BLS) new formula commonly termed the "chained CPI." Such a change would be expected to significantly reduce the rates paid to Social Security recipients, and thereby help to lower the federal deficit. Since the Social Security COLA is also applied annually to the rates for VA disability compensation, DIC, and pensions for wartime veterans and survivors with limited incomes, its application would mean systematic reductions for millions of veterans, their dependents and survivors who rely on VA benefit payments. The IBVSOs urge Congress to reject any and all proposals to use the "chained CPI" for determining Social Security COLA increases, which would have the effect of significantly reducing the level of vital benefits provided to millions of veterans and their survivors.

The IBVSOs also note that the CPI index used for Social Security does not include increases in the cost of food or gasoline, both of which have risen significantly in recent years. While no inflation index is perfect, the IBVSOs believe that VA should examine whether there are other inflation indices that would more appropriately correlate with the increased cost of living experienced by disabled veterans and their survivors.

End Prohibition against Concurrent Receipt of VA Disability Compensation and Military Longevity Retired Pay

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. Most nondisabled military retirees pursue second careers after serving in order to supplement their income, thereby justly enjoying a full reward for completion of a military career with the added reward of full civilian employment income. In contrast, military retirees with service-connected disabilities do not enjoy the same full earning potential since their earning potential is reduced commensurate with the degree of service-connected disability.

In order to place all disabled longevity military retirees on equal footing with nondisabled military retirees, there should be no offset between full military retired pay and VA disability compensation. To the extent that military retired pay and VA disability compensation offset each other, the disabled military retiree is treated less fairly than is a nondisabled military retiree by not accounting for the loss in earning capacity. Moreover, 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 disability compensation and full civilian retired pay—including retirement from any federal civil service position.

While Congress has made progress in recent years in correcting this injustice, current law still provides that service-connected veterans rated less than 50 percent disabled who retire from the armed forces on length of service may not receive disability compensation from VA in addition to full military retired pay. The IBVSOs believe the time has come to remove this prohibition completely. Congress should enact legislation to repeal the inequitable requirement that veterans' military longevity retired pay be offset by an amount equal to the disability compensation awarded to disabled veterans rated less than 50 percent, the same as exists for those rated 50 percent or greater.

SURVIVOR BENEFITS

Increase DIC for Surviving Spouses of Servicemembers

The current rate of compensation paid to the survivors of certain deceased veterans rated permanently and totally disabled and deceased service members is inadequate and inequitable. Under current law, the surviving spouse of a veteran who had a total disability rating is entitled to the basic rate of Dependency and Indemnity Compensation. A supplemental payment is provided to those spouses who were married for at least eight years during which time the veteran was rated permanently and totally disabled. However, surviving spouses of veterans or military service members who die before the eight-year eligibility period, or who die on active duty, respectively, only receive the basic rate of DIC.

Insofar as DIC payments are intended to provide surviving spouses with the means to maintain some semblance of financial stability after losing their loved ones, the rate of payment for service-related deaths of any kind should not vastly differ. Surviving spouses, regardless of the status of their sponsors at the time of death, face the same financial hardships once deceased sponsors' incomes no longer exists. Congress should authorize DIC eligibility at increased rates to survivors of service members who died either before the eight-year eligibility period passes or while on active duty at the same rate paid to the eligible survivors of totally disabled service-connected veterans who die after the eight-year eligibility period.

Repeal of the DIC–SBP Offset

The current requirement that the amount of an annuity under the Survivor Benefit Plan (SBP) be reduced on account of, and by an amount equal to, DIC is inequitable. A veteran disabled in military service is compensated for the effects of service-connected disability. When a veteran dies of service-connected causes, or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the 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 of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay after his or her death, unlike many re-

tirement plans in the private sector. Under the SBP, deductions are made from the veteran's military retirement pay to purchase a survivor's annuity. This is not a gratuitous benefit, but is purchased by a retiree. Upon the veteran's death, the annuity is paid monthly to eligible beneficiaries under the plan. If the veteran died from 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 military service or after the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose the SBP annuity in its entirety.

The IBVSOs 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, coverage is purchased by a veteran and at the time of death, paid to his or her surviving beneficiary. On the other hand, DIC is a special indemnity compensation paid to the survivor of a service member who dies while serving in the military, or a veteran who dies from service-connected disabilities. In such cases, DIC should be added to the SBP, not substituted for it. Surviving spouses of federal civilian retirees who are veterans are eligible for DIC without losing any of their purchased federal civilian survivor benefits. The offset penalizes survivors of military retirees 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 inequitable offset between DIC and the SBP because there is no duplication between these two distinct benefits.

Retention of Remarried Survivors' Benefits at Age 55

Congress should lower the age required for remarriage for survivors of veterans who have died on active duty or from service-connected disabilities to be eligible for retention of DIC to conform with the requirements of other federal programs. Current law allows retention of DIC on remarriage at age 57 or older for eligible survivors of veterans who die on active duty or of a service-connected injury or illness. Although the IBVSOs appreciate the action Congress took to allow restoration of this rightful benefit, 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. This would also bring DIC in line with SBP rules that allow retention with remarriage at the age of 55. Equity with beneficiaries of other federal programs should govern Congressional action for this deserving group. Congress should enact legislation to enable survivors to retain DIC on remarriage at age 55 for all eligible surviving spouses.

Mr. Chairman, that concludes my statement and I would be happy to answer any questions you or other members of the Committee may have.

Prepared Statement of Carl Blake

Chairman Miller, Ranking Member Michaud, 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) for FY 2014.

As the country faces a difficult and uncertain fiscal future, the VA likewise faces significant challenges ahead. Congress and the Administration continue to face immense pressure to reduce federal spending. With these thoughts in mind, we cannot emphasize enough the importance of ensuring that sufficient, timely and predictable funding is provided to the VA. While we are disappointed that it has taken nearly two additional months for the Administration to release its funding recommendations for VA programs for FY 2014, and the advance appropriation recommendation for FY 2015, we are particularly interested in reviewing in greater detail the updated analysis of the funding needs for health care programs for FY 2014 in light of the complex budget deficit and debt negotiations that have been going on for over a year now.

Meanwhile, The *Independent Budget* co-authors are particularly concerned that the broken appropriations process continues to have a negative impact on the operations of the VA. Once again this year Congress failed to fully complete the appropriations process in the regular order, instead choosing to fund the federal government through a 6-month Continuing Resolution and subsequently completing the appropriations work for the current fiscal year nearly 6 months into the year. As

a result of the enactment of advance appropriations, the health care system is generally shielded from the difficulties associated with late appropriations (an occurrence that has become the rule, not the exception). However, we cannot be certain that health care operations have not been negatively impacted by this 6-month continuing resolution. Moreover, the rest of the operations of the VA have most certainly been hampered by this broken process.

The *Independent Budget* co-authors remain concerned about steps VA has taken in recent years in order to generate resources to meet ever-growing demand on the VA health-care system. The Administration continues to rely upon "management improvements," a popular gimmick that was used by previous Administrations to generate savings and offset the growing costs to deliver care. Unfortunately, these savings were often never realized leaving VA short of necessary funding to address ever-growing demand on the health-care system.

Additionally, the VA continues to overestimate and underperform in its medical care collections. Overestimating collections estimates affords Congress the opportunity to appropriate fewer discretionary dollars for the health care system. However, when the VA fails to achieve those collections estimates, it is left with insufficient funding to meet the projected demand. As long as this scenario continues, the VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this nation. The fact that the VA continues to experience problems with its medical care collections reflects an even greater need to Congress to properly analyze, and if necessary, revise the advance appropriations from the previous year to ensure that the VA health care system is getting the resources it needs.

Funding for FY 2014

For FY 2014, The *Independent Budget* recommends approximately $58.8 billion for total medical care, an increase of $3.3 billion over the FY 2013 operating budget. Meanwhile, the Administration recommended, and Congress recently approved in P.L. 113–6, the "Full-Year Continuing Appropriations Act," an advance appropriation for FY 2014 of approximately $54.4 billion in discretionary funding for VA medical care. When combined with the $3.1 billion Administration projection for medical care collections, the total available operating budget recommended for FY 2014 is approximately $57.5 billion. We will be very interested to see if the Administration thoroughly revises the original advance appropriations estimate for FY 2014 in the budget for this year.

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 2014, The *Independent Budget* recommends approximately $47.4 billion for Medical Services, approximately $800 million more than the advance appropriations included in P.L. 113–6 (when medical care collections are also taken into account). Our Medical Services recommendation includes the following recommendations:

Current Services Estimate $45,552,079,000
Increase in Patient Workload $1,184,999,000
Additional Medical Care Program Costs $675,000,000
Total FY 2014 Medical Services $47,412,078,000

Our growth in patient workload is based on a projected increase of approximately 81,200 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $827 million. The increase in patient workload also includes a projected increase of 96,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), as well as Operation New Dawn (OND) veterans at a cost of approximately $358 million. Our recommendations represent an increase in projected workload in this population of veterans over previous years as a result of the withdrawal of forces from Iraq, the drawdown of forces in Afghanistan, and a potential drawdown in the actual number of service members currently serving in the Armed Forces. And yet, we believe that growth in demand for this cohort specifically could be far greater given the changing military policies mentioned above. In fact, we believe that recent reporting from the VA suggests that the actual number of new unique OEF/OIF/OND veterans is greater than 120,000. This leads us to conclude that our estimate of cost for this population should be even greater.

Finally, The *Independent Budget* believes that there are additional projected funding needs for VA. Specifically, we believe there is real funding needed to address issues in the VA's long-term care program and to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service). In order to support the rebalancing of VA long-term care in FY

2014, we believe $112 million should be provided. Additionally, we believe $75 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD–HCBS) program. The remainder of the $375 million that the IB recommends for long-term care services would begin to restore the VA's long-term care capacity to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, the IB recommends an additional $300 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2012 to FY 2013 and the expected continued growth in expenditures for FY 2014.

For Medical Support and Compliance, The *Independent Budget* recommends approximately $5.84 billion. Finally, for Medical Facilities, The *Independent Budget* recommends approximately $5.57 billion. While our recommendation does not include an additional increase for nonrecurring maintenance (NRM), it does reflect a FY 2014 baseline of approximately $750 million. While we appreciate the significant increases in the NRM baseline over the last couple of years, total NRM funding still lags behind the recommended two to four percent of plant replacement value. In fact, VA should actually be receiving at least $1.7 billion annually for NRM. Meanwhile, we have serious concerns with the fact that the advance appropriation for Medical Facilities included in P.L. 113–6 slashes funding for this account and for NRM specifically. This level of funding, particularly if the trend continues in the coming years, will have a devastating impact on the ability of the VA to meet the maintenance needs of the health care system.

For Medical and Prosthetic Research, The *Independent Budget* recommends $611 million. This represents approximately a $28 million increase over the FY 2013 appropriated level. The VA research program is a jewel within the VA that we support without hesitation or reservation. That program and its nearly 4,000 principal investigators have made myriad improvements not only to veterans' health in VA care, but have elevated the standard of health care of the nation and the world. Despite scientific discoveries and prosthetic inventions too numerous to mention here but that are well known, the Administration for the third year running requested either reduced or flat funding for VA research, and Congress effectively acquiesced. From FY 2011 through the FY 2013 appropriation, virtually nothing has been added by Congress to that program's budget baseline. No allowance has been made to cover uncontrollable research inflation, which averages around 3 percent annually; no funds have been provided for new initiatives beyond the baseline; and no funds have been requested or provided to help repair or upgrade VA's research laboratories, concerning which a 2012 independent evaluation estimated that almost $800 million would be required to bring them up to par. And disappointingly, no funds have been requested for special research initiatives focused on the needs of Iraq and Afghanistan veterans. These are major lapses that deserve correction.

Advance Appropriations for FY 2015

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 2013 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 2014) and provide detailed estimates of the funds necessary for the medical care accounts for FY 2015.

For the first time this year, The *Independent Budget* offers baseline projections for funding for the medical care accounts for FY 2015. While we have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we have growing concerns that this responsibility is not being taken seriously. The fact that for two fiscal years in a row the Administration recommended funding levels that were not changed in any appreciable way upon review, and the fact that Congress simply signed off on those recommendations without thorough analysis, leads us to conclude that VA funding is falling farther and farther behind the growth in demand for services. We believe the continued feedback from veterans around the country about long wait times and lack of access to services affirms this belief. As such, we have decided to offer our own estimates of what we believe the true resource needs will be for the VA health care system in FY 2015.

For FY 2015, The *Independent Budget* recommends approximately $61.6 billion for total medical care. Our recommendation includes approximately $49.8 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate $48,042,797,000
Increase in Patient Workload $1,105,821,000
Additional Medical Care Program Costs $675,000,000

Total FY 2015 Medical Services $49,823,618,000

Our growth in patient workload is based on a projected increase of approximately 60,000 new unique patients—priority groups 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $737 million. The increase in patient workload also includes a projected increase of 96,500 new OEF/OIF/OND veterans at a cost of approximately $369 million. Meanwhile, we are particularly interested to see the trends that the VA Budget Request projects for new utilization in the coming years. While the growth in utilization of some new unique patients seems to be trending downward, we believe that the OEF/OIF/OND population will continue to trend upward as the military services drawdown their forces and as worldwide conflicts end. Additionally, it remains to be seen what impact the full implementation of the Affordable Care Act will have on utilization of VA health care services.

As with FY 2014, The *Independent Budget* believes that there are additional projected funding needs for VA. In FY 2015, the IB once again believes that $375 million should be directed towards VA's long-term care program. Additionally, we believe that a continued increase in centralized prosthetics funding will be essential. In order to meet the continued increase in demand for prosthetics, the IB recommends an additional $300 million. Finally, for Medical Support and Compliance, The *Independent Budget* recommends approximately $6.14 billion. Meanwhile, for Medical Facilities, The *Independent Budget* recommends approximately $5.69 billion.

Additionally, GAO's responsibility is more important than ever, particularly in light of their findings concerning the FY 2012 budget submission last year. The GAO report that analyzed the FY 2012 Administration budget identified serious deficiencies in the budget formulation of VA. Yet these concerns were not appropriately addressed by Congress or the Administration. This analysis and the subsequent lack of action to correct these deficiencies simply affirm the ongoing need for the GAO to evaluate the budget recommendations of VA. For this reason, we would like to thank Representative Brownley for introducing H.R. 806, the "Veterans Healthcare Improvement Act." This legislation permanently establishes the Government Accountability Office's reporting requirements as a part of VA advance appropriations. We hope that the Committee will give this legislation consideration as soon as possible, and we urge all members of the Committee to support the bill.

Finally, we would like to applaud Chairman Miller and Ranking Member Michaud for introducing H.R. 813, the "Putting Veterans Funding First Act of 2013." This legislation requires all accounts of the VA to be funded through the advance appropriations process. It would provide protection for the operations of the entire VA from the political wrangling that occurs as a part of the appropriations process every year.

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.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

No federal grants or contracts received.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program—$262,787.

Prepared Statement of Diane M. Zumatto

Chairman Miller, Ranking Member Michaud and Members of the Committee:

On behalf of AMVETS (American Veterans) and our over 500,000 members, I appreciate the opportunity to be here today to share recommendations from The *Independent Budget* (IB) for fiscal year (FY) 2014. In light of the ongoing fiscal challenges facing our nation and the growing demanding for VA services, the IBVSOs call on Congress and the Administration to make it their priority to ensure that the VA continually receives sufficient, timely and predictable funding. It is unfortunate that the Administration's funding recommendations for VA in FY 2014, as well as, the advance appropriations recommendation for FY 2015, have been delayed by almost two months and The IBVSOs are greatly concerned about how VA programs funding may be impacted going forward. Additionally, the ongoing breakdown in the appropriations process is a major concern to the IBVSOs and it will most certainly have a negative effect on all VA operations.

In the midst of all the budget and spending woes, the IBVSOs hope that neither Congress nor the Administration forgets the sacred obligation they have to those who serve and protect this country. Our nation must remain steadfast and committed to ensuring that our military, veterans, their families and survivors receive their earned benefits in a timely and efficient manner. This commitment begins when an individual raises their hand during their enlistment ceremony and should never end. Among the most important parts of this commitment to veterans involves the transition process and finding post-military employment. Congress and the Administration need to ensure that veterans have every opportunity to find living-wage work when they return home, receive the health care and benefits they've earned and have the chance to get a college education through VA's education benefit programs, such as the post-9/11 GI Bill.

The FY 2014 *Independent Budget* (IB) covers a myriad of veteran related issues and makes numerous recommendations to improve veterans benefit programs and the claims processing system; however, the focus of my testimony will be limited to:

- the Transition Assistance Program (T.A.P.);
- Veterans and Post-Service Licensure and Credentials, and
- the National Cemetery Administration

Since, the Administration's budget proposal is still not available at this time; this testimony does not include any comments about the satisfactoriness or un-satisfactoriness of the upcoming budget proposal.

National Cemetery Administration (NCA)

It must always be remembered that the most important obligation of the NCA is to honor the memory of America's brave men and women who have so selflessly served in the United States armed forces. Therefore there is no more sacrosanct responsibility than the dignified and respectful recovery, return and burial of our men and women in uniform. This responsibility makes it incumbent upon NCA to maintain our NCA cemeteries as national shrines dedicated to the memory of these heroic men and women.

The IBSVOs would like to acknowledge the dedication and commitment demonstrated by the NCA leadership and staff in their continued devotion to providing the highest quality of service to veterans and their families. It is the opinion of the IBVSOs that the NCA continues to meet its goals and the goals set forth by others because of its true dedication and care for honoring the memories of the men and women who have so selflessly served our nation. We applaud the NCA for recognizing that it must continue to be responsive to the preferences and expectations of the veterans' community by adapting or adopting new interment options and ensuring access to burial options in the national, state and tribal government-operated cemeteries.

One of the areas that NCA does a good job in is forecasting the future needs of our veterans by:

- securing land for additional cemeteries, including two new national cemeteries in Florida and working in CO & NY;
- getting the word out on burial benefits to stakeholders. Including developing new online resources for Funeral Directors;
- making it easier for family members to locate and chronicle loved ones by partnering with Ancestry.com to Index historic burial records. This partnership will bring burial records from historic national cemetery ledgers (predominantly of Civil War interments) into the digital age making them available to research-

ers and those undertaking historical and genealogical research. From the 1860s until the mid-20th century, U.S. Army personnel tracked national cemetery burials in hand-written burial ledgers or "registers." Due to concern for the fragile documents and a desire to expand public access to the ledger contents, VA's National Cemetery Administration (NCA) duplicated about 60 hand-written ledgers representing 36 cemeteries using a high-resolution scanning process. The effort resulted in high quality digital files that reproduced approximately 9,344 pages and 113,097 individual records. NCA then transferred the original ledgers to the National Archives and Records Administration (NARA) where they will be preserved. In addition to the NCA's ledgers, NARA was already the steward of at least 156 military cemetery ledgers transferred from the Army years ago.

- awarding grant money for State and Tribal Veterans Cemeteries; and
- expanding burial options in rural areas – The Rural Initiative. This program provides full burial services to small rural Veteran populations where there is no available burial option from either a VA national, State or Tribal Veterans cemetery. This initiative will build small National Veterans Burial Grounds in rural areas where the unserved Veteran population is less than 25,000 within a 75-mile radius. VA's current policy for establishing new national cemeteries is to build where the unserved Veteran population is 80,000 or more within a 75-mile radius.
- A National Veterans Burial Ground will be a small three to five acre NCA-managed section within an existing public or private cemetery. NCA will provide a full range of burial options and control the operation and maintenance of these lots. These sections will be held to the same National Shrine Standards as VA national cemeteries. Over the next six years VA plans to open eight National Veterans Burial Grounds in: Fargo, North Dakota; Rhinelander, Wisconsin; Cheyenne, Wyoming; Laurel, Montana; Idaho Falls, Idaho; Cedar City, Utah; Calais, Maine; and Elko, Nevada. This option will increase access to burial benefits to rural veterans and will help NCA to reach its strategic goal of providing a VA burial option to 94 percent of Veterans within a reasonable distance (75 miles) of their residence.

The IBVSOs also believe it is important to recognize the NCA's efforts in employing both disabled and homeless veterans, which is another area that NCA leads the way among federal agencies. Programs include:

- The Homeless Veteran Supported Employment Program (HVSEP) provides vocational assistance, job development and placement, and ongoing supports to improve employment outcomes among homeless Veterans and Veterans at-risk of homelessness. Formerly homeless Veterans who have been trained as Vocational Rehabilitation Specialists (VRSs) provide these services;
- VA's Compensated Work Therapy (CWT) Program is a national vocational program comprised of three unique programs which assist homeless Veterans in returning to competitive employment: Sheltered Workshop, Transitional Work, and Supported Employment. Veterans in CWT are paid at least the federal or state minimum wage, whichever is higher; VA's National Cemetery Administration and Veterans Health Administration have also formed partnerships at national cemeteries, where formerly homeless Veterans from the CWT program have received work opportunities; and
- The Vocational Rehabilitation and Employment (VR&E) VetSuccess Program assists Veterans with service-connected disabilities to prepare for, find, and keep suitable jobs. Services that may be provided include: Comprehensive rehabilitation evaluation to determine abilities, skills, and interests for employment; employment services; assistance finding and keeping a job; and On the Job Training (OJT), apprenticeship, and non-paid work experiences.

Veterans Cemetery Grant Programs

The Veterans Cemetery Grants Program (VCGP) complements the National Cemetery Administration's mission to establish gravesites for veterans in areas where it cannot fully respond to the burial needs of veterans. Since 1980, the VCGP has awarded more than $482 million to 41 states, territories and tribal organizations for the establishment, expansion or improvement of 86 state veteran cemeteries. For example, the NCA can provide up to 100 percent of the development cost for an approved cemetery project, including establishing a new cemetery and expanding or improving an established state or tribal organization veterans' cemetery. New equipment, such as mowers and backhoes, can be provided for new cemeteries. In addition, the Department of Veterans' Affairs may also provide operating grants to help cemeteries achieve national shrine standards.

In FY 2012, with an appropriation of $46 million, the VCGP funded 15 state cemeteries and one tribal organization cemetery. These grants included the establishment or ground breaking of one new state cemetery and one new tribal organization cemetery, expansions and improvements at ten state cemeteries, and six projects aimed at assisting state cemeteries to meet the NCA national shrine standards.

In fiscal year 2011, NCA-supported Veterans cemeteries provided nearly 29,500 interments. Since 1978 the Department of Veterans Affairs has more than doubled the available acreage and accommodated more than a 100 percent increase in burial through this program. The VCGP faces the challenge of meeting a growing interest from states to provide burial services in areas not currently served. The intent of the VCGP is to develop a true complement to, not a replacement for, our federal system of national cemeteries. With the enactment of the "Veterans Benefits Improvement Act of 1998," the NCA has been able to strengthen its partnership with states and increase burial services to veterans, especially those living in less densely populated areas without access to a nearby national cemetery. Through FY 2012, the VCGP has provided grant funding to 88 state and tribal government veterans' cemeteries in 41 states and U.S. territories. In FY 2011 VA awarded its first state cemetery grant to a tribal organization. This is an extremely cost effective program which will need to continue to grow in order to keep pace with ever increasing needs.

Veteran's Burial Benefits

Since the original parcel of land was set aside for the sacred committal of Civil War Veterans by President Abraham Lincoln in 1862, more than 4 million burials, from every era and conflict, have occurred in national cemeteries under the National Cemetery Administration.

In 1973, the Department of Veterans' Affairs established a burial allowance that provided partial reimbursement for eligible funeral and burial costs. The current payment is $2,000 for burial expenses for service-connected deaths, $300 for non-service connected deaths and a $700 plot allowance. At its inception, the payout covered 72 percent of the funeral costs for a service-connected death, 22 percent for a non-service connected death and 54 percent of the cost of a burial plot.

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 until it was removed in 1936. 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. Although neither the plot allowance nor the burial allowance was intended to cover the full cost of a civilian burial in a private cemetery, the recent increase in the benefit's value indicates the intent to provide a meaningful benefit. The IBVSOs are pleased that the 111th Congress acted quickly and passed an increase in the plot allowance for certain veterans from $300 to $700 effective October 1, 2011.

However, we believe that there is still a serious deficit between the original value of the benefit and its current value. In order to bring the benefit back up to its original intended value, the payment for service-connected burial allowance should be increased to $6,160, the non-service connected burial allowance should be increased to $1,918 and the plot allowance should be increased to $1,150. The IBVSOs believe Congress should divide the burial benefits into two categories: veterans within the accessibility model and veterans outside the accessibility model.

The IBVSOs further believe that Congress should increase the plot allowance from $700 to $1,150 for all eligible veterans and expand the eligibility for the plot allowance for all veterans who would be eligible for burial in a national cemetery, not just those who served during wartime. Congress should increase the service-connected burial benefits from $2,000 to $6,160 for veterans outside the radius threshold and to $2,793 for veterans inside the radius threshold.

Additionally, the IBVSOs believe that Congress should increase the non-service connected burial benefits from $300 to $1,918 for all veterans outside the radius threshold and to $854 for all veterans inside the radius threshold. The Administration and Congress should provide the resources required to meet the critical nature of the National Cemetery Administration's mission and to fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

Finally, the IBVSOs call on Congress and the Administration to provide the resources required to meet the critical nature of the NCA mission so that it can fulfill the nation's commitment to all veterans who have served their country so honorably and faithfully.

Does this mean that there are no areas needing improvement at NCA – absolutely not. From October 2011 through March 2012, NCA conducted an internal gravesite review of headstone and marker placements at VA National cemeteries. During that review a total of 251 discrepancies at 93 National cemeteries were discovered which included:

- 218 misplaced headstones;
- 25 unmarked graves;
- 8 misplaced veteran remains

While these incidents were corrected in a respectful, professional and expeditious manner, the initial phase of NCA's internal review failed to identify, and therefore to report, all misplaced headstones and unmarked gravesites. Additional discrepancies came to light thanks to the diligent oversight of Chairman Miller and the HVAC which had tasked the IG with conducting an audit of the internal NCA review. The IG report highlighted several concerns and made corrective recommendations. Based on those recommendations, the Under Secretary for Memorial Affairs developed an appropriate action plan and the IBVSOs recommends continued oversight to ensure the carrying out of all corrective actions.

Veterans and Post-Service Licensure and Credentials

Perhaps some of the reasons for the persistently high unemployment rate among veterans may be found in a June 2012 study conducted by the Center for New American Security. The report entitled, 'Employing America's Veterans: Perspectives from Businesses', examined the effect of military service on former service members as it relates to their employment opportunities. While there were many positive reasons for hiring veterans noted in the report, twenty-five out of the thirty companies involved in the study reported some specific challenges associated with hiring veterans, including:

- difficulty in skill translation;
- negative stereotype;
- skill mismatch;
- possible deployments (National Guard & Reserve members);
- difficult acclimation process; and
- difficulty finding veterans

In considering the many challenges facing transitioning veterans, it appears that perhaps the toughest barrier to breach is employment. It is abundantly clear that transitioning veterans seeking employment, especially those with health issues, face some unique obstacles, including the process of securing the licenses and credentials required by some professions.

The issue of veteran licensing and credentialing continues to be of concern to those within the military and veteran communities and is made especially difficult for veterans due to: its highly parochial nature; the complexities within the civilian credentialing system itself; the fact that each of the military services has its own unique training and credentialing programs; the need to overcome real or perceived gaps in military training, education and experience; the ambiguity about which of the roughly 4,000 different credentials are most important to civilian employers; and perhaps most significantly, many military occupations, unlike their civilian equivalents, have no credential requirements.

Due to its very nature, the problem of credentialing cannot be resolved solely by the Federal government and its agencies. The National Council of State Legislatures (NCSL) and the National Governors Association (NGA) as two of the chief players in the credentialing game should also have a substantial role to play and especially since licensure and certifications are handled at the state-level in most cases. Military service and training are provided at both the state-level for members of the National Guard or the federal-level for active duty and Reserve personnel. In light of this, a massive collaboration between DoD, VA and DOL as well as the Department of Education (DoED), and the individual states will be required. In an ideal world, all proposed legislation or regulations dealing with the credentialing issue would be initiated by NCSL and NGA in order to provide the basic structure for linking military skills, training and service to the requirements and opportunities within each state.

As an invested player in the area of veteran credentialing, VETS is engaged in: sponsoring major conferences to bring together the important players in the licensing and credentialing field; publicizing this specific barrier to employment; identifying on-going difficulties and helping to develop veteran-friendly policies to overcome those challenges; helping to bridge the gap that hampers veterans needing credentials through the involvement of its staff members on a number of national cer-

tification advisory boards, committees and regulatory bodies; and by providing grants to a variety of Workforce Investment credentialing projects.

The IBVSOs applaud the fact that the Administration has offered its support to ensure that servicemembers leave the military career-ready by proposing the following: increased veteran and service-disabled veteran tax credits; a challenge to private sector firms to commit to hiring or training 100,000 unemployed veterans or their spouses by the end of 2013 (this challenge has led to a public private partnership to develop a 'Troops to Energy Jobs' program and a 'Veterans on Wall Street' program; both of which seek to help support, educate and recruit military veterans and their families as they transition to the civilian workplace); 'A Career-Ready Military' which calls for DoD and VA to lead a joint task force with the White House economic and domestic policy teams and other agencies to develop proposals to maximize the career-readiness of all servicemembers including a 'Reverse Boot Camp'; and an initiative to deliver enhanced job search services to transitioning veterans through American Job Centers, including improved TAP workshops.

Adequate funding is the key to the protecting these kinds of programs from fiscal jeopardy in the future.

The IBVSOs recommend that Congress continue to monitor and hold accountable DOL's ongoing implementation of the VOW to Hire Heroes Act provisions, including: mandating that DOD, VA, and DOL work together to identify equivalencies between military and civilian occupations and the credentialing, licensing, and certification so military training meets civilian certification and licensure requirements in each state; the design and implementation of a 'skill equivalencies' study; and the development and execution of the required multi-state demonstration project in order to determine the best way to prepare veterans for transition into civilian employment as well as ways to accelerate their attainment of civilian credentials.

The IBVSOs further recommend that the demonstration project mentioned above must include the development of a clear process so that wherever a veteran chooses to reside after military service, that state will grant an expedited licensure or certification for the civilian equivalent job he or she held while in the military.

Additionally, we recommend that the DOD and other federal agencies tasked with assisting transitioning service members should reach out to and educate private sector employers on the value of their employing veterans. This outreach must include engaging all employers including federal agencies, for-profit and non-profit corporations as well as small businesses.

Congress should engage in a national dialogue, working closely with the Administration generally, and the DOD, VA, and DOL specifically, as well as State Governors and Adjutant Generals, employers, trade and professional associations, and licensure and credentialing entities at all levels, to establish a process so military training meets civilian certification and licensure requirements for states in which veterans choose to live once they leave the military.

Transition Assistance Program (T.A.P.)

The IBVSOs feel it is imperative that Congress ensure proper funding for transition assistance programs and that the programs themselves need to be continually updated and monitored to meeting the ongoing needs of servicemembers repatriating from overseas deployments.

he Transition Assistance Program (TAP), an interagency program, pursuant to section 502 of the "National Defense Authorization Act for Fiscal Year 1991" (P.L. 101–510), was established as a partnership between the Departments of Defense, Veteran Affairs and Labor to provide resources and expertise to assist and prepare Veterans and Service Members to obtain meaningful careers, maximize their employment opportunities, and protect their employment rights. DOL/VETS continues to provide wide-ranging services to meet the ongoing employment and training needs of transitioning veterans, especially those injured or disabled, and to bring together employers and qualified veterans to fill open positions.

A brief overview of some of the programs/initiatives under the auspices of DOL/VETS, according to their FY 2011 Report to Congress (see the full report at *http://www.dol.gov/vets/media/FY2011Annual ReportToCongress.pdf.* includes:

- the Jobs for Veterans State Grant (JVSG) program distributes funding to states for Disabled Veterans' Outreach Program (DVOP) specialists who work with veterans experiencing the most significant barriers to employment and Local Veterans' Employment Representative (LVER) staff, whose main task is work with employers to cultivate employment opportunities for veterans. These individuals provide concentrated case management services to veterans and encourage the hiring of veterans through direct marketing and outreach activities with employers (FY 2013 budget request $170,049,000);

- the Homeless Veterans' Reintegration Program (HVRP) has as its noble goal the reintegration of homeless veterans into both society and the workforce. In FY 2011, the HVRP helped place thousands of previously homeless veterans on the road to recovery and integration FY 2013 budget request $38,185,000);
- the Recovery & Employment Assistance Lifelines (REALifelines) initiative, focuses on services to those transitioning Service Members and Veterans wounded and injured in the wars in Iraq and Afghanistan;
- the Veterans' Workforce Investment Program (VWIP), pursuant to P.L. 105–220, Section 168, provides resources for the training necessary to prepare Veterans for meaningful employment and to encourage effective implementation of services for eligible Veterans facing significant barriers to employment; and
- the focus of this article, the Transition Assistance Program (TAP) Employment Workshops provide critical assistance to Service Members and their spouses by giving them the tools necessary for a successful transition from military to civilian life (FY 2013 budget request $12,000,000). See full VETS budget request at *http://www.dol.gov/dol/budget/2013/pdf/cbj-2013-v3–05.pdf*)

The Department of Labor's (DOL), Veterans' Employment and Training Service (VETS), which originally began providing TAP employment workshops in 1991, provided more than 4,200 TAP classes to nearly 145,000 participants around the world in FY 2011and those figures are expected to increase in 2013 to 5,700 TAP classes provided to over 200,000 participants worldwide. The total budget request submitted by VETS for 2013 was in the amount of $258,870,000 of which $12,000,000 was designated to fund the TAP program.

The need to fully fund ongoing TAP classes cannot be underestimated due to the importance and complexity of transitioning to civilian life. Both the TAP and the Disabled Transition Program (DTAP) will, generally, be mandatory thanks to the "VOW to Hire Heroes Act" (P.L. 112–56) and will result in the program becoming an even greater benefit in meeting the needs of separating service members as they transition into civilian life. The VOW to Hire Heroes Act:

- Directs the DOD and DHS to, generally, require the participation of members of the armed forces being separated from active duty, and their spouses. Waivers of participation would be permitted for those whose participation is not, and would not be, of assistance since such members are unlikely to face major readjustment, health care, employment, or other challenges associated with transition to civilian life; and for those with specialized skills who are needed to support imminent deployment;
- Requires the DOL to conduct a study and provide a report to Congress to identify any equivalencies between the skills developed by members through various military occupational specialties and the qualifications required for various positions of civilian employment. These skills equivalencies will be published on the Internet and updated regularly;
- Directs the DOD to ensure that each member participating in TAP receives an individualized equivalencies assessment and to make each assessment available to VA and the DOL;
- Requires VA to contract, within two years, with appropriate contractors to provide members being separated from active duty, and their spouses, with appropriate TAP services. Retirees may begin TAP classes 2 years prior to retirement and non-retiree service members may begin TAP classes 1 year prior to separation;
- Authorizes the DOL, VA, the DHS, and the DOD, in carrying out TAP, to contract with private entities that have experience with instructing members on relevant topics on job training and job searching, including academic readiness and educational opportunities;
- Authorizes the DOD and DHS, as part of TAP, to permit an eligible member to participate in an apprenticeship or pre-apprenticeship program that provides them with the education, training, and services necessary to transition to meaningful employment;
- Directs the Comptroller General to conduct a review of TAP, and to submit review results and recommendations to Congress;
- Treats an individual as a veteran, a disabled veteran, or a preference eligible for purposes of appointments to federal competitive service positions if the individual meets all other qualifications except for the requirement of discharge or release from active duty under honorable conditions, as long as such individual submits to the federal officer making the appointment a certification that he or she is expected to be discharged or released under honorable conditions within 120 days after submission of the certification. Requires the director of the Office of Personnel Management to (1) designate agencies to establish a program to

provide employment assistance to members being separated from active duty and (2) ensure that such programs are coordinated with TAP; and
- Requires the inclusion of TAP performance measures in annual DOL reports on veterans' job counseling, training, and placement programs.

As noted above, as part of the first major redesign of the TAP program in 20 years, eligible members will be allowed to participate in an apprenticeship or pre-apprenticeship program that provides them with education, training, and services necessary to transition to meaningful employment. These new TAP classes will also upgrade career counseling options and resume writing skills, as well as ensuring the program is tailored for the 21st century job market.

Currently, TAP consists of the following five components:

- pre-separation counseling conducted by the respective military services;
- employment workshops presented by the Department of Labor;
- veterans benefits briefings conducted by VA;
- DTAP facilitated by VA; and
- personalized coaching and practicum.

Since 2005, TAP classes have been offered to eligible, demobilizing Reserve Component members (upon their return from mobilization of 180 days or more). These TAP classes are designed to address the following four areas:

1.transition counseling—mandatory and conducted by the military services;

2."Uniformed Services Employment and Reemployment Rights Act" (USERRA) briefing (normally conducted by the DOL);

3.veterans benefits briefings—facilitated and sponsored by VA; and

4.DTAP facilitated and sponsored by VA

Efforts to improve both TAP and DTAP are under way. The scope of the changes was noted in DOL testimony before the House Veterans Affairs Committee of June 2, 2011:

- redesign both TAP and DTAP to assess each individual's readiness for employment, and their interests;
- updating the content of the employment workshop, to include workshops on employment readiness;
- providing skilled contract facilitators who are trained using newly developed program standards;
- providing an online, e-learning platform that will serve as a comprehensive resource for all service members, veterans, Reserve component members, wounded warriors, and spouses.
- providing customized coaching by phone or online for 60 days after participants attend the workshop; and
- performing metrics and satisfaction surveys after program completion, during the job search phase, and once employment has been obtained.

The *Independent Budget* Veterans' Service Organizations (IBVSOs) understand the plan is to begin piloting the redesigned workshops starting in January 2013 and to roll out the new workshops to all CONUS DVOP/LVER facilitated TAP sites by the end of FY 2012 and to the remainder of the overall sites by Dec. 31, 2012. We look forward to the fielding of the improved TAP and DTAP whose classes are often the only opportunity a service member, or qualifying family member, has to receive the critical information vital to sustaining their quality of life after the military.

The transition from a military career to a civilian and corporate sector career involves a major cultural shift. Veterans not only need employment but often need assistance in making this life-changing adjustment as well. This time of transition is one of the most stressful and challenging times experienced by many veterans. After spending years becoming part of a military culture, service members who leave the military face a new unknown culture when they step into a civilian role or corporate career. This transition is often complicated by injuries they received, both visible and invisible, while serving their country. As battlefield medicine continues to save more lives, VA and the DOD, DOL, and DHS must be ready to adapt and change their current transition and education programs to meet the needs of today's veterans.

Service members leaving the military with service-connected disabilities are offered DTAP, a program that includes the normal three-day TAP workshop, plus additional hours of individual instruction and advice to determine employability and to address their unique needs related to disabilities. DTAP provides important information to wounded service members and their families at a critical nexus. Often

these individuals are hospitalized or receiving medical rehabilitation away from their regular units during their military service discharge periods. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. In this respect, DTAP has not scored the level of success that TAP has achieved, and it is critical that coordination be closer between the DOD, VA, and Veterans Employment and Training Service (VETS) to reduce this disparity for these severely disabled service members.

The IBVSOs believe Congress, the DOD, VA, and the DOL should provide increased funding for TAP and DTAP to support mandatory attendance for all personnel being discharged.

The IBVSOs have also been concerned with the large numbers of reserve and National Guard service members moving through the discharge system with only the benefit of the abbreviated TAP as opposed to the more comprehensive program attended by active component members. Neither the DOD nor VA seems prepared to handle the large numbers and prolonged activation of reserve forces for the global war on terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. If service members are uninjured, they may clear the demobilization station in a few days, and little if any of this time is dedicated to informing them about veterans' benefits and services. Additionally, the DOD personnel at these sites are most focused on processing service members through the sites. Lack of space and facilities often restricts contact between demobilizing service personnel and VA representatives. To ensure full participation in this important program, the IBVSOs have long recommended making participation in the more comprehensive TAP mandatory for all discharging service members. The VOW to Hire Heroes Act should finally bring closure to this issue.

The IBVSOs recommend the following:

- All Transition Assistance Program (TAP) classes should include in-depth VA benefits and health-care education sessions and time for question and answer sessions;
- The Departments of Veterans Affairs, Defense, Labor, and Homeland Security should design and implement a stronger Disabled Transition Assistance Program (DTAP) for wounded service members who have received serious injuries, and for their families;
- Chartered veterans service organizations should be directly involved in TAP and DTAP or, at minimum, serve as an outside resource to TAP and DTAP;
- The DOD, VA, DOL, and DHS must do a better job educating the families of service members on the availability of TAP classes, along with other VA and DOL programs regarding employment, financial stability, and health-care resources;
- Increase the funding for DVOPs to ensure that there are enough to meet the expected demand, with special focus on rural areas;
- Establish an incentivized Grant process for any innovative programs utilizing improved methods of meeting the needs of veterans; and
- Improve internal audit system capabilities in order to monitor compliance with appropriate rules and regulations.

Congress and the Administration must provide adequate funding to support TAP and DTAP to ensure that all transition service members, whether Active or Reserve Component, receive proper services during their transition periods.

9 April 2013

The Honorable Representative Jeff Miller, Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20510

Dear Chairman Miller:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the upcoming 11 April 2013, House Committee on Veterans' Affairs hearing on the U.S. Department of Veterans' Affairs Budget Request for Fiscal Year 2014.

Sincerely,

Diane M. Zumatto, AMVETS
National Legislative Director

Prepared Statement of Raymond Kelley

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 2 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.

As VA strives to improve the quality and delivery of care for our wounded, ill and injured veterans, the facilities that provide that care continue to erode. With buildings that have an average age of 60 years, VA has a monumental task of improving and maintaining these facilities. Since 2004, utilization at VA facilities as grown from 80 percent to 120 percent, while the condition of these facilities has eroded from 81 percent to 71 percent over the same period of time. It is important to remember that VA facilities are where our veterans receive care, and they are just as important as the doctors who deliver it. Every effort must be made to ensure these facilities remain 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 for our veterans.

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately $45 billion. Although VA has decreased the number of critical infrastructure gaps, there remain more than 4,000 gaps that will cost between $51 and $62 billion to close with an additional $11 billion in activation costs.

The two categories that concern The *Independent Budget* veterans service organizations (IBVSOs) the most are condition and access. To determine and monitor the condition of its facilities, VA conducted a Facility Condition Assessment (FCA). These assessments include inspections of building systems, such as electrical, mechanical, plumbing, elevators and structural and architectural safety; and site conditions consist of roads, parking, sidewalks, water mains, water protection. The FCA review team can grant ratings of A, B, C, D, and F. A through C assessments conclude the rating is in new to average condition. D ratings mean the condition is below average and F means the condition is critical and requires immediate attention. To correct these deficiencies, VA will need to invest nearly $9.8 billion.

To close the gaps in access, VA will need to invest between $30 and $35 billion dollars in major and minor construction and leasing. The remaining $20 billion is needed to close the remaining non-recurring maintenance (NRM) deficiencies.

Quality, accessible health care continues to be the focus for the IBVSOs, and to achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital asset plan is important, which VA has done, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization and safety gaps will not fulfill VA's mission: "to care for him who shall have borne the battle . . . "

Major Construction Accounts:

Decades of underfunding has led to a major construction backlog that has reached between $21 billion and $ 25 billion. There are currently 21 VHA major construction projects that have been partially funded dating back to 2007. None of these projects are funded through completion and only four received funding in FY 2013. The total unobligated amount for all currently budgeted major construction projects exceeds $2.9 billion. Yet the total budget proposal for FY 2013 major construction accounts was less than $533 million.

To finish existing projects and to close current and future gaps, VA will need to invest at least $21.7 billion over the next 10 years. At current requested funding levels, it will take between 40 years to complete VA's 10-year plan.

In the short-term, VA must start requesting and Congress must start funding major construction at a level that begins to reduce the backlog. The IBVSOs recommend doubling the requested level, providing VA with $1.1 billion in major construction funding in FY 2014. VA must also begin presenting long-term proposals that will outline how the Department will address closing all major construction gaps.

Minor Construction Accounts:

To close all the minor construction gaps within their 10-year timeline, VA will need to invest between $8.5 billion and $10.5 billion, up $1 billion from last year. For several years VA minor construction was funded at a level to meet its 10-year goal. However, the Administration and Congress have lost their commitment and proposed a drastic funding decrease for minor construction over the past two years. The budget proposal for FY 2013 was $607.5 million, an increase from the prior year, but still underfunded to close existing minor construction gaps. At this funding rate, current minor construction gaps will take more than 16 years to close.

The IBVSOs believe that minor construction accounts can be brought back on track by investing approximately $880 million per year over the next decade to close existing gaps and to prevent unmanageable future gaps in minor construction.

Additionally, for capital infrastructure, renovations, and maintenance, we recommend $50 million or more for up to five major construction projects in VA research facilities; and $175 million in non-recurring maintenance and Minor Construction funding to address Priority 1 and 2 deficiencies identified in the capitol infrastructure report (in accounts that are segregated from VA's other major, minor, and maintenance and repair appropriations).

Nonrecurring Maintenance Accounts:

Even though non-recurring maintenance (NRM) is funded through VA's Medical Facilities account and not through construction account, it is critical to VA's capitol infrastructure. NRM embodies the many small projects that together provide for the long-term sustainability and usability of VA facilities. NRM projects are one-time 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.

VA is moving further from closing current NRM safety, utilization and access gaps, and continues to fall behind on preventing future gaps from occurring. Just to maintain what they have, in the condition that it is in, VA's Non-Recurring Maintenance (NRM) account must be funded at $1.35 billion per year, based on The *Independent Budget* veterans service organizations (IBVSO) estimated Plant Replacement Value. It is currently being funded at $712 million per year. More will need to be invested to prevent the $22.4 billion NRM backlog from growing larger.

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.

Capital Leasing:

The fourth cornerstone to VA's capital planning is leasing. The current lease plan calls for little more than $2 billion over the next 10 years. The VA enters into two types of leases. First, VA leases properties to use for each Agency within VA, ranging from community-based outpatient clinics (CBOC) and medical centers, to research and warehouse space. These leases do not fall under the larger construction accounts, but under each Administration's and Staff Office operating accounts.

VA faces a new problem regarding leasing protocols for major medical facilities; facilities that average an annual rental payment of more than $1 million. Prior to 2012 the Congressional Budget Office (CBO) used the assumption that these leases were short-term agreements used for existing and renewed leases only. While CBO prepared its cost estimate for H.R. 6375, the VA Major Construction Authorization and Expiring Authorities Extension Act of 2012, budget analysts realized most of the leases were for newly-built facilities over extended periods of time.

CBO views these types of leases in the same vein as purchasing a facility, and therefore concluded that VA must fully account for funding of such leases in first year of the lease.

Under these rules, VA would have to base its major facility leases by using a revolving fund similar to the General Services Administration's (GSA). This is prob-

lematic for VA because the agency would now have to offset approximately $1.2 billion this fiscal year to comply with current budget rules and proceed with the current requested leases.

In the absence of VA rewording these leases in a way that would prompt CBO to calculate major facility leases in their pre-2012 method, the IBVSOs request that Congress forego current budget rules, enabling these leases to move forward while a long-term solution is determined. Providing quality, timely and accessible health care should be the highest priority, even above current budget rules.

The second type of lease, called enhanced-use lease (EUL), allows VA to lease property they own to an outside-VA entity. These leases allow VA to lease properties that are unutilized or underutilized for projects such as veterans' homelessness and long-term care. Proper use of leases provides VA with flexibility in providing care as veterans' needs and demographics changes.

EUL gives VA the authority to lease land or buildings to public, non-profit or private organizations or companies as long as the lease is consistent with VA's mission and that the lease "provides appropriate space for an activity contributing to the mission of the Department." Although, EUL can be used for a wide range of activities, the majority of the leases result in housing for homeless veterans and assisted living facilities. Unfortunately, EUL authority has expired, leaving the VA struggling to enter into agreements for under and unused property. Congress must reauthorize this authority.

Empty or Underutilized Space at Medical Centers:

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 or reapportioned for another use. 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 intradepartmental adjacencies that must be maintained for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it. 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. Another important problem with this existing unused space is often location. Much of it is not in a prime location; otherwise, it would have been previously renovated or demolished for new construction.

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. 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 has identified 494 buildings that have been identified for repurposing. Building Utilization Review and Repurposing or BURR will focused on identifying sites in three major categories; housing for veterans who are homeless or at risk for being homeless; senior veterans capable of independent living and veterans who require assisted-living and supportive services. The three phases planned include identifying campuses with buildings and land that are either vacant or underutilized; sites visit to match the supply of building and land with the demand for services and availability of financing and lastly identifying campuses using VA's enhanced-use leasing authority. Under the BURR initiative, if no repurposing for a building is identified, VA will begin to assess its vacant capital inventory by demolishing or disposing of buildings that are unsuitable for reuse or beyond their usefulness.

The IBVSO's have stated that VA must continue to develop these plans, working in concert with architectural master plans, community stakeholders and clearly identifying the long-range vision for all such sites.

Prepared Statement of Louis J. Celli, Jr.

"On or after the first Monday in January but not later than the first Monday in February of each year, the President shall submit a budget of the United States Government for the following fiscal year."

Budget and Accounting Act of 1921

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

On behalf of Commander Koutz and the 2 and a half million members of The American Legion, we welcome this opportunity to comment on the federal budget, and specific funding programs of the Department of Veterans Affairs.

The American Legion is a resolution based organization; we are directed and driven by the millions of active legionnaires who have dedicated their money, time, and resources to the continued service of veterans and their families. Our positions are guided by nearly 100 years of consistent advocacy and resolutions that originate at the grassroots level of the organization – the local American Legion posts and veterans in every congressional district of America. The Headquarters staff of the Legion works daily on behalf of veterans, military personnel and our communities through roughly 20 national programs, and hundreds of outreach programs led by our posts across the country.

As thousands of troops return from deployments to Afghanistan and elsewhere in the world, and the United States shifts its policies in Iraq and Afghanistan, thus producing a new national security focus, The American Legion reminds the Committee that national security changes do not change the fact that veterans of these wars, as well as prior conflicts, must still be taken care of in the aftermath of these wars, and this care will extend for these veterans and their caregivers for the next sixty years.

In October of last year National Commander James Koutz provided the Committee The American Legion's guidance for a robust Department of Veterans Affairs (VA) budget that adequately provides for the health care and benefits for veterans of all wars during this period of difficult fiscal times. The VA will continue to be faced by the growing number of thousands of new patients and claimants even though the wars are winding down, and the Department of Defense is reducing its authorized endstrength of military personnel. This increase in veterans will continue for the foreseeable future and this Committee must provide the Department the resources necessary to care for these veterans and their families.

While grateful for prior VA funding, The American Legion remains vigilant to ensure that VA is not going to be shortchanged of the funding it truly needs, because the lack of appropriate funding will ultimately endanger veteran care and benefits. The American Legion has, for years, been testifying before the Congress of The Unites States, reminding them that the cost of war, especially prolonged war, is expensive and that the true costs are only realized decades after the war is over. Last month the Harvard Kennedy School issued a report that projected the total cost of these current conflicts to cost between $4 and $6 trillion. The report goes on to say;

"The single largest accrued liability of the wars in Iraq and Afghanistan is the cost of providing medical care and disability benefits to war veterans. Historically, the bill for these costs has come due many decades later. The peak year for paying

disability compensation to World War I veterans was in 1969 – more than 50 years after Armistice. The largest expenditures for World War II veterans were in the late 1980s. Payments to Vietnam and first Gulf War veterans are still climbing. The magnitude of future expenditures will be even higher for the current conflicts [1]"

American Legion members have answered the call to service. Our members, 22 million American veterans, and their families, have paid for the defense of this nation with our blood, sweat, and tears. And while Senator McCain, who has so many homes that he has lost count, stands before the Senate to proclaim "I know of no one who joined the military because of Tricare, (though) I hear (it) from all the retirees ... I have not yet met a single 18-year-old, including my own son who joined the Marine Corps, who said: 'Gee, I want to join the Marine Corps because of Tricare.", The American Legion agrees. 18 year old millionaires don't join the military for the benefits; they also don't make the military a career. Those committed men and women who do dedicate their lives to wearing the uniform of this nation, however, do expect this government to honor its promise to our military families, and provide the health care and other benefits promised them. In 2001 I retired at the top of the enlisted pay grade. At that time, the monthly base pay for an E–8 in the military was $3,138 a month. After taxes, that's about $15 an hour for a senior manager with 22 years of experience, so no, 18 year old enlistees don't join for the TRICARE, but mid level military members definitely calculate the value of their TRICARE benefit versus the financial sacrifice they make while wearing the uniform when they make decisions to reenlist, and think about how they are going to continue to provide for their families.

In December, while fighting to increase TRICARE costs, Senator Coburn told colleagues on the Senate floor;

"We have used a trick ... that will require (more funding for) the health account ... which means we will not have $1.7 billion for naval exercises, for flight training, for tank training, for range training."

The President's budget calls for increasing TRICARE fees for retirees so the Department of Defense can dedicate more of their budget to funding personnel and equipment; and adjusting the Cost of Living Allowance (COLA) calculation that supports disabled military retiree payments in an attempt to reduce spending. The estimated "savings" of these two programs combined, the President hopes, will offset future spending by approximately $600 billion through the next 10 years.

It is unthinkable to ask less than one percent of the American population to volunteer to defend the United States, against all enemies, foreign and domestic, to pay them wages far lower than their nonmilitary peers, require them to move their families every three years, sustain multiple deployments year after year, suffer extraordinary wounds, and protect the men women and children of the world, then require them to "pitch in" yet again once they get home because DoD feels we have become too expensive to maintain.

VA Leased Facilities in Jeopardy

In FY 2012 H.R. 2646 authorized the VA sufficient appropriations to continue to fund and operate leased facility projects that support our veterans all across the country. In November of 2012 the FY 2013 appropriations for the same facilities was eliminated from appropriations due to a "scoring change" initiated by the Congressional Budget Office (CBO). While the locations, projects, leases, and funding requirements did not change – the way in which CBO scored the projects did, which resulted in the appearance that the project would cost more than 10 times the actual needed revenue. As a result of CBO's adjustment in scoring review, Congress refused to introduce the FY 2013 appropriations bill needed to keep these community based centers open. As these leases now become due, there are 15 major medical facilities that will be forced to close unless Congress acts quickly to provide the appropriate funding to these centers.

If these centers are allowed to close due to insufficient funding, the impact on our veterans, and the VA would be devastating. Not only would the center employees have to either relocate within the VA or be terminated, the VA could be subject to legal action for prematurely defaulting on their leases. The veterans currently being served by these facilities would then have to either travel long distances to the nearest VA facility, or would have to find care at local hospital that the VA would be required to pay for, at a fee-for-services basis. This would ultimately cost the VA

[1] Bilmes, Linda J. Harvard Kennedy School. The Financial Legacy of Iraq and Afghanistan: How Wartime Spending Decisions Will Constrain Future National Security Budgets Faculty Research Working Paper Series. March 2013

an estimated 4 times what the original appropriations would have cost for these shuttered facilities. The facilities currently in jeopardy are located in; Albuquerque, New Mexico, Brick, New Jersey, Charleston, South Carolina, Cobb County, Georgia, Honolulu, Hawaii, Lafayette, Louisiana, Lake Charles, Louisiana, New Port Richey, Florida, Ponce, Puerto Rico, San Antonio, Texas, West Haven, Connecticut, Worchester, Massachusetts, Johnson County, Kansas, San Diego, California, and Tyler, Texas.

The American Legion implores Congress to fund these centers as originally planned. The funds that these centers need has already been obligated, and refusal to fund these centers will cause a false perception of excess monies to exist within the federal budget, which The American Legion is afraid will be falsely reported as a money saving initiative.

Advance Appropriations for FY 2015

The Veterans Health Administration manages the largest integrated health-care system in the United States, with 152 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers and domiciliaries serving more than 8 million veterans every year. The American Legion believes those veterans should receive the best care possible.

The needs of veterans continue to evolve, and VHA must ensure it is evolving to meet them. The rural veteran population is growing, and options such as telehealth medicine and clinical care must expand to better serve that population. Growing numbers of female veterans mean that a system that primarily provided for male enrollees must now evolve and adapt to meet the needs of male and female veterans, regardless whether they live in urban or rural areas.

An integrated response to mental health care is necessary, as the rising rates of suicide and severe post-traumatic stress disorder are greatly impacting veterans and active-duty servicemembers alike.

If veterans are going to receive the best possible care from VA, the system needs to continue to adapt to the changing demands of the population it serves. The concerns of rural veterans can be addressed through multiple measures, including expansion of the existing infrastructure through CBOCs and other innovative solutions, improvements in telehealth and telemedicine, improved staffing and enhancements to the travel system.

Patient concerns and quality of care can be improved by better attention to VA strategic planning, concise and clear directives from VHA, improved hiring practices and retention, and better tracking of quality by VA on a national level.

Better Care for Female Veterans

A 2011 American Legion study revealed several areas of concern about VA health-care services for women. Today, VA still struggles to fulfill this need, even though women are the fastest-growing segment of the veteran population. Approximately 1.8 million female veterans make up 8 percent of the total veteran population, yet only 6 percent use VA services.

VA needs to be prepared for a significant increase of younger female veterans as those who served in the War on Terror separate from active service. Approximately 58 percent of women returning from Iraq and Afghanistan are ages 20 to 29, and they require gender-specific expertise and care. Studies suggest post-traumatic stress disorder is especially prevalent among women; among veterans who used VA in 2009, 10.2 percent of women and 7.8 percent of men were diagnosed with PTSD.

The number of female veterans enrolled in the VA system is expected to expand by more than 33 percent in the next three years. Currently, 44 percent of Iraq and Afghanistan female veterans have enrolled in the VA health-care system.

VA needs to develop a comprehensive health-care program for female veterans that extend beyond reproductive issues. Provider education needs improvement. Furthermore, as female veterans are the sole caregivers in some families, services and benefits designed to promote independent living for combat-injured veterans must be evaluated, and needs such as child care must be factored into the equation. Additionally, many female veterans cannot make appointments due to the lack of child-care options at VA medical centers. Since the 2011 survey, The American Legion has continued to advocate for improved delivery of timely, quality health care for women using VA. The American Legion is encouraged that the President's budget recognizes the need for additional funding in this critical area, and has proposed an increase of almost 14% over last year's authorization levels, which combined with years 2009 through 2013 represents an increase in funding of more than 130%.

Repair Problems in Mental Health

During the past half decade, VA has nearly doubled their mental health care staff, jumping from just over 13,500 providers in 2005 to over 20,000 providers in 2011. However, during that time there has been a massive influx of veterans into the system, with a growing need for psychiatric services. With over 1.5 million veterans separating from service in the past decade, 690,844 have not utilized VA for treatment or evaluation. The American Legion is deeply concerned about nearly 700,000 veterans who are slipping through the cracks unable to access the health care system they have earned through their service.

Post-traumatic stress disorder and traumatic brain injury are the signature wounds of today's wars. Both conditions are increasing in number, particularly among those who have served in Operation Iraqi Freedom and Operation Enduring Freedom. The President's request for a 57% increase in funding in this area is appropriate considering that a 2011 Senate Committee on Veterans Affairs survey of 319 VA mental health staff revealed that services for veterans coping with mental health issues and TBI are lacking considerable support. Among the findings:

- New mental health patient appointments could be scheduled within 14 days, according to 63 percent of respondents, but only 48.1 percent believed veterans referred for specialty appointments for PTSD or substance abuse would be seen within 14 days.
- Seventy percent of providers said their sites had shortages of mental health space.
- Forty-six percent reported that a lack of off-hours appointments was a barrier to care.
- More than 26 percent reported that demand for Compensation and Pension (C&P) exams pulled clinicians away from direct care.
- Just over 50 percent reported that growth in patient numbers contributed to mental health staff shortages.

VHA and, at the request of Congress, VA's Office of the Inspector General have studied the problem since the survey was conducted. On April 23, 2012, the VAOIG released the report, "Review of Veterans' Access to Mental Health Care." It found that VHA's mental health performance data was neither accurate nor reliable. In VA's fiscal 2011 Performance and Accountability Report, VHA grossly over-reported that 95 percent of first-time patients received a full mental health evaluation within 14 days. However, it was found that VHA completed approximately 64 percent of new-patient appointments for treatment within 14 days of their desired date, but approximately 36 percent of appointments exceeded 14 days. VHA schedulers also were not following procedures outlined in VHA directives, and were scheduling clinic appointments on the system's availability rather than the patient's clinical need.

The American Legion believes VA must focus on head injuries and mental health without sacrificing awareness and concern for other conditions afflicting servicemembers and veterans. As an immediate priority, VA must ensure staffing levels are adequate to meet the need. The American Legion also urges Congress to invest in research, screening, diagnosis and treatment for PTSD and TBI and will continue to monitor VA to ensure that they remain good stewards of the people's money

The American Legion was a strong proponent of funding VHA in advance of the traditional budget cycle. All accounts – medical services, medical support and compliance, and medical facilities – should receive increased funding to offset the increase in cost of living and Congress should supplement these accounts if necessary.

Although The American Legion supports advance appropriations, we remain concerned accurate projections on population and utilization and other challenges still remain.

One such challenge this year regards the procurement of medical equipment and Information Technology (IT) purchases. When IT within the VA was combined together across the entire agency it was implemented to improve efficiency, contracting, management, and other challenges inherent with three disjoint IT management teams. This has proved somewhat successful. However we are hearing that procurement of medical equipment and IT is hampered at medical facilities due to budget implementation failures through continuing resolutions. While a VA medical center director might have his/her operational funding beginning October 1 because of advance appropriations, much needed IT or medical equipment might be delayed due to a continuing resolution impasse in Congress. This has a detrimental impact on the veteran and his/her care. Therefore, The American Legion recommends the IT portion of the budget be added to advance appropriations and help smooth those budget challenges. Additionally, The American Legion remains committed to work-

ing with the VA in any way possible to move the VA toward their goal of becoming a paperless system. We are eager to see how the VA plans to spend the $155 million improving the Veterans Benefits management System, and the $136.4 million that is proposed to convert the paper to electronic files.

Medical Services

Over the past two decades, VA has dramatically transformed its medical care delivery system. Through The American Legion visits to a variety of medical facilities throughout the nation during our System Worth Saving Task Force, we see firsthand this transformation and its impact on veterans in every corner of the nation.

While the quality of care remains exemplary, veteran health care will be inadequate if access is hampered. Today there are over 23 million veterans in the United States. While 8.3 million of these veterans are enrolled in the VA health care system, a population that has been relatively steady in the past decade, the costs associated with caring for these veterans has escalated dramatically.

For example between FYs 2007 and 2010, VA enrollees increased from 7.8 million to 8.3 million[2]. During the same period, inpatient admissions increased from 589 thousand to 662 thousand. Outpatient visits also increased from 62 to 80.2 billion. Correspondingly, cost to care for these veterans increased from $29.0 billion to $39.4 billion. This 36% increase during those two years is a trend that dramatically impacts the ability to care for these veterans.

While FY2010 numbers seemingly leveled off – to only 3% annual growth – will adequate funding exist to meet veteran care needs? If adequate funding to meet these needs isn't appropriated, VA will be forced to either not meet patient needs or shift money from other accounts to meet the need.

Even with the opportunity for veterans from OIF/OEF to have up to 5 years of care following their active duty period, we have not seen a dramatic change in overall enrollee population. Yet The American Legion remains concerned that the population estimates are dated and not reflective of the costs. If current economic woes and high unemployment rates for veterans remain and with the Vietnam Era veterans beginning to retire and needing healthcare that may no longer be provided by their employers, VA medical care will become enticing for a veteran population that might not have utilized those services in the past.

Finally, ongoing implementation of programs such as the PL 111–163 "Caregiver Act" will continue to increase demands on the VA health care system and therefore result in an increased need for a budget that can adequately deal with the challenges.

The final FY 2013 advanced appropriations for Medical Services was $41.3 billion. In order to meet the increased levels of demand, even assuming that not all eligible veterans will elect to enroll for coverage, and keep pace with the cost trend identified above, there must be an increase to account for both the influx of new patients and increased costs of care.

Medical Support and Compliance

The Medical Support and Compliance account consists of expenses associated with administration, oversight, and support for the operation of hospitals, clinics, nursing homes, and domiciliaries. Although few of these activities are directly related to the personal care of veterans, they are essential for quality, budget management, and safety. Without adequate funding in these accounts, facilities will be unable to meet collection goals, patient safety, and quality of care guidelines.

The American Legion has been critical of programs funded by this account. We remain concerned patient safety is addressed at every level. We are skeptical if patient billing is performed efficiently and accurately. Moreover, we are concerned that specialty advisors/counselors to implement OIF/OEF outreach, "Caregiver Act" implementation, and other programs are properly allocated. If no need for such individuals exists, should the position be placed within a facility? Simply throwing more money at this account, increasing staff and systems won't resolve all these problems.

During the previous budget, this account grew by nearly 8% to $5.31 billion. The American Legion questions the necessity for that rate to continue at this time.

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[2] Source: Department of Veterans Affairs, Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. Prepared by the National Center for Veterans Analysis and Statistics

Medical Facilities

During FY 2012, VA unveiled the Strategic Capital Investment Planning (SCIP) program. This ten-year capital construction plan was designed to address VA's most critical infrastructure needs within VA. Through the plan, VA estimated the ten-year costs for major and minor construction projects and non-recurring maintenance would total between $53 and $65 billion over ten years. Yet during the FY 2012 budget, these accounts were underfunded by more than $4 billion.

The American Legion is supportive of the SCIP program which empowers facility managers and users to evaluate needs based on patient safety, utilization, and other factors. While it places the onus on these individuals to justify the need, these needs are more reflective of the actuality as observed by our members and during our visits. Yet, VA has taken this process and effectively neutered it through budget limitations thereby underfunding the accounts and delaying delivery of critical infrastructure.

So while failing to meet these needs, facility managers will be forced to make do with existing aging facilities. While seemingly saving money in construction costs, the VA will be expending money maintaining deteriorating facilities, paying increased utility and operational costs, and performing piecemeal renovation of properties to remain below the threshold of major or minor projects.

This is inefficient byproduct of budgeting priorities. Yet, as will be noted later, the reality remains that the SCIP program is unlikely to be funded at levels necessary to accomplish the ten year plan. Therefore, this account must be increased to meet the short term needs within the existing facilities.

Medical and Prosthetic Research

The American Legion believes VA research must focus on improving treatment for medical conditions unique to veterans. Because of the unique structure of VA's electronic medical records (VISTA), VA research has access to a great amount of longitudinal data incomparable to research outside the VA system. Because of the ongoing wars of the past decade, several areas have emerged as "signature wounds" of the Global War on Terror, specifically Traumatic Brain Injury (TBI), Posttraumatic Stress Disorder (PTSD) and dealing with the effects of amputated limbs.

Much media attention has focused on TBI from blast injuries common to Improved Explosive Devices (IEDs) and PTSD. As a result, VA has devoted extensive research efforts to improving the understanding and treatment of these disorders. Amputee medicine has received less scrutiny, but is no less a critical area of concern. Because of improvements in body armor and battlefield medicine, catastrophic injuries that in previous wars would have resulted in loss of life have led to substantial increases in the numbers of veterans who are coping with loss of limbs.

As far back as 2004, statistics were emerging which indicated amputation rates for US troops were as much as twice that from previous wars. By January of 2007, news reports circulated noting the 500th amputee of the Iraq War. The Department of Defense response involved the creation of Traumatic Extremity Injury and Amputation Centers of Excellence, and sites such as Walter Reed have made landmark strides in providing the most cutting edge treatment and technology to help injured service members deal with these catastrophic injuries.

However, The American Legion remains concerned that once these veterans transition away from active duty status to become veteran members of the communities, there is a drop off in the level of access to these cutting edge advancements. Ongoing care for the balance of their lives is delivered through the VA Health Care system, and not through these concentrated active duty centers.

Many reports indicate the state of the art technology available at DoD sites is not available from the average VA Medical Center. With so much focus on "seamless transition" from active duty to civilian life for veterans, this is one critical area where VA cannot afford to lag beyond the advancements reaching service members at DoD sites. If a veteran can receive a state of the art artificial limb at the new Walter Reed National Military Medical Center (WRNMC) they should be able to receive the exact same treatment when they return home to the VA Medical Center in their home community, be it in Gainesville, Battle Creek, or Fort Harrison.

American Legion contact with senior VA health care officials has concluded that while DoD concentrates their treatment in a small number of facilities, the VA is tasked with providing care at 152 major medical centers and over 1,700 total facilities throughout the 50 states as well as in Puerto Rico, Guam, American Samoa and the Philippines. Yet, VA officials are adamant their budget figures are sufficient to ensure a veteran can and will receive the most cutting edge care wherever they choose to seek treatment in the system.

The American Legion remains concerned about the ability to deliver this cutting edge care to our amputee veterans, as well as the ability of VA to fund and drive top research in areas of medicine related to veteran-centric disorders. There is no reason VA should not be seen at the world's leading source for medical research into veteran injuries such as amputee medicine, PTSD and TBI.

In FY 2011 VA received a budget of $590 million for medical and prosthetics research. Only because of the efforts of the House and Senate, was this budget kept at that level during the FY 2012 budget due to significant pressure from The American Legion. Even at this level, The American Legion contends this budget must be increased, and closely monitored to ensure the money is reaching the veteran at the local.

Medical Care Collections Fund (MCCF)

In addition to the aforementioned accounts which are directly appropriated, medical care cost recovery collections are included when formulating the funding for VHA. Over the years, this funding has been contentious because they often included proposals for enrollment fees, increased prescription rates, and other costs billed directly to veterans. The American Legion has always ardently fought against these fees and unsubstantiated increases.

Beyond these first party fees, VHA is authorized to bill health care insurers for nonservice-connected care provided to veterans within the system. Other income collected into this account includes parking fees and enhanced use lease revenue. The American Legion remains concerned that the expiration of authority to continue enhanced use leases will greatly impact not only potential revenue, but also delivery of care in these unique circumstances. We urge Congress to reauthorize the enhanced use lease authority with the greatest amount of flexibility allowable.

In May 2011, the VA Office of Inspector General (OIG) issued a report auditing the collections of third party insurance collections within MCCF. Their audit found that "VHA missed opportunities to increase MCCF by . . .46%." Because of ineffective processes used to identify billable fee claims and systematic controls, it was estimated VHA lost over $110 million annually. In response to this audit, VHA assured they'd have processes in place to turn around this trend.

Yet even if those reassurances were met, the MCCF collection would not meet the quarterly loss beneath the budgeted amounts. Without those collections, savings must be garnered elsewhere to meet these shortfalls, thereby causing facility administrators and VISN directors to make difficult choices that ultimately negatively impact veterans through a lack of hiring, delay of purchasing, or other savings methods.

It would be unconscionable to increase this account beyond the previous levels that were not met. To do so without increasing co-payments or collection methods would be counterproductive and mere budget gimmickry. While we recognize the need to include this in the budget, The American Legion cannot be part of a budget that penalizes the veteran for administrative failures.

Appropriations for FY 2014

The remainder of the accounts within VA are being allocated funding for FY 2014. These include funding for general operation of VA Central Office (VACO), the National Cemetery Administration (NCA) and Veteran Benefits Administration (VBA).

Veteran Benefits Administration

National Commander Koutz testified in October that when speaking to The American Legion National Convention in August 2010, VA Secretary Eric Shinseki declared VA would "break the back of the backlog by 2015" by committing to 98 percent accuracy, with no claim pending longer than 125 days. Over the past three years, VA has gone backward, not forward, in both of these key areas.

According to VA's own figures, over 65 percent of veterans with disability benefits claims have been waiting longer than 125 days for them to be processed. In contrast, when Secretary Shinseki made his promise, only 37.1 percent of claims had been pending longer than 125 days. The American Legion has found through its field research the problem varies greatly by regional office. While some regional offices may have an average rate of 76 days per claim, others take 336 days—a troubling inconsistency.

Unfortunately, accuracy is also a problem, according to Legion site visits and field research. VA has been reluctant to publicly post accuracy figures in its Monday Morning Workload reports, but VA's own STAR reports for accuracy place the rate in the mid 80s. The American Legion's Regional Office Action Review (ROAR) team

typically finds an even higher error rate, sometimes up to two thirds of all claims reviewed.

VA is hopeful that the Veterans Benefits Management System (VBMS) will eliminate many of the woes that have led to the backlog, but electronic solutions are not a magic bullet. Without real reform for a culture of work that places higher priority on speed rather than accuracy, VA will continue to struggle, no matter the tools used to process claims.

The American Legion has long argued that VA's focus on quantity over quality is one of the largest contributing factors to the claims backlog. If VA employees receive the same credit for work, whether it is done properly or improperly, there is little incentive to take the time to process a claim correctly. When a claim is processed in error, a veteran must appeal the decision to receive benefits, and then wait for an appeals process that may take months and months to resolve and possibly years for before delivery of the benefit.

The American Legion believes VA must develop a processing model that puts as much emphasis on accuracy as it does on the raw number of claims completed. Nowhere does VA publicly post its accuracy figures. America's veterans need to have confidence in the work done by VA, and that requires transparency.

The VBMS system could allow VA to develop more effective means of processing claims, such as the ability to separate single issues that are ready to rate, starting a flow of relief to veterans while more complex medical issues are considered and decided.

Information Technology

In addition to the VBMS system, the greatest long awaited project is the launch of the joint VA and Department of Defense (DoD) lifetime record – Virtual Lifetime Electronic Record (VLER). American Legion Resolution 42–2012 supports a single unified medical record for military members and veterans. We have heard from VA that this initiative is still vital and an important piece of their overall solution, but The American Legion remains concerned that DoD has yet to commit to ensuring this project is completed.

During the previous budgeting, VA was unable to provide information on the overall cost of creating such a system, but assured veteran advocates there was enough flexibility to address any costs associated with the project. In the meantime, several releases and announcements have been issued by VA towards the continued evolution of this project, but there is little to demonstrate we're any closer to producing a ready model. The American Legion calls upon Congress to continue to pressure VA and DoD to move towards this system as expeditiously as possible. With the development and launch of VBMS nearly complete, the entire IT focus should center on VLER.

In order to provide the necessary resources for the nationwide rollout of VBMS and still maintain efforts towards development of VLER, The American Legion believes a small increase is justified within IT.

Major and Minor Construction

After two years of study the VA developed the Strategic Capital Investment Planning (SCIP) program. It is a ten-year capital construction plan designed to address VA's most critical infrastructure needs within the Veterans Health Administration, Veterans Benefits Administration, National Cemetery Administration, and Staff Offices.

The SCIP planning process develops data for VA's annual budget requests. These infrastructure budget requests are divided into several VA accounts: Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Enhanced-Use Leasing, Sharing, and Other Investments and Disposal. The VA estimated costs were between $53 and $65 billion.

The American Legion is very concerned about the lack of funding in the Major and Minor Construction accounts. Based on VA's SCIP plan, Congress underfunded these accounts. Clearly, if this underfunding continues VA will never fix its identified deficiencies within its ten-year plan. Indeed, at current rates, it will take VA almost sixty years to address these current deficiencies.

The American Legion also understands there is a discussion to refer to SCIP in the future as a "planning document" rather than an actual capital investment plan. Under this proposal, VA will still address the deficiencies identified by the SCIP process for future funding requests but rather than having an annual appropriation, SCIP will be extended to a five year appropriation, similar to the appropriation process used by the Department of Defense as its construction model. Such a plan will have huge implications on VA's ability to prioritize or make changes as to de-

sign or project specifications of its construction projects. The American Legion is against this five year appropriation model and recommends Congress continue funding VA's construction needs on an annual appropriations basis.

The American Legion recommends Congress adopt the 10-year action plan created by the SCIP process. Congress must appropriate sufficient funds to pay for needed VA construction projects and stop underfunding these accounts. In FY 2014 Congress must provide increased funding to those accounts to ensure the VA-identified construction deficiencies are properly funded and these needed projects can be completed in a timely fashion.

State Veteran Home Construction Grants

Perhaps no program facilitated by the VA has been as impacted by the decrease in government spending than the State Veteran Home Construction Grant program. This program is essential in providing services to a significant number of veterans throughout the country at a fraction of the daily costs of similar care in private or VA facilities. As the economy rebounds and states are pivoting towards resuming essential services, taking advantage of depressed construction costs, and meeting the needs of an aging veteran population, greater use of this grant program will continue. The American Legion encourages Congress to maintain the funding level of this program.

National Cemetery Administration (NCA)

No aspect of the VA is as critically acclaimed as the National Cemetery Administration (NCA). In the 2010 American Customer Satisfaction Index, the NCA achieved the highest ranking of any public or private organization. In addition to meeting this customer service level, the NCA remains the highest employer of veterans within the federal government and remains the model for contracting with veteran owned businesses.

While NCA met their goal of having 90% of veterans served within 75 miles of their home, their aggressive strategy to improve upon this in the coming five years will necessitate funding increases for new construction. Congress must provide sufficient major construction appropriations to permit NCA to accomplish this goal and open five new cemeteries in the coming five years. Moreover, funding must remain to continue to expand existing cemetery facilities as the need arises.

While the costs of fuel, water, and contracts have risen, the NCA operations budget has remained nearly flat for the past two budgets. Unfortunately recent audits have shown cracks beginning to appear. Due predominantly to poor contract oversight, several cemeteries inadvertently misidentified burial locations. Although only one or two were willful violations of NCA protocols, the findings demonstrate a system about ready to burst.

To meet the increased costs of fuel, equipment, and other resources as well as ever-increasing contract costs, The American Legion believes a small increase is necessary. In addition, we urge Congress to adequately fund the construction program to meet the burial needs of our nation's veterans.

State Cemetery Grant Program

The NCA administers a program of grants to states to assist them in establishing or improving state-operated veterans' cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, this program funds nearly 100% of the costs to establish a new cemetery, or expand existing facilities. For the past two budgets this program has been budgeted $46 million to accomplish this mission.

New authority granted to VA funds Operation and Maintenance Projects at state veterans cemeteries to assist states in achieving the national shrine standards VA achieves within national cemeteries. Specifically, the new operation and maintenance grants have been targeted to help states meet VA's national shrine standards with respect to cleanliness, height and alignment of headstones and markers, leveling of gravesites, and turf conditions. In addition, this law allowed VA to provide funding for the delivery of grants to tribal governments for native American veterans. Yet we have not seen the allocation of funding increased to not only meet the existing needs under the construction and expansion level, but also the needs from operation and maintenance and tribal nation grants. Moreover, as these cemeteries age, the $5 million limitation must be revoked to allow for better management of resources within the projects.

Additional concerns of The American Legion

Turn Military Experience Into Careers

Servicemembers and veterans receive some of the finest technical and professional training in the world. Many have experience in health care, electronics, computers, engineering, drafting, air-traffic control, nuclear energy, mechanics, carpentry, and other fields. Many of these military acquired skills require some type of license or certificate to qualify for civilian jobs. In too many cases, this license or certificate requires schooling already completed through military training programs. The American Legion is fighting for a major overhaul of the licensure and certification policies as they relate to military job skills, on the national and state levels alike. As demand for qualified workers in a diverse range of occupations continues to grow, veterans offer skills, training, dedication and discipline that translate well into specialized fields and trades.

The American Legion is working with credentialing and licensing agencies to help veterans receive credit for their experiences, maximize their abilities and move quickly into productive careers. While the VOW to Hire Heroes Act and the Veterans Skills to Jobs Act of 2012, are important steps that The American Legion strongly supported and helped shape, they are only a good start in a long march to improve career opportunities for those who have served in uniform.

Ease the Military-to-Civilian Transition

Unfortunately, this transition has been hampered by poor communication and coordination between DoD and VA. Efforts have been made to correct the process, which is improving, but too many veterans still slip through the cracks and fail to receive the benefits they earned and deserve or the support they need to restart their lives. Transition Assistance Programs (TAP) are now mandatory across all branches of military service, a change The American Legion commends. While TAP will require much fine tuning to accurately deliver what veterans need, implementing the program universally already is a major improvement.

Current DoD policy requires new inductees to enroll in the eBenefits portal, which will help all future generations of veterans. While VA and DoD still try to iron out differences in electronic data systems necessary to make the Virtual Lifetime Electronic Record (VLER) effective, the eBenefits portal holds great promise.

Fast-tracking the VLER program to ensure seamless transfer of medical records must be a top priority, and necessary funds must be allocated to fulfill it. The delays that have plagued this program are inexcusable. The American Legion urges Congress and the administration to work together to put the program back on track.

While The American Legion is encouraged by the progress made in TAP, the program is still new and will require dedicated oversight and attention to ensure it is meeting the needs of the servicemembers it is designed to help.

Conclusion

In conclusion, The American Legion is optimistic the President has proposed a budget that addresses many of the needs that the almost two million service members who are returning after deployments in support of the Global War on Terror will soon need. We're hopeful savings generated through downsizing of the military are leveraged against the need of thousands of servicemembers who are or soon will be discharged to create the savings. However, The American Legion has seen in previous years, these are not used to provide the care and benefits afforded to our nation's veterans. Too often while veteran advocates celebrate dramatically increased budgets, the veteran patient, claimant, or widow is left wondering where the money went.

Our nation's veterans deserve adequate and responsible funding to the fullest extent possible. After over a decade of service, our newest era of veterans will now join the ranks of generations of their brothers and sisters who served in prior wars and conflicts and all are owed a great debt.

Questions For The Record

Letter From: Hon. Michael H. Michaud, Ranking Member, To: VA

April 18, 2013

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 2014" that took place on April 11, 2013, I would appreciate it if you could answer the enclosed hearing questions by the close of business on May 24, 2013.

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. Attached are additional questions directed to you.

In preparing your answers to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a Word document, to Carol Murray at *Carol.Murray@mail.house.gov* by the close of business on May 24, 2013. If you have any questions please contact her at 202–225–9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

MHM:cm

Questions Submitted by Rep. Beto O'Rourke

1. What is your process for determining what regions get a full service VA hospital?

2. Exactly how will low and moderate income veterans be protected from benefit cuts under the President's Chain CPI proposal? When will those details be provided?

Questions Submitted by Rep. Corrine Brown

1. In FY13, there was a line item for 508 compliance of $9.43 million. However, there is no line item in the FY14 budget for 508 compliance, specifically 508 compliance to IT systems. What staffing resources and line item funding will be available for FY14? Please explain.

2. In the fall of 2012, Congress passed HR 1627, which became PL 112–154. Section 111 of the law directed the VA to develop a plan for recovery and collection of amounts for Department of Veterans Affairs Medical Care Collections Fund. Congress approved this language so that the VA would develop and implement a better process and system of controls to ensure accurate and full collections by the VA health care system.

a. Please provide details on the plan and the VA's efforts to implement its provisions.

3. The issue of third party payers and the Veterans Health Administration's Medical Care Collections Fund has been the subject of a number of government reports over the years. To help better understand this issue, please provide the following data:

a. Total amount the VA sought in third party billings for each of the past 6 years.

b. The percentage increase in billings for each year compared to the previous year's billing.

c. The percentage of collections for each year for the past 6 years.

d. The collection rate for claims over $1500 for each of the past 6 years.

e. The collection rate for claims under $1500 for each of the past 6 years.

Questions Submitted by Rep. Negrete McLeod

1. Homelessness among veterans is a serious problem in my district in California. How many housing vouchers through the HUD–VASH program do you anticipate will be funded by your requested amount of $278 million?

2. In order to receive payment from VA, mental health providers are often required to have a COAMFTE certification. This is not available in most California universities, resulting in 95% of licensed therapists not qualifying to receive payment. These therapists are 100% qualified to treat Veterans. What can VA do to work with California therapists to ensure access to mental health care despite this bureaucratic barrier?

3. As you mentioned in your testimony, the number of women Veterans enrolled in VA healthcare has increased by 22% since 2009. What is VA's timeline for increasing the number of facilities that have comprehensive women's clinics beyond the current 50%?

Questions Submitted by Ranking Member Michaud

1. We have received numerous complaints that the performance and adjudication of pension claims for the veterans of Maine has gotten worse since the consolidation of pension claims at the Philadelphia VA Regional Office.

a. Please provide the Committee with the reasons for this shift from a high performing Regional Office such as Togus to Philadelphia.

b. Please provide the Committee with the average days to complete these claims at the Togus VA Regional Office for the three years prior to shifting this workload to the Philadelphia. In addition, since the shift in workload, please provide the information relating to timeliness and quality metrics of the Philadelphia VA Regional Office.

c. Has there been any consideration to shifting this workload back to high performing regional offices such as Togus?

2. It has come to the Committee's attention that the VA is planning to shift additional FTE back to some of the worst performing VA Regional Offices. Many of the worst VA Regional Offices are in high cost-of-living areas where it is difficult for VA to recruit and, most importantly, retain employees.

a. In light of VA's plan to move to an electronic processing system, where claims could be processed at any station in the country simultaneously, what are reasons for providing additional FTE to these lower-performing stations instead of moving workload to higher-performing stations?

b. Has the VA considered reviewing where it will be able to recruit the most talented workforce and considered expanding at those locations for the best return on investment?

3. In terms of meeting your stated goal of ending the claims backlog by 2015, does your FY 2014 budget provide additional resources for overtime pay? Is this a strategy you plan to utilize in the coming fiscal year?

4. Continued investment in technology is a big component of VA's strategy to expand access to benefits and services, eliminate the claims backlog, and end veteran homelessness, the top three priorities of the VA. You have requested nearly an 11 percent increase.

a. Can you point to specific programs and initiatives that support your top three priorities that you will be able to undertake with this increase?

b. Please provide the Committee with any strategic plan that is in place that directly correlates your IT systems and software with your three stated priorities, including proposed lifespan of these systems and software and identified necessary investments in the next five fiscal years.

5. A large component of your IT budget, $2.2 billion, is for "sustainment." This includes spending on legacy systems.

a. Do you have a long-term strategy to reduce your expenditures on legacy systems? What are the short and medium term steps in this plan?

b. Is VA's spending on legacy systems in line with other Federal agencies and the private sector?

6. Your information technology budget for FY 2014 projects $252 million, or 51 percent of the development budget request of $495 million, to fund the Interagency Program Office (IPO), which will manage the integrated Electronic Health Record (iEHR) and the Virtual Lifetime Electronic Record (VLER). Given the problems with the management of the IPO that were examined in a recent hearing, what substantive changes have been made to the structure of the IPO that will improve its performance and what are the measurable outcomes you expect to achieve with this $252 million dollar expenditure?

7. You have requested an increase of 13.6 percent in discretionary spending for the Veterans Benefits Administration.

a. Can you point to specific program elements and achievements that this increase supports in terms of your goal of ending the claims backlog by 2015?

b. If you were provided an additional $300 million for this account, what specifically could you do with such an increase that would provide the biggest bang for the buck this year in terms of ending the claims backlog?

8. Your budget estimates a 16 percent increase in mandatory spending for Compensation and Pension.

a. Please provide the Committee with information regarding the factors driving these large increases in mandatory spending?

9. I understand that VA has been generally successful in addressing the issue of veteran homelessness. According to your budget submission, you plan to spend just under $1.4 billion on this initiative. I also understand that there is a group of veterans out there who are chronically homeless and suffer from co-morbid issues such as substance abuse and post-traumatic stress disorder and are the most in need of veteran homeless services.

a. Please provide the Committee with detailed information regarding how current programs and initiatives address this population.

b. Have these programs and initiatives been effective in terms of this population, and has the VA seen a decrease in the numbers of this homeless population as a result of these programs and initiatives?

10. In your FY 2014 budget submission you have proposed new savings of $482 million dollars in your medical care accounts, $370 million from new acquisition savings and $112 million from improved operations.

a. Please provide the Committee with detailed explanations regarding these proposed savings, including details on how they will be achieved and how VA will determine whether these proposals have been successful.

b. VA's current estimates for its FY 2013 budget include $200 million in savings, $150 million from "Acquisition Proposals" and $50 million from "Travel Campaign to Cut Waste." Have these savings been realized?

c. In terms of savings related to "Acquisition Proposals" you attribute $150 million in FY 2013, and $370 million respectively in FY 2014 and FY 2015. Please provide detailed information regarding how the VA will realize $890 million in savings over these three fiscal years. Once these savings have been realized for a specific fiscal year, should future savings not realized by additional efforts and initiatives be reflected in the VA's base budget and not listed as an additional saving?

d. Please explain the $257 million dollars of clinical and pharmaceutical savings that are embedded in the actuarial model used to project VA health care requirements.

11. In your budget submission you estimate that VA will spend $258 million in 2014 on new models of care such as the patient centered medical home model. Over the last four years VA has put the structure in place to bring the initiatives to fruition. Some of the outcomes VA would like to achieve in the next 7 to 10 years include improved patient satisfaction, access, and efficiency.

a. What is the strategic plan VA has in place to assess the outcomes of this major initiative that, by your own admission, will take close to a decade to achieve?

b. The budget also references improving access by adopting various eHealth technologies. Can you provide some examples of what those might be and is the cost for those various technologies part of the $258 million?

12. Providing effective, timely, and quality mental health care is a challenge that faces not just the VA but the nation as a whole. We know that provider shortages, nationally, affect VA's ability in some areas to provide timely mental health care. I think we can all agree that VA cannot do it alone. VA projects to spend $7 billion dollars on mental health programs in fiscal year 2014.

a. Please provide the Committee with information regarding VA's efforts to work with other Federal agencies, States, and communities to address this issue in a strategic way nationally.

13. It is estimated that medical inflation is currently running at an annual rate of 3.7 percent. This would seem to indicate, looking ahead, an approximate $2 billion increase for medical care accounts for 2015, $1 billion more than VA have requested.

a. Is VA assuming a drastically lower rate of medical inflation or are there programmatic changes that you expect to undertake in order to provide the same level of medical care in 2015 that you are providing today?

Pre-Hearing Questions From HVAC Majority and VA Responses

Question 1: The President's Fiscal Year 2014 updated request and the Fiscal Year 2015 advance appropriation request for medical care was formulated using, in part, projected resource estimates derived from VA's Enrollee Healthcare Projection Model (EHCPM).

a. What was the updated EHCPM estimate of total resources for Fiscal Year 2014 medical care and the Fiscal year 2015 medical care advance?

VA Response: The 2012 VA Enrollee Health Care Projection Model estimates for total expenditures for modeled services were $50.43 billion for FY 2014 and $52.85 billion for FY 2015. The estimates include the projections for ambulatory care, inpatient care, rehabilitation care, mental health care, prosethetics care, and dental care.

b. When will the Spring EHCPM update occur?

VA Response: The VA Enrollee Health Care Projection Model is updated annually. The 2013 Model update will be completed in April 2013 and will be used to inform the development of the VA medical care budget that will be sent to Congress in early 2014.

c. Do you agree to share with the Committee the updated EHCPM estimates this Spring and the impact those revised estimates will have on

1) the current 2013 budget and initiatives contained within it;

2) the 2014 budget and initiatives within it; and

3) the 2015 medical care advance?

VA Response: The 2013 Model estimates are the starting point for informing VA's medical care budget. These projections will likely be updated as additional guidance is received on issues such as wage policies. These estimates are predecisional and for internal use only until the final budget submission is released.

d. What is the total resource estimate for VA medical care in 2014 and the 2015 advance derived from both EHCPM estimates and non-EHCPM estimates?

VA Response: The total resource estimate for VA medical care in FY 2014 is $57.9 billion, and the FY 2015 advance appropriation is $59.1 billion. The direct appropriation request for FY 2014 is $54.6 billion and in FY 2015 is $55.6 billion.

The total resource estimate for VA medical care in FY 2014 is $57.9 billion, and the FY 2015 advance appropriation is $59.1 billion (see detailed breakout below).

Dollars in Thousands

Description	2014 Estimate	2015 Estimate
Appropriation (including transfers)	$54,447,000	$55,619,227
Annual Appropriation Adjustment	$157,500	
Collections	$3,064,000	$3,174,000
Reimbursements	$265,000	$272,000
Total Obligations	$57,933,500	$59,065,227

Question 2: What is the budgetary effect on VA, if any, of the impending full implementation of the Affordable Care Act? Please explain the impact and how/where it may occur.

VA Response: The FY 2014 VA medical care budget requests $85 million to ensure VA is prepared to respond to additional Veteran enrollment and utilization of health care services due to the implementation of the Affordable Care Act (ACA). In addition, the FY 2014 VA IT budget includes $3.4 million to build functionality needed to deliver statements to enrolled Veterans and beneficiaries enrolled in CHAMPVA and Spina Bifida who maintain Minimal Essential Coverage through VA. This funding will also go towards building the tool to identify and report on individuals who are enrolled in VA health programs identified as Minimal Essential Coverage. VA expects to see a modest increase in enrollment as a result of ACA implementation. VA continues to engage with its Federal partners to identify collaborative opportunities on areas that affect VA and Veterans.

Question 3: Please provide a listing of all Senior Executive Service bonuses/performance awards for Fiscal Year 2012. In providing the listing, please include the following information:

a. The name of the individual approved to receive the bonus or performance award;

b. The title of the individual;

c. The VA organizational unit the individual belongs to; and

d. The amount of the bonus or performance award.

VA Response: A final decision regarding FY 2012 performance awards has not been made. VA will provide a response after the final decisions have been made.

Question 4 – Part 1: In hearing testimony last Congress VA indicated it would re-evaluate the size and structure of the various VISN headquarters. What is the result of that re-evaluation?

VA Response: To ensure consistent and efficient use of staffing resources in each Veterans Integrated Service Network (VISN) office, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) chartered a VISN Staffing Levels Implementation Work Group to conduct a review of each VISN office. The workgroup reviewed the mission and function of each VISN and attempted to identify core staff and certain flexible additional staff to support the mission and function of the VISN. This review was intended to achieve an alignment of resources to the mission of the VISN, and to essentially allow certain resources to be returned to facilities in closer support of patient care. The workgroup established definitions of VISN staff functions, identified targeted staffing levels, developed an implementation timeline and plan for each VISN's adjustment in staffing levels, and created a monitoring mechanism to assure achievement and ongoing management of the targeted staffing levels.

The Under Secretary for Health approved the DUSHOM workgroup's proposal to adapt a standard set of core positions for all VISN headquarters, with an additional allocation of staff provided to each VISN based on the complexity of the VISN health network. Implementation of VISN staffing realignments started in the fourth quarter of FY 2012 and will be monitored and executed through December 31, 2013.

Question 4 – Part 2: What impact did the re-evaluation have on the number of employees working at the various VISN headquarter offices?

VA Response: Under the approved structure, each VISN will have 47.5 base staff and 6 administrative support staff, for a total of 53.5 core FTEE. In addition, each network received a variable staffing level above the base staffing allotment to utilize

at their discretion to meet local needs. This additional staffing allotment varies from 2 to 12 FTEE, based upon the size, complexity and scope of each VISN. The number of staff at each VISN will range between 55 and 65, resulting in an overall decrease in VISN staff levels from 1,719.9 FTE to a total of 1,235 FTE. The average VISN size will decrease from approximately 82 FTE to 59 FTE – a reduction of 23 FTE on average, per VISN.

VHA does not expect any layoffs or other adverse actions to employees to occur as a result of the VISN staffing realignment. Adjustments are primarily expected to be accomplished through the transfer of functions to facilities, attrition or other similar processes. Further, VISN organizations contain "legacy" positions that VISN leadership would not be inclined to refill if the incumbent vacated the position. VISNs are being allotted more than 12 months to effect staffing changes, so that any disruption to employees and/or mission is minimized. VISN management teams were instructed to ensure employees are provided every available opportunity to be involved in their new assignments and follow, as appropriate, any bargaining agreements with labor unions. VHA and the VISNs are engaging the workforce throughout the implementation to ensure their issues and concerns are addressed for all affected employees.

Question 4 - Part 3: Please provide a breakdown, by VISN, of headquarter staffing for each of Fiscal Years 2011, 2012, and 2013.

VA Response: Below are FTEE assigned to VISN offices in FY 2011. These totals were based on a data call with each VISN providing the number of individuals considered to be VISN staffing. This total was collected as the baseline to begin the VISN staffing review. There was no additional data call in FY 2012 as the staffing review was well underway. Also included below are the targeted FTEE VISN staffing levels to be reached at the completion of this process on December 31, 2013.

VISN	FY2011 Actual	FY 2013 Target
1	132.7	59.5
2	95.3	55.5
3	55.2	57
4	61	59
5	53	55.5
6	68.2	59
7	163.3	61
8	81.6	65.5
9	85.9	59
10	67	57
11	103	59
12	87.8	59
15	73	57
16	118.3	63
17	75.4	59
18	67.6	59
19	55.8	57

VISN	FY2011 Actual	FY 2013 Target
20	70.3	59
21	59.5	59
22	60.7	59
23	85.3	59
TOTAL	1719.9	1237

Question 5: How much has been spent on the Veterans Benefits Management System? Was that system based, in part, on VA's "Virtual VA" initiative? If so, how much was spent on Virtual VA and when was it initiated?

VA Response: VA will have invested $325.6 million (IT) into VBMS development from FY 2010 through FY 2013. Additionally, VBA invested $103.3 million in general operating expenses (GOE) funding (non-IT) into VBMS during this same period to support development.

Virtual VA remained a separate project from VBMS. Virtual VA was initiated in 1999. VBMS and Virtual VA development teams began discussions on Virtual VA to VBMS migration efforts in November 2012.

Question 6: The President's budget will likely contain new policy initiatives for VA. What is the number and total dollar amount of these initiatives? Does the budget request for the initiatives represent full funding, or will subsequent appropriations in future years be required?

VA Response: The FY 2014 President's Budget will propose a number of initiatives, and the details will be available on April 10, 2013. Future requirements will be evaluated as part of the budget process in FY 2015 and beyond.

Question 7: The President's budget will likely request extension of certain expiring legal authorities. Does the appropriation request in the budget submission assume that those legal authorities will, in fact, be extended?

VA Response: Yes. The 2014 President's Budget scheduled for release on April 10th, does request extension of certain expiring provisions and assumes enactment of these authorities.

Question 8: What was the administrative impact on the various VA administrations/accounts which, unlike medical care, were operating under a continuing resolution until a week ago? Should consideration be given to advance fund additional or all VA accounts? Please explain.

VA Response: In general, VA would have been able to begin full execution of all of its annual operating plans without delays or uncertainties, had full-year funding been enacted at the start of the fiscal year. The impact of operations under a Continuing Resolution (CR) in other than Medical accounts varied in accordance with comparisons of the levels of funding from 2012 to 2013. VBA had no administrative impact under the CR, which included anomaly funding at the President's request level. NCA felt minimal impact as most of its contracts are awarded in the second half of the fiscal year. The General Administration account funding requested in the 2013 President's budget was at the 2012 level and thus the CR had no or minimal impact to operations. For the Office of Information Technology account, the CR created significant uncertainty.

Question 9: Please describe the efforts made and the results obtained in reducing improper payments across all VA elements.

VA Response: VA's number one financial initiative is identifying, preventing, and recovering improper payments.

Three years ago, VA established a set of goals and initiatives to strengthen financial management across the Department. We have been successful in implementing these initiatives, including: (1) eliminating the three long-standing material weaknesses in our financial systems, financial operations and estimation of liabilities, (2) reducing the number of significant deficiencies found in our annual audit from 16 to one, (3) increasing compliance from 44 percent to over 95 percent in a $14 billion

purchasing program – greatly reducing the risk of fraud, waste and abuse, (4) updating all of our financial policies and procedures to ensure that our employees know what is expected of them in performance of their duties, and (5) providing training to over 5,000 financial management employees so that they had the knowledge to do their jobs correctly.

These initiatives were prioritized as we entered each fiscal year to determine what was most important to the Department (for example, our top financial managementt priority in 2010 was to eliminate the three material weaknesses). Once priorities were set, we worked each initiative accordingly. Following that same approach, the Department entered fiscal year 2013 making our latest, and current, top priority for financial management the elimination of improper payments.

It is important to note at the outset of this discussion that in taking measures to eliminate improper payments at VA, we must be conscious of the need to ensure we do not cause hardship for our Veterans and their families. In some instances, the law governing payments takes this balance into account and may even require VA to make "improper" payments (as counted by current accounting guidelines) in order to protect Veterans' interests. A good example is our pension program, where we make initial payments to Veterans before the income data provided by the Veteran can be verified and, once it is verified, we may learn that it was not accurate.

As a result, there are improper payments that we "cannot stop" as well as improper payments that we "can stop." The total $2.2 billion of improper payments in 2011 includes both of these types of payments. For the "cannot stop" improper payments, our focus must be on utilizing debt collection tools in an attempt to recover the payments. For the "can stop," we must eliminate these improper payments up front so they never occur. A key component of our plan over the next several months is to determine which improper payments are "cannot stop" and which are "can stop." Only when we know this distinction will we be positioned to learn and address the root causes of the improper payments we "can stop."

Attached as enclosures are VA's plans for achieving compliance with the Improper Payments Elimination and Recovery Act (IPERA), which was provided to Congress on August 13, 2012, in accordance with IPERA, and OMB Circular A–123 and corrective action plans published in VA's FY 2012 Performance and Accountability Report.

For many years, VA has been implementing initiatives to reduce improper payments. These initiatives include data matching programs with the Social Security Administration and the Internal Revenue Service, recovery auditing, and the use of software designed to detect improper payments. These efforts have had a positive impact, but clearly, we can do more – and we will.

Question 10: In testimony last Congress VA indicated that both, the number of, and costs associated with, conferences would be reduced. Please provide information that this has occurred.

VA Response: In accordance with Office of Management and Budget (OMB) Memoranda 11–35, and 12–12, in February 2013, VA reported costs of approximately $72.7 million for 127 individual conferences and training events which exceeded $100,000, for Fiscal Year 2012. OMB's memos define a conference as "[a] meeting, retreat, seminar, symposium or event that involves attendee travel. The term 'conference' also applies to training activities that are considered to be conferences under 5 CFR 410.404." Additionally, in accordance with Public Law (P.L.) 112–154, section 707, VA is required to report to Congress on "covered conferences" on a quarterly basis. Under the law's definition, a covered conference is "a conference, meeting, or other similar forum that is sponsored or co-sponsored by the Department and is— (1) attended by 50 or more individuals, including one or more employees of the Department; or (2) estimated to cost the Department at least $20,000." VA's First Quarter FY 2013 report to Congress, as required by P.L. 112–154, estimated approximately $12 million was spent on 93 conference and training events. In the submission, it was noted that not all data required for full reporting for that quarter had been received and processed. An update to the First Quarter Report reflected actual costs to be approximately $9.8 million for those 93 events. The First Quarter update will be submitted to Congress with the Second Quarter FY 2013 report due on April 30, 2013.

Post-Hearing Questions From HVAC Majority and VA Responses

Questions Submitted by Ranking Member Michaud

Question 9: I understand that VA has been generally successful in addressing the issue of veteran homelessness. According to your budget submission, you plan to spend just under $1.4 billion on this initiative. I also understand that there is a group of veterans out there who are chronically homeless and suffer from co-morbid issues such as substance abuse and post-traumatic stress disorder and are the most in need of veteran homeless services.

a. Please provide the Committee with detailed information regarding how current programs and initiatives address this population.

VA Response: The Department of Veterans Affairs (VA) is committed to serving chronically homeless Veterans. VA serves chronically homeless Veterans who, as defined by McKinney-Vento Act, have been continuously homeless for a year or more or who have experienced 4 or more episodes of homelessness in the past 3 years. VA focused on chronically homeless Veterans through the Housing and Urban Development – VA Supportive Housing (HUD–VASH) Program. HUD–VASH is an evidence-based intervention with a proven ability to get the most chronically homeless Veterans off the street, and into stable housing with wraparound treatment services to help maintain housing and improve their quality of life. With the adoption of Housing First principles, discussed more thoroughly below, and the provision of ongoing case management services, this program has not only housed some of our most chronically homeless Veterans, but it has been able to maintain them in recovery, addressing many of the issues that contributed to them becoming homeless.

Since the first expansion of the HUD–VASH Program in fiscal year (FY) 2008, VA has recognized the need to prioritize chronically homeless Veterans. HUD–VASH Program leadership regularly communicates with program field staff about best practices for aiding chronically homeless Veterans. VA has partnered with the "100,000 Homes" Campaign and other community-based organizations to identify and engage chronically homeless Veterans in HUD–VASH. HUD–VASH Program leadership has provided objective screening and assessment tools to help program field staff determine chronic homelessness and vulnerability characteristics. VA's focus on targeting the chronically homeless was further formalized in the HUD–VASH Program Handbook. VA has also emphasized its commitment to targeting the chronically homeless by installing a performance measure in FY 2013 that requires a minimum threshold of 65 percent of Veterans enrolled in HUD–VASH in FY 2013 to be chronically homeless. In the first 2 quarters of FY 2013, 65 percent of the admissions to HUD–VASH were chronically homeless Veterans. However, based on VA's experience in the field, HUD–VASH also admits Veterans who, while having a clear history of long-term chronic homelessness do not technically meet the definition of "chronically homeless" at the time of the assessment. This is usually due to incarceration, or other long-term institutional placement. Although not represented in VA's data as "chronically homeless," VA continues to serve these vulnerable Veterans who have many of the same characteristics as the chronically homeless population.

Beyond the performance measure referenced above, the HUD–VASH Program has also embraced a Housing First philosophy and model. Housing First is a form of permanent supportive housing that centers on providing homeless individuals rapid access to permanent housing and then wrapping treatment and other support services around the individual to help him/her maintain permanent housing and improve his/her quality of life. What differentiates a Housing First approach from other strategies, such as housing ready or treatment first approaches, is that within Housing First, there is an immediate and primary focus on helping homeless individuals rapidly access and sustain permanent housing. The adoption of Housing First signifies VA's heightened commitment to ensuring that Veterans who have experienced chronic homelessness are the priority for HUD–VASH services, and that they receive the intensive long-term case management supports they need to both obtain and sustain permanent housing. Preliminary data from the Housing First Initiative, a demonstration sponsored by the VA National Center on Homelessness among Veterans in 14 high priority cities, shows a 93 percent focus on chronically homeless Veterans. Within these 14 high priority cities, the Housing First model is rapidly assisting chronically homeless Veterans transition from the streets to a home and then supporting them with services that assist with health care and other commu-

nity reintegration supports. The Housing First model is being fully implemented across VA in support of the goal of ending Veteran homelessness in 2015.

In addition to HUD–VASH, VA has also implemented Homeless Patient Aligned Care Teams (H–PACT), comprising a 32-site demonstration project. H–PACTs provide comprehensive, wrap-around primary care coupled with homeless programming to help Veterans make the transition out of homelessness and to help keep them housed. Beginning in January 2012, the H–PACT initiative created a structure that formally links health care to housing status, providing a vehicle for the case management and longitudinal care necessary for the Housing First model to succeed. During the first 9 months of program operations, Veterans enrolled in H–PACTs had over 8,160 primary care visits, 4,100 specialty care appointments, and 90 percent of the H–PACT Veterans were actively receiving homeless program supports. At H–PACT sites, VA observed a 66 percent reduction in emergency department use as compared with care received prior to enrolling in H–PACT. VA plans to expand the use of H–PACT in FY 2013, with H–PACTs representing a part of the larger VA effort to implement system-wide services focused on rapid access to health care and permanent housing.

b. Have these programs and initiatives been effective in terms of this population, and has the VA seen a decrease in the numbers of this homeless population as a result of these programs and initiatives?

VA Response: VA has had considerable success in reducing the number of homeless Veterans. Volume I of the 2012 Annual Homeless Assessment Report, which reports the Point-In-Time (PIT) estimates of homelessness, indicates that on a single night in January 2012, 62,619 Veterans were homeless in the United States; 56 percent were living in emergency shelters or transitional housing, while the remaining were living in an unsheltered location. The 2012 PIT estimate is a more than 7 percent decline from 2011 and a 17 percent decline from 2009. Furthermore, VA continues to have success in placing homeless Veterans in permanent housing. For example, in FY 2011, VA successfully housed 26,238 unique Veterans in permanent housing. By FY 2012, this number continued to grow, VA housed another 31,493 unique Veterans in permanent housing, a substantial increase over VA's efforts the previous fiscal year. Similarly, in FY 2011, VA successfully housed 4,454 unique chronically homeless Veterans in permanent housing. That number more than doubled in FY 2012, when VA housed another 9,316 unique chronically homeless Veterans housed in permanent housing. These permanent housing numbers are evidence that VA, and in particular HUD–VASH, has been effective in reducing chronic homelessness. For example, based on VA's experience in the field, many local HUD–VASH sites, including New York City, are reporting significant decreases in Veterans who meet the chronically homeless criteria. Many HUD–VASH sites are reporting difficulties in locating VA-health-care-eligible Veterans who meet the Federal definition of "chronically homeless," indicating a significant decrease in this population. Furthermore, VA continues to target chronically homeless Veterans throughout all of VA homeless programs. For example, in FY 2011, 21,175 Veterans throughout VA homeless programs were assessed as chronically homeless in the Homeless Operations Management and Evaluation System. In FY 2012, the number of unique Veterans assessed as chronically homeless rose to 31,331.

Question 10: In your FY 2014 budget submission you have proposed new savings of $482 million dollars in your medical care accounts, $370 million from new acquisition savings and $112 million from improved operations.

a. Please provide the Committee with detailed explanations regarding these proposed savings, including details on how they will be achieved and how VA will determine whether these proposals have been successful.

VA Response: Specific acquisition savings initiatives, estimated at a total of $370 million in FY 2014, include:

- Sourcing of Generic Pharmaceuticals - VA Acquisition Regulations require the use of Federal Supply Schedule (FSS) contracts before VA makes open market purchases. The intent of this requirement was to ensure that VA pays the lowest price possible for goods and services. In practice, however, the rule has had the opposite effect, with many generic drugs available through direct contracts at prices well below FSS prices. By exempting pharmaceuticals from this requirement, VA will use spot contracts for purchasing generic pharmaceuticals to take advantage of periodic price reductions.
- Reverse Auctions - The Government Accountability Office (GAO) has approved the use of reverse auctions to increase efficiency and enhance competition. By

increasing the use of reverse auction tools, VA will drive increased price competition into commodities and standard service contracts.
- Pharmacy Prime Vendor Discounts - VA has negotiated a new 5-year contract that includes higher discounts than the previous contract.
- Increased use of Medical Surgical Prime Vendor - Increased use of this procurement method will generate rebates from the distributor, reducing VA cost for these items.
- Strategic Sourcing - Establishment of national contracts will introduce improved pricing associated with volume discounts.
- Medical Sharing Agreements - Increased negotiation of Sharing Agreement contracts under VA's 38 U.S.C. § 8153 authority will result in reduced prices for medical services and support contracts.

Specific improved operations savings initiatives, estimated at a total of $112 million in FY 2014, include:

- Employee Travel Reduction (-$50 million) - In support of the President's Campaign to Cut Waste, Veterans Health Administration (VHA) employee travel will be capped in 2014 at the budgeted level for 2013.
- Patient-Centered Community Care (-$13 million) - Patient-Centered Community Care will provide centrally supported health care contracts throughout VHA for purchasing Non-VA Medical Care. Savings will be achieved by standardizing Non-VA Care processes and rates through contractual agreements, replacing more costly individual authorizations for purchasing health care services from non-VA sources.
- Corporate Office Reduction (-$24 million) - VA's medical program offices located at the VA Central Office in Washington, DC, will have their annual recurring budgets, compared to 2013 levels, reduced in 2014 to achieve these savings.
- New VISN Structure (-$25 million) - VA's 21 Veteran Integrated Service Networks (VISN) are being reorganized around a standard staffing structure for each VISN. Each VISN Director has authority to customize a portion of the new VISN structure, but the majority of the staffing will be standard for each VISN. Total VISN staffing will be reduced through this initiative by realigning current staff to fill other vacancies within VA.

b. VA's current estimates for it FY 2013 budget include $200 million in savings, $150 million from "Acquisition Proposals" and $50 million from "Travel Campaign to Cut Waste." Have these savings been realized?

VA Response: These savings were removed prospectively from the FY 2013 budget and VHA operated within the reduced budget.

c. In terms of savings related to "Acquisition Proposals" you attribute $150 million in FY 2013, and $370 million respectively in FY 2014 and FY 2015. Please provide detailed information regarding how the VA will realize $890 million in savings over these three fiscal years. Once these savings have been realized for a specific fiscal year, should future savings not realized by additional efforts and initiatives be reflected in the VA's base budget and not listed as an additional saving?

VA Response:

Medical Sharing Agreements

VA has taken steps over the last year to improve the business relationship with its affiliate partners through collaborative meetings and has launched a strategic plan to formulate partnerships with stakeholders and the academic community. The Medical Sharing/Affiliate Office (MSO) developed a basic and advance training course for healthcare procurements. These courses have a defined curriculum to enhance and increase the competencies of contracting officials by understanding the complex clinical organization of medical schools and their reimbursement models.

Significant progress has been made in improving and establishing formalized professional negotiation teams for high dollar procurements. The MSO has direct oversight of these teams to ensure standardized methodologies are consistent with regulation and agency policy. Steps were included in the procurement to maximize the use of longer term contracts to allow VA to take advantage of its buying power while at the time meeting its strong commitment to the resident education mission defined by statutory authority.

Reverse Auctions

This cost saving program allows VA buyers to compete commodity requirements in an online reverse auction marketplace where multiple sellers compete by lowering their prices through online bidding. VA will utilize reverse auctions to in-

crease efficiency, enhance competition, and realize savings on commodity supply and service acquisitions. VA policy that governs first consideration and use of reverse auctions for all commodity procurements has already been implemented.

VA reverse auction utilization and savings reporting metrics are in place and reviewed on a weekly basis. Day-to-day program support is provided through the reverse auction program office. VA training courseware has been developed and is delivered to all VA acquisition professionals through scheduled online and onsite training sessions. The VA reverse auction training program which incorporates VA policy and procedures, and provides supplemental job aids, has already been conducted for over 2,500 VHA acquisition professionals.

Increased Use of Medical/Surgical Prime Vendor

It is necessary for VHA to maximize the value of Medical/Surgical Prime Vendor (MSPV) contracts. To this end, the MSPV will receive considerable focus to ensure that VA medical centers are appropriately leveraging this vehicle. The maximization of MSPV will improve the quality (e.g. accuracy and compliance) of hospital supply acquisitions and will improve logistics/supply chain operations.

Strategies to enhance use of this contracting strategy include reviewing and redefining business processes, defining inventory management processes to fully support supply chain operations and developing a continuous improvement methodology to incorporate industry best practices.

Strategic Sourcing

Strategic sourcing will advance standardization of major health care services, technology, and supplies. This will occur through a partnership between VHA Chief Business Office, VHA Healthcare Technology Management, VHA Logistics and the VA Strategic Acquisition Center and will focus on the following activities:

- Sourcing of Non-VA Care: VHA will award a national contract to introduce standard pricing, quality and information sharing. A Request for Proposals was issued in December, 2012, with industry submitting proposals in March 2013 and VHA evaluation occurring in March and April.
- Standardization of High Cost High Tech Medical Equipment: VHA will award national or regional contracts for the acquisition of surgery, telemetry and imaging technologies. Multiple procurement packages to improve pricing associated with volume discounts are underway.
- Standardization of hospital supply and improved supply chain management: VHA will maximize use of the MSPV contract as described above.

d. Please explain the $257 million dollars of clinical and pharmaceutical savings that are embedded in the actuarial model used to project VA health care requirements.

VHA Response: VA is continually striving to improve the quality and efficiency of the VA health care system. The VA Enrollee Health Care Projection Model includes assumptions that VA's level of health care management will continue to improve over the 20-year projection period. Future improvements will result from a wide range of activities that collectively improve VA's level of management in medical and pharmacy services, including:

- Improved coordination of care from activities that result in reductions in hospitalizations for ambulatory care sensitive conditions (i.e., Patient Aligned Care Team (PACT), home Telehealth expansion, and improved disease management);
- A focus on creating alternative services, such as intensive outpatient mental health programs, support services, and alternative locations of care; and
- VHA's inpatient systems redesign initiatives, including admission appropriateness and continued stay reviews.

Question 11: In your budget submission you estimate that VA will spend $258 million in 2014 on new models of care such as the patient centered medical home model. Over the last four years VA has put the structure in place to bring the initiatives to fruition. Some of the outcomes VA would like to achieve in the next 7 to 10 years include improved patient satisfaction, access, and efficiency.

a. What is the strategic plan VA has in place to assess the outcomes of this major initiative that, by your own admission, will take close to a decade to achieve?

VA Response: An integral part of the New Models of Care Initiative has been an ongoing evaluation. From the outset, a team of analysts in the VHA Office of Analytics and Business Intelligence, Office of Informatics and Analytics (OIA) has worked closely with the Offices of Primary Care and Primary Care Operations to construct a comprehensive database related to this initiative, concentrating on the

largest component, Patient-Aligned Care Teams (PACT). This database is housed within VA's Corporate Data Warehouse and contains extensive information on all patients who are enrolled in primary care. To date, this evaluation has yielded a broad-range of highly relevant results including clinical outcomes, patient experience (satisfaction), access, continuity, coordination, team function, provider attitudes.

To accurately assess satisfaction, VA revised its ongoing Survey of Health Experiences of Patients (SHEP) to include a module that was recently developed by the National Center for Quality Assurance (NCQA) to assess Patient-Centered Medical Homes. To measure access, the evaluation team has gathered information not only about availability of face-to-face appointments but also access by telephone, telehealth and secure messaging. In terms of efficiency, a team of health economists has performed a detailed analysis to estimate the return-on-investment (ROI) of the PACT and overall New Models of Care initiatives. This analysis has provided estimates of ROI during the first two years of these initiatives as well as projections through 2019. Results of these analyses have been reported on a quarterly basis to the PACT steering committee and regularly to the VHA Office of the Undersecretary for Health.

In addition to the national evaluation, VA has created five PACT Demonstration Laboratories that have conducted detailed local assessments of various aspects of PACT. The Demonstration Labs work with local clinical leadership and primary care teams to monitor and evaluate PACT implementation and are actively engaged in collection of qualitative and quantitative evaluation data from VA staff and administrative data sources.

Examples of the assessments that have recently been completed include: formative and outcomes evaluations of PACT implementation, including training opportunities, team development and organizational process; staff, patient and caregiver experiences of PACT; assessment of PACT implementation at academic medical centers and rural CBOCs; and dual use of VA and non-VA services. Arguably, the prospective evaluation of the New Models of Care Initiative that has been undertaken by VA is more extensive and ambitious than that for any new delivery system implemented by a health care system.

b. The budget also references improving access by adopting various eHealth technologies. Can you provide some examples of what those might be and is the cost for those various technologies part of the $258 million?

VA Response: Under the New Models of Care Transformation Initiative in VA, $65.2 million is budgeted to sustain and further develop telehealth. This includes the following areas of telehealth:

- Home Telehealth
- Clinical Video Telehealth between VA Medical Centers and CBOCs
- Telemental Health
- Teleaudiology
- Teledermatology
- Teleretinal Imaging
- Telepathology

Question 12: Providing effective, timely, and quality mental health care is a challenge that faces not just the VA but the nation as a whole. We know that provider shortages, nationally, affect VA's ability in some areas to provide timely mental health care. I think we can all agree that VA cannot do it alone. VA projects to spend $7 billion dollars on mental health programs in fiscal year 2014.

a. Please provide the Committee with information regarding VA's efforts to work with other Federal agencies, States, and communities to address this issue in a strategic way nationally.

VA Response: Facilities and VISNs have held long-standing agreements with community agencies to improve access to care in areas with shortages. For example, in Montana, part or all of 54 of the state's 56 counties are designated mental health care shortage areas per the Department of Health and Human Services regulations. Montana has the second-highest Veteran per capita population. The availability of mental health providers, a geographically large area, and population dispersion are factors that pose challenges for Montana's Veterans in need of mental health services.

VA mental health care in Montana is based on a wide ranging strategy to build ways to provide care and enhance engagement with the public agencies in the state.

Montana is divided into four regions for non-VA community mental health services: the Eastern Montana Community Mental Health Centers (EMCMHC), the

South Central Regional Mental Health Centers (SCRMHC), the Centers for Mental Health (CMH), and the Western Montana Mental Health Centers (WMMHC). Each region consists of a regional mental health center and several satellite offices.

VA Montana Health Care System contracted with SCRMHS in 2001 to provide mental health care to Veterans at their various satellites/clinics. In 2003, VAMTHS contracted with WMMHC and CMH for mental health services, and the EMCMHC clinical sites were sub-contracted under the SCRMHC contract.

Under these contracts, Veterans are seen by mental health providers at 45 sites including 11 EMCMHS sites, 11 CMH sites, 8 SCRMH sites, and 14 WMMHC sites. Patients access contract care through the Ft. Harrison VA Medical Center Access to Care Unit. If the patient has not been seen within 24 hours by a VA mental health professional, a telephone assessment will be conducted within 24 hours. An assigned provider completes the telephone assessment and a written note is sent to Access to Care Unit clinicians, who then set up a referral to an appropriate contract provider nearest to the patient. The choice of contract provider depends on the type of clinical services required.

At a national level, VA is using the experience of facilities like Montana to develop a national model. In response to the Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," from August 31, 2012, VA is working with the Department of Health and Human Services (HHS) to establish pilot projects whereby VA contracts or develops formal arrangements with community based providers, such as community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of Veterans in a timely way. HHS has been consulted and is providing information on a list of HHS certified community healthcare providers. HHS has also provided informational points of contact.

VA has established initial pilot projects through formal arrangements with 15 community-based mental health and substance abuse providers across 7 states and 4 VISNs. VA expects to add additional pilots in the future. The current 15 pilots have been established across Georgia, Tennessee, Wisconsin, Mississippi, South Dakota, Nebraska, and Iowa. By the end of May, the program expects to expand to include additional partnerships in the Pacific Northwest, Coastal Texas, and Indiana, as well as additional counties in Mississippi, and Georgia. Pilot programs are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. VA has developed interagency agreements with the Indian Health Service (IHS) to allow Veterans to use IHS facilities, and VA is exploring other forms of partnership, as well including the recruitment and sharing of providers with community agencies.

Question 13: It is estimated that medical inflation is currently running at an annual rate of 3.7 percent. This would seem to indicate, looking ahead, an approximate $2 billion increase for medical care accounts for 2015, $1 billion more than VA have requested.

a. Is VA assuming a drastically lower rate of medical inflation or are there programmatic changes that you expect to undertake in order to provide the same level of medical care in 2015 that you are providing today?

VA Response: VA's Enrollee Health Care Projection Model (EHCPM) assumes inflation trends of 2.3 perent in FY 2013; 2.6 percent in FY 2014; and 2.3 percent in FY 2015. These inflation trends reflect the following assumptions:

1) Reflects the Civilian Wage Policy iassumption of 1 percent in Calendar Year (CY) 2014. For purposes of the FY 2015 advance appropriations request, VA also assumes 1 percent in CY 2015;

2) Non-Personnel inflation (excluding pharmacy and prosthetics) is estimated using Medicare market basket inflation trends weighted by VA obligations; and

3) Excludes non-modeled services: State nursing home, domiciliary programs, readjustment counseling, foreign medical, and spina bifida.

Reference page 1A–6 of Department of Veterans Affairs, Volume II, Medical Programs & Information Technology Programs, Congressional Submission, FY 2014 Funding and FY 2015 Advance Appropriations Request:

VA's budget development process under the Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111–81) requires VA to submit its medical care budget for 2 years in each budget submission. This allows the Administration to review the initial advance appropriations request during the development of the next budget. As part of this process, VA produces budget estimates for more than 85 per-

cent of its medical program using a sophisticated actuarial model that estimates the health care services requirements for enrolled Veterans. Each year, VA updates the model estimates to incorporate the most recent data on health care utilization rates, actual program experience, and other factors, such as economic trends in unemployment and inflation.

By updating the model's inputs and revisiting the assumptions that underlie the actuarial projections each year, VA is able to produce budget estimates that more accurately reflect the projected medical demands of enrolled Veterans.

VA's approach to advance appropriations for Medical Care is to provide essential funding to ensure continuity of health care services for Veterans in the event of budget delays. In 2014, funding shown for initiatives reflects the total estimated costs of these programs. The 2015 advance appropriations request will be revisited during the 2015 budget process. At that time, any necessary adjustments will be made based on updated data and workload requirements.

Questions Submitted by Congresswoman Corrine Brown

Question 2: In the fall of 2012, Congress passed HR 1627, which became P.L. 112–154. Section 111 of the law directed the VA to develop a plan for recovery and collection of amounts for Department of Veterans Affairs Medical Care Collections Fund. Congress approved this language so that the VA would develop and implement a better process and system of controls to ensure accurate and full collections by the VA health care system.

a. Please provide details on the plan and the VA's efforts to implement its provisions.

VA Response: P.L. 112–154, Section 111 requires VA to develop and implement a plan no later than 270 days after the date of enactment to ensure recovery and collection from Veterans' health insurance for medical care and services provided through VA's Fee Basis authorities. VA has completed all actions associated with the requirements of Section 111 as described below:

- **Improved identification of billable fee claims:** The VHA Chief Business Office chartered a workgroup to re-engineer business processes that support maximizing the cost recovery of billable fee services. The team developed and implemented new Standard Operating Procedures for billing and pre-certification processes of applicable fee claims.
- **Training:** Training on the identification of billable fee claims has been provided to applicable fee and revenue operations staff within a number of different functional areas. Staff received both written guidebooks and fact sheets to help them improve the identification of billable fee opportunities.
- **Fee Revenue Goals:** Beginning in FY 2012, VHA established station-level third party collection goals for fee care utilizing an Integrated Collections Forecasting Model.
- **Monitors:** To better track fee performance related to collections, VHA deployed four new performance metrics to be monitored beginning in FY 2012. These metrics are monitored on a monthly basis.

Policies and Procedures for Medical Care Collections Fund (MCCF) Recovery: Deployment of seven industry best Consolidated Patient Account Centers (CPACs) is the cornerstone of ensuring long term success in MCCF Recovery. These CPACs, which were fully deployed in FY 2012, operate based on standardized processes and procedures utilizing intensive employee training to ensure maximum accountability.

Question 3: The issue of third party payers and the Veterans Health Administration's Medical Care Collections Fund has been the subject of a number of government reports over the years. To help better understand this issue, please provide the following data:

a. Total amount the VA sought in third party billings for each of the past 6 years.

VA Response:

Fiscal Year	Total Third Party Billings
2007	$3,325,052,175
2008	$4,107,259,321
2009	$5,290,964,587
2010	$5,490,122,279
2011	$5,775,314,495
2012	$5,556,546,698

b. The percentage increase in billings for each year compared to the previous year's billing.

VA Response:

Fiscal Year	Total Third Party Billings	Percent (%) Change from Prior Fiscal Year
2007	$3,325,052,175	-
2008	$4,107,259,321	23.52%
2009	$5,290,964,587	28.82%
2010	$5,490,122,279	3.76%
2011	$5,775,314,495	5.19%
2012	$5,556,546,698	-3.79%

c. The percentage of collections for each year for the past 6 years.

VA Response:

Fiscal Year	Percent of Total Collections
2007	46.9%
2008	43.7%
2009	41.1%
2010	39.3%
2011	35.7%
2012	36.2%

d. The collection rate for claims over $1500 for each of the past 6 years.

VA Response:

Fiscal Year	Collection rate for Claims over $1500
2007	46.3%
2008	43.1%
2009	40.6%
2010	38.8%
2011	35.2%
2012	36.0%

e. The collection rate for claims under $1500 for each of the past 6 years.

VA Response:

Fiscal Year	Collection rate for Claims under $1500
2007	47.8%
2008	44.6%
2009	41.9%
2010	40.1%
2011	36.3%
2012	36.4%

Questions Submitted by Congresswoman Negrete McLeod

Question 1: Homelessness among veterans is a serious problem in my district in California. How many housing vouchers through the HUD–VASH program do you anticipate will be funded by your requested amount of $278 million?

VA Response: The HUD–VASH Program has been funded by Congress through special appropriations for this program. Congress has provided funding to the Department of Housing and Urban Development (HUD) to provide section 8 Housing Choice Vouchers and provided funding to VA for supportive wrap around case management services to the Veterans housed in HUD–VASH units. VA does not provide HUD–VASH vouchers; rather, VA solely provides the necessary case management services associated with these vouchers.

VA has requested $278 million to cover the cost of all HUD–VASH Program staff in FY 2014. VA's specific purpose funding request will be used to hire multidisciplinary case management teams to provide the supportive wrap-around case-management and other services necessary to assist these homeless Veterans in searching for appropriate permanent housing, connecting to treatment and other supportive services, and achieving and maintaining stability in their recovery. Increased funding in each fiscal year is used to sustain existing staff and hire new program staff. To further expand the HUD–VASH Program, HUD is requesting an additional $75 million to fund approximately 10,000 vouchers in FY 2014. VA's budget request of $278 million will provide services to Veterans utilizing these additional 10,000 along with all previously appropriated HUD–VASH vouchers; VA expects there will be a total of approximately 68,000 HUD–VASH vouchers in FY 2014. Presently, HUD has 48,335 vouchers allocated to Public Housing Authorities to administer the vouchers. Although HUD is still finalizing the FY 2013 allocation of HUD–VASH vouchers, HUD's FY 2013 appropriation will bring the total to approximately 58,335 vouchers by the end of FY 2013.

VA recognizes that the State of California continues to have the highest percentage of homeless Veterans in the nation, and in the past, vouchers have been disbursed accordingly. In FY 2008 through FY 2012, California received almost 17 percent of the allocated HUD–VASH vouchers for the entire country. This is the largest percentage of vouchers allocated to any one state. The VA Greater Los Angeles (GLA) Health Care System was allocated 3,320 vouchers in FY 2008 through FY 2012, to be used for the homeless Veteran population in Los Angeles and adjoining communities. In FY 2012 alone, 950 HUD–VASH vouchers were allocated for GLA. The Loma Linda VA Medical Center (VAMC), which includes the San Bernardino area, received 440 vouchers from FY 2008 through FY 2012; in FY 2012 alone, Loma Linda VAMC received 175 vouchers. Vouchers in FY 2013 will be allocated based on relative need. Presently, HUD is working on finalizing the voucher allocations and expects that notification for the FY 2013 HUD–VASH vouchers will occur in late May or early June 2013.

Question 2: In order to receive payment from VA, mental health providers are often required to have a COAMFTE certification. This is not available in most California universities, resulting in 95% of licensed therapists not qualifying to receive payment. These therapists are 100% qualified to treat Veterans. What can VA do to work with California therapists to ensure access to mental health care despite this bureaucratic barrier?

VA Response: The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) certification requirement is a hiring requirement only for the occupational series of Licensed Marriage and Family Therapists (LMFT). While VA is increasing the number of LMFTs hired, this profession currently represents a small minority of VA mental health professionals. The requirement is important as it allows VA to be assured of the quality of the educational program at the university, as attested to by subject matter experts within the LMFT community. This type of educational requirement is found in all VA occupational series to ensure that VA is hiring only the most qualified healthcare professionals to provide care to Veterans within VA.

Question 3: As you mentioned in your testimony, the number of women Veterans enrolled in VA healthcare has increased by 22% since 2009. What is VA's timeline for increasing the number of facilities that have comprehensive women's clinics beyond the current 50%?

VA Response: In the past 5 years, VA has enhanced provision of care to women Veterans by focusing on the goal of developing Designated Women's Health Providers (DWHP) at every site where women access VA. By April 30, 2013, VA had trained over 1,500 women's health providers, and by the end of FY 2012, VA had at least one DWHP at all of VA's Healthcare Systems. In addition, 84 percent of community-based outpatient clinics (CBOC) had a DWHP in place. VA is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a DWHP.

For each site of care, the local community of Veterans must have input into how care will be delivered. We have found that for some women Veterans, separate clinic space is very important, however, for other women such clinics are seen as not ideal because they are being isolated from other Veterans. In accordance with VHA Handbook 1330.01, "Health Care Services for Women Veterans," (2010) a VHA facility may choose one or more of the following Comprehensive Primary Care Clinic Models to best meet the needs of women Veterans and to achieve the standards for Comprehensive Primary Care for Women Veterans:

"a. **Model 1. General Primary Care Clinics.** Comprehensive primary care for the women Veteran is delivered by a designated Women's Health Primary Care Provider (WH PCP) who is interested and proficient in women's health. Women Veterans are incorporated into the WH PCP panel and seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the general gender-neutral Primary Care Clinic in accordance with the Primary Care-Mental Health Integration. Efficient referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance (less than 50 miles).

b. **Model 2. Separate but Shared Space.** Comprehensive primary care services for women Veterans are offered by designated WH PCP(s) in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.

c. **Model 3. Women's Health Center.** VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

(1) WHC offers comprehensive primary care services by a designated WH PCP(s) in an exclusive separate space. Whenever possible, a WHC needs to have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity and physical comfort.

(2) Specialty gynecological care, mental health and social work services *must* be co-located in this space.

(3) Other sub-specialty services such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., may also be provided in the same physical location.

(4) Women Veterans receiving comprehensive primary care through general primary care clinics in sites with WHC need to be referred to the WHC for gynecological care, mental health treatment, and other sub-specialty care."

To summarize, Model 3 clinics are Comprehensive Women's Centers that have dedicated separate space, Model 2 are women's clinics that also have a separate space, but the space may be shared with other services when the women's clinic is not in session. Model 1 clinics provide women's health primary care in integrated settings. All three models should have DWHPs and can be available at either medical centers or CBOCs. Accordingly, all Model 2 and Model 3 are defined as "women's clinics."

Number of Women's Clinics

Within VA's 140 Healthcare Systems, 150 Medical Centers and 795 CBOCs provide Primary Care Services for Women Veterans. According to the FY 2012 Women's Assessment Tool for Comprehensive Health survey, VHA reported:

Total Model 1 = 783 clinics
Total Model 2 = 101 clinics
Total Model 3 = 79 clinics

Post-Hearing Questions From HVAC Minority and VA Responses

Ranking Member Michaud

4. Continued investment in technology is a big component of VA's strategy to expand access to benefits and services, eliminate the claims backlog, and end veteran homelessness, the top three priorities of the VA. You have requested nearly an 11 percent increase.

a. Can you point to specific programs and initiatives that support your top three priorities that you will be able to undertake with this increase?

VA Response: VA's information technology (IT) development budget includes significant investments in meeting the agency's priority goals of expanding access to benefits and services, eliminating the claims backlog, and ending Veteran homelessness, including:

- $150 million to support elimination of the backlog (Veterans Benefits Management. System, Veterans Relationship Management, legacy systems)
- $250 million to support integrated Electronic Health Record development.
- Expanded healthcare, benefits and services for our Nation's Veterans.
  - New Models of Care and Healthcare Access = $36.2 million.
  - Veterans Relationship Management = $120.1 million.
  - Virtual Lifetime Electronic Record = $11.3 million.
  - Affordable Care Act = $3.4 million.
- Continued work on Virtual Lifetime Electronic Record.
- Finishing our work on the other Transformational Initiatives such as GI Bill automation enhancements.
- Improving efficiency and effectiveness of operations and maintenance of existing systems and infrastructure.
- International Statistical Classification of Diseases and Related Health Problems, revision 10 (ICD–10).

The increase in VA's IT budget also supports sustainment of ongoing efforts to meet its priority goals. Some of these IT sustainment costs include:

- Providing the IT equipment and solutions needed for new users given the full time equivalent (FTE) growth throughout the Department;
- As new applications supporting agency goals are added to the infrastructure, they must be supported and maintained;
- New facilities have been activated; once activated, those facilities require continued IT dollars to sustain the equipment suite;
- Telecom cost increases driven by telework, telehealth, telemedicine applications; and
- Increases in telecom use generally by the VA user community.

b. Please provide the Committee with any strategic plan that is in place that directly correlates your IT systems and software with your three stated priorities, including proposed lifespan of these systems and software and identified necessary investments in the next five fiscal years.

VA Response: As part of VA strategic planning process, VA is working on a revised strategic plan, which includes IT. VA will provide the completed plan to the committee upon publication.

5. A large component of your IT budget, $2.2 billion, is for "sustainment." This includes spending on legacy systems.

a. Do you have a long-term strategy to reduce your expenditures on legacy systems? What are the short and medium term steps in this plan?

VA Response: VA is committed to ensuring that it gets the best possible return on its IT investment for Veterans and taxpayers. VA has aggressively addressed rising sustainment costs in order to ensure every IT dollar at VA is well spent.

VA has been working to develop and pursue approaches to reducing spending on IT systems, services, and processes that may be inefficient, redundant, or overpriced, specifically through its Ruthless Reduction Task Force. These efforts are focused on both new and legacy systems. VA is continuously soliciting ideas and recommendations, following up with research and analysis, and initiating reduction projects as warranted. Each approved project will be assigned a budget, a project manager or managers, target dates, and cost avoidance targets.

VA has identified many areas where potential savings may exist, including data consolidation (with no impact to patient care) and data reuse, retiring expensive legacy systems, and reducing duplicative system processes. Not only will these efforts allow VA to better spend critical IT dollars, they should introduce better business value by increasing system response times. Other sustainment divestment plans include consolidating data warehouses, controlling the number of mobile devices assigned, moving to multifunction printing devices instead of desktop printers, and eliminating dedicated fax lines.

b. Is VA's spending on legacy systems in line with other Federal agencies and the private sector?

VA Response: The private sector and public sector are very different in terms of financial management, budgeting, and financial tracking. While the private sector is concerned with revenue and expenditures, public sector leaders focus on appropriations and obligations, making it difficult to match performance to expenditure. The lack of information technology cost data makes it difficult to compare legacy IT costs to the private sector.

However, this is why VA instituted the Project Management Accountability System (PMAS). PMAS allows VA to focus its resources in a way that can be accurately and objectively measured (time and functionality) versus those that cannot (cost and progress). Today, VA has 256 active development projects, tracked in real-time through a dashboard. PMAS principles enforce fiscal discipline by limiting software deliveries to six months or less, detecting and stopping wasteful programs early in their lifecycle. Since PMAS was required for all IT projects in 2010, VA has delivered 83 percent of projects on time, and a total of 98 percent of all IT projects ultimately deliver on their requirements, compared to the industry rate of approximately 42 percent.

6. Your information technology budget for FY 2014 projects $252 million, or 51 percent of the development budget request of $495 million, to fund the Interagency Program Office (IPO), which will manage the integrated Electronic Health Record (iEHR) and the Virtual Lifetime Electronic Record (VLER). Given the problems with the management of the IPO that were examined in a recent hearing, what sub-

stantive changes have been made to the structure of the IPO that will improve its performance and what are the measurable outcomes you expect to achieve with this $252 million dollar expenditure?

VA Response: VA's $252 million request is for iEHR. VA is working with DoD and the IPO to implement the spending and project management approaches at the IPO that we have at the VA. This includes managing iEHR deliverables under the VA's Project Management Accountability System (PMAS), including the key PMAS principles of incremental delivery and "3 strikes" for projects. By using an incremental focus, VA delivers software and feature enhancements with direct value to the customer every six months or less. The 3 strikes rule mandates that any project missing three delivery dates will be stopped for review, after which the project will either be refactored with a new project team or canceled. Moreover, many projects are reviewed and restructured or canceled before reaching a third strike. At VA, these changes have allowed us to meet an on-time delivery rate of over 83 percent, and all projects ultimately meet their delivery requirements 98 percent of the time. We are working with the IPO to require incremental delivery for iEHR projects. VA hopes that instituting these changes at IPO will help better position IPO to meet its critical iEHR delivery dates.

Rep. Corrine Brown

1. In FY13, there was a line item for 508 compliance of $9.43 million. However, there is no line item in the FY14 budget for 508 compliance, specifically 508 compliance to IT systems. What staffing resources and line item funding will be available for FY14? Please explain.

VA Response: Previously, VA's Section 508 IT compliance efforts were divided between the "Section 508 Program Office" within the Office of Information and Technology (OIT), and the "Health 508 Office" in the Veterans Health Administration (VHA). In FY 2014, all 508 efforts will be centralized within OIT.

In FY 2014, the combined government IT staff for both offices will be 11 FTE. The FY 2014 President's Budget has $37.265 million identified for "Product Development Tools Management Competency." This line item includes funding for Product Development IT's "Product Assessment Competency Division" of which $11,871,309 is for VA's 508 program."

Funding will cover:

- Contracted resources to support the development and execution of Section 508-related training for developers, testers and non-technical staff.
- Testing support services to: (1) bring new software into compliance with Section 508 requirements, and (2) audit existing Section 508-compliant software to ensure that it remains compliant.
- Maintenance of hardware and software that is used to test IT systems for Section 508 compliance.
- Development of an enterprise-wide approach to bring all VA SharePoint repositories into compliance with Section 508 requirements.

Additional Post-Hearing Questions From HVAC Minority and VA Responses

Questions Submitted by Ranking Member Michaud

1. We have received numerous complaints that the performance and adjudication of pension claims for the veterans of Maine has gotten worse since the consolidation of pension claims at the Philadelphia VA Regional Office.

a. Please provide the Committee with the reasons for this shift from a high performing Regional Office such as Togus to Philadelphia.

VBA Response: In fiscal year (FY) 2003, the Veterans Benefits Administration (VBA) completed the consolidation of pension maintenance work to three regionally-aligned Pension Management Centers (PMCs) in Philadelphia, Pennsylvania; St. Paul, Minnesota; and Milwaukee, Wisconsin. VBA consolidated pension, dependency and indemnity compensation, and burial benefit claims at the PMCs in FY 2009. The consolidation provides greater processing efficiency and focuses attention and resources on the needs of survivors and wartime Veterans who require supplemental income.

In addition to providing dedicated resources for survivors and certain wartime Veterans, consolidation of claims at the PMCs included the development of new per-

formance measures that increased transparency and accountability and improved program oversight.

The success of consolidation can be seen in the quality of our pension claim adjudications. The accuracy rate for pension entitlement decisions improved from 87% to 96.8% from FY 2008 to the end of March 2013, while the accuracy of pension maintenance work improved from 93% to 97.6% over the same period.

b. Please provide the Committee with the average days to complete these claims at the Togus VA Regional Office for the three years prior to shifting this workload to the Philadelphia. In addition, since the shift in workload, please provide the information relating to timeliness and quality metrics of the Philadelphia VA Regional Office.

VBA Response: The chart below shows the average days to complete (ADC) for original Veterans pension claims at the Togus RO prior to consolidation in 2008.

	FY 2005	FY 2006	FY 2007
Original Pension - ADC	85.2	74.4	79.1

The chart below shows the quality and ADC for original Veterans pension claims at the Philadelphia PMC after consolidation in 2008. The ADC for pension claims increased at the Philadelphia PMC due to the increased workload following consolidation. Quality at the Philadelphia RO for pension claims has been historically high following consolidation. Quality data for FY 2008 and 2009 is unavailable.

		FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FYTD 2013 (through March 31)
Original Pension	ADC	63.4	85.1	129.0	115.1	102.1	127.2
Original Pension	Quality	-	-	93.4%	96.8%	94.6%	93.6%

The ADC for all types of compensation and pension claims has increased nationwide over this period due to the dramatic growth in the volume of incoming claims. For comparison purposes, similar increases in ADC can be seen at the Togus RO in processing compensation rating claims, as shown below:

		FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FYTD 2013 (through March 31)
Rating Workload	ADC	145.1	140.4	142.2	203.7	200.0	127.3

c. Has there been any consideration to shifting this workload back to high performing regional offices such as Togus?

VBA Response: There are no plans to decentralize the PMC workload, VBA continuously looks for ways to create additional efficiencies, such as the recent elimination of pension eligibility verification reports and improved data exchange agreements with the Internal Revenue Service and Social Security Administration.

2. It has come to the Committee's attention that the VA is planning to shift additional FTE back to some of the worst performing VA Regional Offices. Many of the worst VA Regional Offices are in high cost-of-living areas where it is difficult for VA to recruit and, most importantly, retain employees.

a. In light of VA's plan to move to an electronic processing system, where claims could be processed at any station in the country simultaneously, what are reasons for providing additional FTE to these lower-performing stations instead of moving workload to higher-performing stations?

VBA Response: The Veterans Benefits Management System (VBMS) is a web-based, electronic claims processing solution, complemented by improved business processes, that serves as the technology platform for quicker, more accurate claims processing. As of May 24, 2013, 51 regional offices (ROs) and our Appeals Management Center have fielded this capability. The remaining ROs will field VBMS by the end of June 2013. As VBMS is deployed, all new incoming claims are being established and processed using the new system, which will gradually eliminate paper processing of claims.

VBMS allows VBA to seamlessly manage and route workload throughout the nation, with no cost associated with moving and shipping paper. Although VA is moving from paper-based processing into an electronic environment, ROs are still processing pending workload previously established in our legacy systems using paper.

VBA provided additional FTE to specific lower-performing ROs to help reduce their backlog and increase production.

b. Has the VA considered reviewing where it will be able to recruit the most talented workforce and considered expanding at those locations for the best return on investment?

VBA Response: As we transition into an electronic environment, VBA will be able to assign the workload without regard to the location of the Veteran's residence. VBA will also be able to expand its telework capacity. As VBA continues to expand in a virtual environment, we will continue to evaluate how to most effectively carry out workforce recruitment.

3. In terms of meeting your stated goal of ending the claims backlog by 2015, does your FY 2014 budget provide additional resources for overtime pay? Is this a strategy you plan to utilize in the coming fiscal year?

VBA Response: VBA's FY 2014 budget request includes at least $53 million in overtime pay. VBA will continue utilizing overtime as a strategy in targeting production capacity where it is most effective. On May 15, 2013 VA announced mandatory overtime for claims processors in its 56 regional benefits offices through the end of fiscal year 2013 to help eliminate the backlog, with continued emphasis on high-priority claims for homeless Veterans and those claiming financial hardship, the terminally ill, former Prisoners of War, Medal of Honor recipients, and Veterans filing fully developed claims.

4. You have requested an increase of 13.6 percent in discretionary spending for the Veterans Benefits Administration.

a. Can you point to specific program elements and achievements that this increase supports in terms of your goal of ending the claims backlog by 2015?

VBA Response: VBA's FY 2014 budget request includes a $63.4 million increase in discretionary spending over the FY 2013 baseline of $2.16 billion to cover inflation in current services, such as pay, benefits, rent, and utilities. The remaining $228 million increase supports the following improved services to our transitioning Servicemembers and Veterans, survivors, and their families:

- The Veterans Claims Intake Program (VCIP) increase of $119 million supports VBA's Transformation Plan designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days with 98 percent accuracy in 2015. VCIP is responsible for the conversion of claims from paper to an electronic format for processing in VBMS.
- Increased resources to eBenefits/Veterans Online Application (VONAPP) of $5 million for greater capability and support for Veterans, survivors, and their families to apply for benefits directly online. There are currently 47 self-service features available via the eBenefits portal, with 2.5 million registered users as of March 31, 2013. VONAPP Direct Connect provides "Turbo Tax"-like claims submission for original and supplemental compensation claims, as well as dependency adjustments.

The remaining $104 million increase is needed to implement the VOW to Hire Heroes Act of 2011 (P.L. 112–56). This increase supports mandatory participation in the Transition Assistance Program that helps separating Servicemembers understand the benefits and services that VA offers and successfully make the transition from military to civilian life.

b. If you were provided an additional $300 million for this account, what specifically could you do with such an increase that would provide the biggest bang for the buck this year in terms of ending the claims backlog?

VBA Response: The FY 2014 budget submission invests heavily in VBA's plan to eliminate the disability claims backlog in 2015, a goal which VA is making progress toward. Given additional resources, VA would take actions that would provide positive, near-term improvement toward the claims backlog, specifically those that would increase claims production capacity. An increase in planned overtime for the processing of compensation and pension claims would provide an increase in production capacity, and VA has already reallocated resources to expand overtime for the remainder of fiscal year (FY) 2013.

VA would also use additional funding to reduce claims development time, such as the time awaiting medical exams. VBA has the authority to contract for medical exams under Public Law 108–183 and will execute an estimated 27,380 examinations at six regional offices in FY 2013 at an average cost of $785 per examination. If VBA was provided additional resources for contract medical exams, there would be near-term gains in claims production as more claims are made "ready for decision" earlier in the process. These production gains, however, are not unbounded. As more resources are added to contract medical exams, there comes a point of diminishing returns as the process flow becomes constrained by the processing capacity at each regional office.

5. Your budget estimates a 16 percent increase in mandatory spending for Compensation and Pension.

a. Please provide the Committee with information regarding the factors driving these large increases in mandatory spending?

VBA Response: The FY 2014 budget authority for the Compensation and Pension (C&P) account increased 16 percent over the FY 2013 level; however, total obligations increased 7.3 percent over the FY 2013 level. Unobligated balances of $5 billion at the end of FY 2012 reduced the FY 2013 appropriation request. The C&P account is authorized to obligate until expended. The $5 billion in carryover was previously authorized and was therefore not included in budget authority again in FY 2013.

The budget authority also reflects a request for a transfer from the Readjustments Benefits account to the C&P account to fully fund FY 2013 expected obligations. This request is consistent with the Administrative Provision Sec. 201, and when coupled with the $5 billion in previously authorized funding available for obligation in FY 2013, and $60.6 billion in appropriations, supports anticipated obligations of $66.4 billion.

The FY14 appropriation request does not anticipate an unobligated balance carried forward from FY 2013; therefore, FY 2014 budget authority equals obligations.

Obligations for the C&P account increase to $71.2 billion in FY 2014. This is a 7.3 percent increase over FY 2013 obligations of $66.4 billion. This increase in obligations is consistent with historical annual increases due to net increases in caseload, an upward trend in Veterans' average degree of disability, and cost-of-living adjustments to monthly payments. An estimated 4.2 million Veterans and survivors will receive compensation, and over 517 thousand will receive pension benefits in 2014.

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